



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 1, 2019

Michael Littman, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Littman:

On **July 24, 2019**, a Facility Fire Safety and Construction survey was conducted at **Lacrosse Health & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance.

Michael Littman, Administrator
August 1, 2019
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NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 14, 2019**. Failure to submit an acceptable PoC by **August 14, 2019**, may result in the imposition of civil monetary penalties by **September 5, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 28, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 22, 2019**. A change in the seriousness of the deficiencies on **September 7, 2019**, may result in a change in the remedy.

Michael Littman, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **August 28, 2019**, includes the following:

Denial of payment for new admissions effective **October 24, 2019**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 24, 2020**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 24, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Michael Littman, Administrator
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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

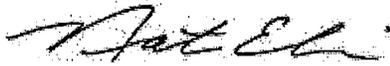
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 14, 2019**. If your request for informal dispute resolution is received after **August 14, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2019
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814.
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (111) structure, constructed in 1967. The facility is comprised of seven smoke compartments, is fully sprinklered and equipped with an interconnected fire alarm system, including smoke detection in corridors and open spaces. The 300 and 600 halls have additional smoke detection in each resident sleeping room. The facility is equipped with a ventilator unit, which was approved in November of 2011 for 24 beds. The Type 1 EPSS (Emergency Power Supply System) is supplied by a diesel powered, on-site automatic generator with 96 hours of fuel supply on hand. The facility is currently licensed for 100 SNF/NF beds and had a census of 73 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 23 - 24, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan Of Correction constitutes this facility's written allegation of compliance for the deficiencies cited.</p> <p style="text-align: center;">RECEIVED AUG 12 2019 FACILITY STANDARDS</p>	
K 291 SS=F	<p>Emergency Lighting CFR(s): NFPA 101</p> <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:</p>	K 291	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>There were no residents identified</p>	8/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Littman</i>	TITLE E.D.	(X6) DATE 8-28-2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 291	<p>Continued From page 1</p> <p>Based on record review, interview, and operational testing, the facility failed to ensure emergency lighting was operational and testing performed and documented in accordance with NFPA 101. Failure to maintain and test the emergency lighting could hinder egress of residents during an emergency. This deficient practice affected all residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of the emergency lighting test logs on July 23, 2019, from approximately 9:00 AM to 12:35 PM, records revealed a 30 second monthly test of the emergency lighting had not been performed in August 2018 or April 2019. Additionally, no documentation for a 90-minute annual test of the emergency lighting could be produced.</p> <p>2.) During the facility tour on July 24, 2019, from approximately 8:00 AM to 11:00 AM, operational testing of the emergency lighting revealed the emergency light in the medication room behind the 1-5 nurse's station was non-operational. Interview of the Maintenance Director on July 23, 2019 at approximately 11:00 AM, revealed the facility was unaware of the missing testing documentation. During the facility tour on July 24, 2019 at approximately 10:30 AM when the non-operational emergency light in the medication room behind the 1-5 nurse's station was discovered, the Maintenance Director stated the light was working when he tested it earlier in the month and the facility was unaware it was now non-operational.</p> <p>Actual NFPA standard:</p>	K 291	<p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>The 30 second monthly test of the emergency lighting has been performed as of 8/9/19 and documented results entered in TELS system.</p> <p>The 90 minute annual test of the emergency lighting system as been performed and results documented in TELS system as of 8/12/19.</p> <p>The emergency light in the medication room behind the 1-5 nurses' station is operational as of 8/12/19 and documentation entered in TELS system</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>Required audits, inspections and documented results will be presented at QAPI monthly X 12 months for verification and educational opportunities.</p> <p>Person responsible for compliance. Maintenance Director or designee.</p>	
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K 291	<p>Continued From page 2</p> <p>NFPA 101</p> <p>19.2.9 Emergency Lighting.</p> <p>19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>1.) 7.9.3 Periodic Testing of Emergency Lighting Equipment.</p> <p>7.9.3.1 Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.</p> <p>7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).</p> <p>(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1-1/2 hours if the emergency lighting system is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.2 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30</p>	K 291		
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K 291	<p>Continued From page 3</p> <p>seconds and a diagnostic routine.</p> <p>(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.</p> <p>(4) A visual inspection shall be performed at intervals not exceeding 30 days.</p> <p>(5) Functional testing shall be conducted annually for a minimum of 1-1/2 hours.</p> <p>(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1-1/2-hour test.</p> <p>(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.</p> <p>(2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.</p> <p>(3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1-1/2 hours.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3).</p> <p>(5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.</p> <p>2.) 7.9.2.1* Emergency Illumination shall be provided for a minimum of 1-1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average</p>	K 291		
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K 291	Continued From page 4 of 1 ft-candle (10.8 lux) and, at any point, not less than 0.1 ft-candle (1.1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6.5 lux) and, at any point, not less than 0.06 ft-candle (0.65 lux) at the end of 1-1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.2.6* Existing battery-operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electrical Code.	K 291		
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(a): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments	K 325	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. Residents residing at the facility have the potential to be affected by this deficient practice.	8/28/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 325	<p>Continued From page 5</p> <ul style="list-style-type: none"> * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure alcohol-based hand rub (ABHR) dispensers were maintained in accordance with NFPA 101. Failure to ensure ABHR dispensers are clear of ignition sources and tested during refilling procedures, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected all residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of provided maintenance inspection/testing records conducted on July 23, 2019, from approximately 9:00 AM to 12:35 PM, no documentation could be produced for the testing of ABHR dispensers each time they are refilled.</p> <p>2.) During the facility tour conducted on July 24, 2019, from approximately 8:00 AM - 11:00 AM, manual ABHR dispensers were observed throughout the facility. Further observation revealed an ABHR dispenser had been installed directly over a light switch in the dining room, directly outside of the kitchen door.</p> <p>On July 24, 2019 at approximately 9:30 AM when the ABHR was discovered directly over the light switch in the dining room, the Maintenance Director stated the facility was unaware of installation requirements for ABHR dispensers,</p>	K 325	<p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Policy and Procedure and education has been Provided to staff associated with the testing of ABHR dispensers each time they are refilled or replaced. P&P includes a log and audit sheet to denote verification of audit, replacement, repair and date of appropriate action.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>Required audits, inspections and documented results will be presented at QAPI monthly X 3 months for verification and educational opportunities.</p> <p>Person responsible for compliance. Housekeeping Manager or designee.</p>	
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K 325	<p>Continued From page 6 and immediately removed the ABHR dispenser from that location. He further stated the facility was unaware of the requirement for testing dispensers each time a refill is installed.</p> <p>Actual NFPA standard: NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or</p>	K 325		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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K 325	<p>Continued From page 7</p> <p>(3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p> <p>(e) The dispenser shall be designed, constructed,</p>	K 325		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2019
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 325	Continued From page 8 and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer 's care and use instructions each time a new refill is installed.	K 325		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect and maintain suppression systems has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected all	K 353	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. Residents residing at the facility have the potential to be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Documentation demonstrating the completion if a monthly wet system control valve and gauge inspection completed 8/12/2019. Documentation demonstrating completing of a quarterly water flow alarm test shall be provided by facility compliance date. Sprinkler heads in copy room, 200 hallway near exit door and hall way outside room # 103 shall be repaired or replaced by compliance date.	8/28/19

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K 353	<p>Continued From page 9 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of provided facility inspection and testing records conducted on July 23, 2019 from approximately 9:00 - 12:35 PM, the following records were not available for review:</p> <ul style="list-style-type: none"> - No documentation of monthly wet system control valve and gauge inspections. - No documentation demonstrating completion of a quarterly waterflow alarm tests for second quarter 2019. <p>2.) During the facility tour on July 24, 2019, from approximately 8:00 AM - 11:00 AM, observation of the sprinkler head in the dirty linen room appeared to be "loaded" with greasy dust and lint. Further observation revealed painted sprinkler heads in the following locations:</p> <ul style="list-style-type: none"> - Copy machine room. - 200 Hallway near exit door. - 100 Hallway outside of room #103. <p>Interview of the Maintenance Director on July 23, 2019 at approximately 11:05 AM revealed the facility was not aware of the missing documentation prior to the date of the survey. When the loaded and painted sprinkler heads were discovered during the facility tour on July 24, 2019 from approximately 8:00 AM - 11:00 AM, the Maintenance Director stated the facility was unaware of the loaded and painted sprinkler heads.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the</p>	K 353	<p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>Required audits, inspections and documented results will be presented at QAPI monthly X 3 months for verification and educational opportunities.</p> <p>Person responsible for compliance. Maintenance Director or designee.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2019
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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K 353	<p>Continued From page 10 floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer</p> <p>5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.</p> <p>Chapter 13 Valves, Valve Components, and Trim</p> <p>13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p>	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 712	<p>Continued From page 11</p> <p>Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected all residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During record review on July 23, 2019, from approximately 9:00 AM to 12:35 PM, fire drill documentation revealed the facility failed to perform the following drills: 1.) First and second shift, first quarter 2019. 2.) Second shift, second quarter 2019. 3.) All of fourth quarter 2018. Interview of the Maintenance Director on July 23, 2019, at approximately 11:10 AM, revealed the facility was aware of the missing fire drills. The Maintenance Director stated he was new to his position, and the previous Maintenance Director had failed to perform the required fire drills.</p>	K 712	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>There were no residents identified</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Documentation demonstrating completing of required fire drills, one per shift per quarter shall occur by facility compliance date.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>Required audits, inspections and documented results will be presented at QAPI monthly X 3 months for verification and educational opportunities.</p> <p>Person responsible for compliance. Maintenance Director or designee.</p>	8/28/19
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08/12/2019 11:29

PRINTED: 07/31/2019
FORM APPROVE
OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE FACILITY BUILDINGS 1 & 2 B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2019
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NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814
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K 712	Continued From page 12 Actual NFPA standard: 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected all residents and staff on the dates of the survey. Findings include: During the facility tour on July 24, 2019, from approximately 8:00 AM to 11:0 AM, a remote manual stop station for the EES generator could	K 911	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. Residents residing at the facility have the potential to be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur. Manual remote stop station shall be installed by facility outside the building to prevent inadvertent or unintentional operation by facility compliance date.	8/28/19

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K 911	Continued From page 13 not be located. When asked on July 24, 2019, at approximately 10:50 AM during the facility tour, the Maintenance Director stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 99 6.4.1.1.16.2 Safety Indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.	K 911	How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained. Required audits, inspections and documented results will be presented at QAPI monthly X 1 months for verification and educational opportunities. Person responsible for compliance. Maintenance Director or designee.	
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents identified How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. Residents residing at the facility have the potential to be affected by this deficient practice.	8/28/19

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K 918	<p>Continued From page 14</p> <p>simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected all residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>1.) During review of the facility generator inspection and testing records on July 23, 2019, from approximately 9:00 AM to 12:35 PM, the facility failed to provide weekly generator inspection logs for the following weeks: - 9/16/18 - 9/22/18; 9/23/18 - 9/29/18; 9/30/18 - 10/6/18; All of October, November & December 2018; All of January 2019; 2/3/19 - 2/9/18;</p>	K 918	<p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Weekly generator inspections have begun with documented findings logged and entered in TELS system. Monthly generator load tests have begun with Documented findings logged and entered in TELS System.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained.</p> <p>Required audits, inspections and documented results will be presented at QAPI monthly X 3 months for verification and educational opportunities.</p> <p>Person responsible for compliance. Maintenance Director or designee.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 918	<p>Continued From page 15</p> <p>2/10/19 - 2/18/19; 2/17/19 - 2/23/19; 2/24/19 - 3/2/19; 3/10/19 - 3/16/19; 3/17/19 - 3/23/19; 3/24/19 - 3/30/19; All of April 2019; 5/26/19 - 6/1/19; 6/23/19 - 6/29/19.</p> <p>2.) During review of the facility generator inspection and testing records on July 23, 2019, from approximately 9:00 AM to 12:35 PM, the facility failed to provide monthly load tests for the months of September, October, November and December 2018; January 2019; and April 2019.</p> <p>When asked on July 23, 2019, at approximately 11:15 AM, the Maintenance Director stated he was new to his position, and the previous Maintenance Director had failed to maintain generator inspection and testing logs.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing.</p> <p>8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p> <p>8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating</p>	K 918		
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 1, 2019

Michael Littman, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Littman:

On **July 24, 2019**, an Emergency Preparedness survey was conducted at Lacrosse Health & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2019
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E 000	<p>Initial Comments</p> <p>The facility is a single story, type V (111) structure, constructed in 1967. The facility is comprised of seven smoke compartments, is fully sprinklered and equipped with an interconnected fire alarm system, including smoke detection in corridors and open spaces. The 300 and 600 halls have additional smoke detection in each resident sleeping room. The facility is equipped with a ventilator unit, which was approved in November of 2011 for 24 beds. The Type 1 EPSS (Emergency Power Supply System) is supplied by a diesel powered, on-site automatic generator with 96 hours of fuel supply on hand. The facility is currently licensed for 100 SNF/NF beds and had a census of 73 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on July 23 - 24, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The surveyor conducting the survey was:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000	<p style="text-align: center;">RECEIVED AUG 12 2019 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michael Lottman TITLE E.D. (X6) DATE 8-28-2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.