

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

PRINTED: 09/24/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135042</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/10/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LACROSSE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>210 WEST LACROSSE AVENUE</b> <b>COEUR D'ALENE, ID 83814</b>		
(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	
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>On September 9, 2019 through September 10, 2019, an onsite revisit and complaint investigation survey was conducted to verify correction of deficiencies noted during the survey June 21, 2019. LaCrosse Health &amp; Rehabilitation Center it was found to be in substantial compliance with federal health care regulations as of July 26, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Jim Troutfetter, QIDP, Team Coordinator Karen George, RN</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/18/2019

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.



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

January 16, 2020

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

Provider #: 135042

Dear Mr. Littman:

On **September 9, 2019** through **September 10, 2019**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008175**

**ALLEGATION #1:**

The facility failed to ensure residents received showers.

**FINDINGS #1:**

During the survey, record reviews were conducted with the following results.

Six resident bathing records, dated 5/23/19 through 9/10/19, were reviewed. All bathing records documented residents were bathed or refused bathing at their scheduled bathing times.

Based on the investigative findings, the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility failed to ensure the environment was clean and free from offensive odors.

**FINDINGS #2:**

Observations of the facility were conducted throughout the survey.

During observations of resident rooms and common areas, the facility was noted to be clean and free from unpleasant odors.

Based on the investigative findings, the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The facility failed to ensure residents' families were notified of significant events.

**FINDINGS #3:**

Six residents' records were reviewed, and one staff member was interviewed.

Five of six resident records documented appropriate notifications of significant events were provided to the family. One resident's record contained a handwritten letter from the resident that requested family members not be notified of information related to them.

During an interview on 9/10/19 at 10:15 a.m., the Social Worker stated a named resident had not designated any individual(s) to be notified of any significant events.

Based on the investigative findings, the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

Michael Littman, Administrator  
January 16, 2020  
Page 3 of 3

**ALLEGATION #4:**

The facility failed to ensure tracheostomy care was provided in a manner consistent with professional standards.

**FINDINGS #4:**

One resident's tracheostomy care was observed. One resident's record was reviewed. Staff were observed for infection control measures during resident cares.

During an observation of tracheostomy care, appropriate infection control measures and tracheostomy care were observed.

The record of one resident documented she had a tracheostomy and was on mechanical ventilation. The record documented it was the resident's choice to consume food orally, and she was aware of the risk of aspiration. The resident subsequently developed pneumonia secondary to food aspiration.

Based on the investigative findings, the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj