December 9, 2015

Tiffany Goin, Administrator
Life Care Center of Lewiston
325 Warner Drive
Lewiston, ID 83501-4437

Provider #: 135128

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Goin:

On December 1, 2015, a Facility Fire Safety and Construction survey was conducted at Life Care Center of Lewiston 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 one that comprises a pattern 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. **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 **December 22, 2015.** Failure to submit an acceptable PoC by **December 22, 2015,** may result in the imposition of civil monetary penalties by **January 11, 2016.**

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 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 5, 2016,** (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 **January 5, 2016.** A change in the seriousness of the deficiencies on **January 5, 2016,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by January 5, 2016, includes the following:

Denial of payment for new admissions effective March 1, 2016.
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 June 1, 2016, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 December 1, 2015, 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:

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 December 22, 2015. If your request for informal dispute resolution is received after December 22, 2015, 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.

Sincerely,

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures
**CENfERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 135128

**STATEMENT OF DEFICIENCIES**

**NAME OF PROVIDER OR SUPPLIER:** LIFE CARE CENTER OF LEWISTON

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 325 WARNER DRIVE, LEWISTON, ID 83501

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 135128

**ID PREFIX TAG:** K 000

**SUMMARY STATEMENT OF DEFICIENCIES**

**ID PREFIX TAG:** K 072

**NFPA 101 LIFE SAFETY CODE STANDARD**

**SS=E**

**MEANS OF EGRESS**

This STANDARD is not met as evidenced by:

Based on observation, operational testing and interview, the facility failed to ensure that means of egress were free from impediments. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency. This deficient practice

**K 072**

**COMPLETION DATE:** 12/4/15

**SPECIFIC RESIDENTS**

No residents were directly affected by this practice

**OTHER RESIDENTS**

All residents are at risk from this potentially deficient practice

**SYSTEMATIC CHANGES**

The hookbolt lock on the front entrance was removed on 12/4/15.

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

**DATE:** 12/18/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.
DÉPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:
135128

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
12/01/2015

NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF LEWISTON

STREET ADDRESS, CITY, STATE, ZIP CODE
325 WARNER DRIVE
LEWISTON, ID 83501

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>affected residents, staff and visitors utilizing the main entrance on the date of the survey. The facility is licensed for 121 SNF/NF beds and had a census of 93 on the day of the survey.</td>
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Findings include:

During the facility tour conducted on December 1, 2015 from 8:30 AM to 12:00 PM, observation of the controlled access door located at the main entrance found the door adjacent to the main reception desk was equipped with a keyed, hookbolt lock in addition to a controlled access locking arrangement. Operational testing of this door revealed that this hookbolt, when activated, would prevent the motion activated operation of the door and would prohibit the door from breaking away as designed. When asked why the hookbolt locks were installed, the Maintenance Director indicated he was not aware this locking arrangement was not permitted.

Actual NFPA standard:

7.1.10 Means of Egress Reliability.
7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

NFPA 101
18.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>K072</td>
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<td>Maintenance department will perform monthly audits on all means of egress to ensure they are free of obstruction. Maintenance Director will report any negative findings to QA committee on a monthly basis.</td>
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FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: KKT821
Facility ID: MDS001410
If continuation sheet Page 2 of 4
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

LIFE CARE CENTER OF LEWISTON

**STREET ADDRESS, CITY, STATE, ZIP CODE**

325 WARNER DRIVE
LEWISTON, ID 83501

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**K 072** Continued From page 2

Care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 18.1.1.1.5 and 18.2.2.2.5.)

Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.

Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.

7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met.

(a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor.

(b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress.

(c) The doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows:

**PUSH TO EXIT**

When operated, the manual release device shall result in direct interruption of power to the lock-independent of the access control system.
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<td>Continued From page 3 electronics - and the doors shall remain unlocked for not less than 30 seconds. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset.</td>
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