



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

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

**CERTIFIED MAIL: 7009 0820 0000 2798 7151**

May 24, 2011

Debbie Freeze, Administrator  
Lewiston Rehabilitation & Care Center  
3315 Eighth Street  
Lewiston, ID 83501

Provider #: 135021

Dear Ms. Freeze:

On **May 19, 2011**, a Complaint Investigation survey was conducted at Lewiston Rehabilitation & Care 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/or 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, and a similar State Form 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. **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). **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.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

Debbie Freeze, Administrator  
May 24, 2011  
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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 6, 2011**. Failure to submit an acceptable PoC by **June 6, 2011**, may result in the imposition of civil monetary penalties by **June 27, 2011**.

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,
- Provide dates when corrective action will be completed.

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 **June 23, 2011 (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 **June 23, 2011**. A change in the seriousness of the deficiencies on **June 23, 2011**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 23, 2011** includes the following:

Denial of payment for new admissions effective **August 19, 2011**. [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.

Debbie Freeze, Administrator  
May 24, 2011  
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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 19, 2011**, 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 Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (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 **May 19, 2011** 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 noncompliance 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:

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

go to the middle of the page to **Information Letters - Long Term Care** section and click on **State** and select the following:

[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

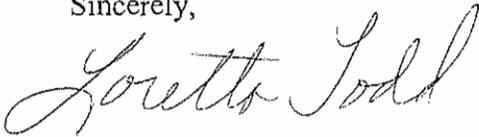
This request must be received by **June 6, 2011**. If your request for informal dispute resolution is

Debbie Freeze, Administrator  
May 24, 2011  
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received after **June 6, 2011**, 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,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj  
Enclosures

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

PRINTED: 05/19/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/19/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LEWISTON REHABILITATION &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3315 8TH STREET LEWISTON, ID 83501</b>
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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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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during a complaint investigation of your facility.</p> <p>The surveyor conducting the survey was: Karen Marshall, MS, RD, LD Team Coordinator</p> <p>Survey Definitions: CVA = Cerebrovascular Attack HTN = Hypertension ADL = Activities of Daily Living CHF = Congestive Heart Failure</p> <p>F 164 SS=E 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of</p>	F 000	<p><b>RELEASED</b></p> <p><b>JUN 06 2011</b></p> <p><b>FACILITY STANDARDS</b></p> <p><b>Release of information -</b></p> <p><b>All records to be released will be reviewed twice before distribution to the requestor.</b></p> <p><b>The records will be reviewed by the Health Information Personnel and the Executive Director before distribution to ensure that all identifying information other than what is designated on the request is removed, and that no information regarding any other resident is present in the records to be released.</b></p> <p><i>No other resident information has been released since this event.</i></p>	<p>5/29-11</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debbie Frey</i>	TITLE <i>Director</i>	(X6) DATE <i>5/27-11</i>
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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 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.

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F 164	<p>Continued From page 1</p> <p>the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a public complaint, record review, and staff interview, it was determined the facility failed to ensure the confidentiality of residents' personal, clinical information. This related specifically to the release of information of 4 residents to an individual who did not have authorization to receive the information. This affected 4 of 5 (#s 2-5) sampled residents. Findings included:</p> <p>A complaint was received by fax by the Bureau of Facility Standards (BFS) on May 18, 2011. The complaint stated that information about 4 residents was given to an individual who did not have authorization to receive the information.</p> <p>The information that was released by the facility were copies of five different incidents documented on the "Resident-to-Resident Contact, Investigation Conclusions and Plan for Prevention" forms. The fax indicated that information was requested pertaining to Resident #1. Four of the five incidents contained confidential information about 4 other residents. The reports documented in part:</p> <p>Date of Incident: 9/29/10, Resident #1 slapped Resident #2 on her right leg. No injuries occurred. The form contained the following personal information pertaining to Resident #2.</p>	F 164		

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F 164	<p>Continued From page 2</p> <p>"[Resident's first and last name and date of admission] with CVA, depression, HTN, anemia, dementia. Resident is usually very quiet and is alert and oriented at times. She self propels in her wheelchair. Resident needs assistance with ADL's."</p> <p>Date of Incident: 1/24/11, Resident #1 slapped Resident #3 with an open hand in the face. After clinical assessment, no injuries were noted. The form contained the following personal information pertaining to Resident #3.</p> <p>"[Resident's first and last name and date of re-admission] with CVA late effect with cognitive deficits, Diabetes Mellitus, Depressive disorder, Peripheral Vascular disease, Morbid Obesity, Mental disorders, Impulse Control disorder, Osteoporosis, SHF [systolic heart failure], Urine Retention...Lack of Coordination, Dysphasia, General Muscle weakness, Chronic Airway Obstruction, Anemia, Anxiety. Currently a long term resident, he is alert and disoriented. [Resident's name] has a history of outburst and will yell out for no apparent reason. His voice is rather loud, intimidating, and could be frightening. He does curse at staff inappropriately. He is not physically aggressive with staff or residents."</p> <p>On 3/19/11, Resident #1 kicked Resident #4 when they were sitting at the dining room table waiting for lunch. No injuries occurred. The form contained the following personal information pertaining to Resident #4.</p> <p>"[Resident's first and last name and admission date] with depression, osteoporosis, Parkinson's. Resident is usually very quiet and is alert and oriented at times. She self propels in her wheelchair. Resident needs assistance with</p>	F 164		

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F 164	<p>Continued From page 3 ADL's."</p> <p>On 4/22/11, Resident #1 and Resident #5 started to argue and kicked at each other. No injuries occurred.</p> <p>The form contained the following personal information pertaining to Resident #5. "[Resident's first and last name and admission date] with history of falls, chronic airway obstruction, difficulty walking, weakness and CHF, Resident is alert and oriented with mild cognitive impairment, able to self proper in wheelchair and requires moderate assistance for ADL cares."</p> <p>On 5/18, 2011 at 1:00 p.m. (mountain time), the Long Term Care Co-Supervisor spoke to the Administrator, over the telephone, about the issue. The Administrator was very forthcoming and stated, "Yes, I did that. It was my mistake. Should not have happened." The Co-Supervisor informed the Administrator that this was a violation of Resident's Right to Privacy. The Administrator acknowledged agreement. No further information was received from the facility.</p>	F 164		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135021</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/19/2011</b>
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C 000	16.03.02 INITIAL COMMENTS  The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiency was cited during a complaint investigation of your facility.  The surveyor conducting the survey was: Karen Marshall, MS, RD, LD Team Coordinator	C 000	<b>Release of information --</b>  <b>All records to be released will be reviewed twice before distribution to the requestor.</b>  <b>The records will be reviewed by the Health Information Personnel and the Executive Director before distribution to ensure that all identifying information other than what is designated on the request is removed, and that no information regarding any other resident is present in the records to be released.</b>	5/29-11
C 124	02.100,03,c,viii  viii. Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care facility, or as required by law or third-party payment contract; This Rule is not met as evidenced by: Please refer to F164 as it related to the release of confidential resident information to an individual who did not have authorization to receive the information.	C 124		

Bureau of Facility Standards

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

STATE FORM

*[Handwritten Signature]*

TITLE *E.D.*

(X6) DATE

*5/27-11*



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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3232 Elder Street  
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May 24, 2011

Debbie Freeze, Administrator  
Lewiston Rehabilitation & Care Center  
3315 Eighth Street  
Lewiston, ID 83501

Provider #: 135021

Dear Ms. Freeze:

On **May 19, 2011**, a Complaint Investigation survey was conducted at Lewiston Rehabilitation & Care Center. Karen Marshall, R.D. conducted the complaint investigation. A total of fifty minutes was required to complete this complaint investigation.

The Bureau of Facility Standards received a fax from the Idaho Area II Agency on Aging. The fax contained copies of documents given to an individual who, according to the fax, resided in a different state.

The documents were reviewed and the administrator was interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00005078**

**ALLEGATION #1:**

The complainant stated that personal information about four different residents was released to an individual who did not have authorization to receive the information.

**FINDINGS:**

The information that was released by the facility were copies of five different incidents

Debbie Freeze, Administrator  
May 24, 2011  
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documented on the facility's "Resident-to-Resident Contact, Investigation Conclusions and Plan for Prevention" forms. The fax indicated that information was requested pertaining to an identified resident. However, four of the five incidents contained confidential information about four other identified residents.

The interview with the administrator revealed that the information related to four of the five identified residents was inadvertently released to an individual who did not have authorization to receive the information.

The facility was cited at F164 for non-compliance.

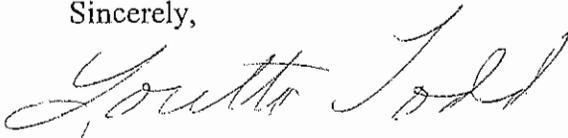
**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj