



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

March 7, 2014

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

Provider #: 135128

Dear Ms. Goin:

On February 26, 2014, an on-site follow-up revisit of your facility was conducted to verify correction of deficiencies noted during the Recertification and State Licensure survey of October 25, 2013. Life Care Center of Lewiston was found to be in substantial compliance with health care requirements as of **November 29, 2013**. In addition, a Complaint Investigation survey was conducted in conjunction with the on-site follow-up.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing the deficiencies that have been corrected is enclosed. The findings to the Complaint Investigation is being processed and will be sent to your facility under separate cover.

Thank you for the courtesies extended to us during our follow-up revisit. If you have any questions, concerns or if we can further assist you, please call this office at (208) 334-6626.

Sincerely,

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures



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March 10, 2014

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

Provider #: 135128

Dear Ms. Goin:

On **February 26, 2014**, a Complaint Investigation survey was conducted at Life Care Center of Lewiston. Susan Gollobit, R.N., and Karen Marshall, R.D., conducted the complaint investigation. This complaint was investigated in conjunction with the facility's follow-up survey to the annual Recertification and State Licensure survey.

The survey team reviewed the following documents:

- Resident Council Meeting minutes from November 29, 2013 to February 24, 2014;
- The facility's Concern and Comment forms (including grievances) from November 1, 2013 through February 24, 2014;
- Incident and Accident reports from November 1, 2013 through February 24, 2014;
- The identified resident's closed record;
- The facility's admission, transfer and discharge reports from October 1, 2013 through February 24, 2014; and
- The identified resident's local hospital Emergency Department (ED) reports; Discharge Summary, History and Physical and Patient Summaries.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006268

ALLEGATION #1:

FILE COPY

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When the family member and friend arrived at the facility, the resident was found with a decreased level of consciousness, was sleepy and not quite awake, was acting a bit drunk, had a horrible smell, and was slumped over in his wheelchair. The family member and a friend took the resident home.

At home, the resident's skin was very hot and his temperature was 102 (one-hundred and two) degrees Fahrenheit. The resident's catheter bag contents were red and thick with blood and pus.

On November 8, 2013, at 9:00 p.m., the resident was taken to a local hospital where the resident was diagnosed with Urosepsis and blood sepsis. The resident was admitted to the hospital's Intensive Care Unit.

The family member called the facility and spoke with the Administrator and the Director of Nursing Services who said they would investigate the family's concerns.

FINDINGS:

The identified resident's local hospital ED report documented the resident went to the ED on November 8, 2013, at 9:23 p.m.

The identified resident was admitted to the facility on October 14, 2013, from a local hospital with multiple diagnoses, including paraplegia, Foley catheter gravity drain and aftercare following surgery of the skin and subcutaneous tissue (left ischial flap closure).

The resident discharged to home on November 8, 2013, at 5:00 p.m.

On admission to the facility, the resident's physician ordered a Foley catheter due to paraplegia. The nursing staff was to change the Foley catheter drainage bag on the seventh day of each month and provide Foley catheter care every shift. Nursing staff was also to check for signs and symptoms of retention, changes in output and signs and symptoms of infection every shift.

The resident's October and November 2013 Treatment Records documented nursing staff provided the following Foley catheter cares:

- Checked for signs and symptoms of retention, changes in output and signs and symptoms of infection every shift, every day;
- Foley catheter care every shift, every day;
- Changed the resident's Foley catheter on November 7, 2013; and
- Changed the Foley catheter drainage bag on November 7, 2013.

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Review of the resident's Progress Notes provided evidence the resident was confused at times and was alert and oriented other times. The resident's body temperature ranged from a low of ninety-seven point two (97.2) to a high of ninety-nine point eight (99.8) degrees Fahrenheit. The resident was repositioned or turned every two hours. For approximately two weeks after admission, the resident was on a bed rest program for healing of the surgical incision site. The Foley catheter was patent with yellow urine.

The resident's November 8, 2013, at 3:32 p.m. Progress Note documented the resident's Foley catheter was patent with yellow urine. The resident was alert, oriented, pleasant, and able to make his needs known.

The resident's last Progress Note dated November 8, 2013, 5:05 p.m. documented the resident discharged home accompanied by a family member.

The resident's November 8, 2013, local hospital Patient Summary documented upon arrival at the Emergency Department at 9:29 p.m. the resident's temperature was ninety-eight point 2 (98.2). The resident had a urinary catheter in place and the urine was very cloudy. The nursing staff cleaned the resident of stool from home.

The resident's local hospital Discharge Summary documented the resident discharged from the local hospital on November 14, 2013. The resident's diagnoses included in part, septic shock with blood culture positive for vancomycin-sensitive enterococcus viridans, streptococcus viridans sepsis, and acute pyelonephritis with quinolone-resistant Escherichia coli.

The resident's Resident Care Manager (RCM) was interviewed. The RCM said he did not remember any time during the resident's stay in the facility when there were problems or concerns with the resident's Foley catheter, urine color or elevated temperature.

The Director of Nursing (DoN) was interviewed. The DoN remembered a telephone conversation with the resident's family member after the resident's discharged to home. The family member told the DoN that the resident was admitted to a local hospital with a urinary tract infection. The DoN said she reviewed the resident's Progress Notes and discussed the Progress Notes with the concerned family member.

The survey team was able to verify the resident was admitted to a local hospital and was diagnosed with septic shock, streptococcus sepsis and Escherichia coli.

It could not be substantiated that the resident's condition was due to the lack of nursing care while the resident resided in the facility.

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CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION#2:

The complainant stated an identified resident was admitted to the facility after having revisions done on his wounds. The complainant stated the identified resident was always on his back and was never turned.

FINDINGS:

On admission to the facility, the resident's physician ordered wound care for the resident. Nursing staff were to cleanse the left ischium with normal saline and apply Bacitracin twice daily; cleanse the left ischium with normal saline and apply Bacitracin twice daily as needed if loose or soiled; and, use the facility wound care protocol as needed.

The resident's care plan directed nursing staff to assist the resident with repositioning needs frequently for pressure relief and comfort.

The resident's Progress Note dated October 29, 2013, 11:18 a.m., documented, in part, that the resident's doctor met with the resident and told the resident he could start getting up out of bed as he wanted. The resident declined and said he would rather stay in bed until he discharged home.

The resident's Progress Note dated October 29, 2013, 1:28 p.m., documented, in part, that the resident was fearful of getting out of bed as he did not want anything to happen to his incision site.

The resident's Progress Notes documented the resident was on a repositioning program for every two hours and was turned and repositioned every two hours.

The resident's November 2013 Treatment Record documented that on November 6, 2013, the resident's left ischium was healed and the orders for Bacitracin twice daily were discontinued.

The resident's November 8, 2013 Patient Summary from a local hospital documented the resident's skin condition as having no redness and it looked good. The Summary further documented the prior month's surgery, which involved the resident's buttocks, was "good surgery."

The resident's local hospital History and Physical documented the resident's skin had no

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suspicious lesions, minimal area of redness around the coccyx, and minimal stasis changes in the lower extremities.

The resident's RCM was interviewed. The RCM said the resident's doctor told the resident to stay in bed at first and after a time the doctor told the resident he could get out of bed as he wanted. The RCM said he remembered the resident was hesitant to get out of bed because the resident had a skin repair before and the resident did not want to do anything to cause the skin to open again.

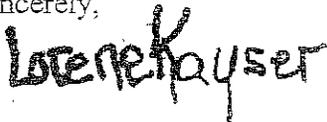
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

As only one of the complaint's allegations was substantiated, but not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LK/lj