



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

August 11, 2016

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

Provider #: 135128

Dear Ms. Goin:

On **July 28, 2016**, a survey was conducted at Life Care Center of Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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. 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

Tiffany Goin, Administrator  
August 11, 2016  
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 22, 2016**. Failure to submit an acceptable PoC by **August 22, 2016**, may result in the imposition of penalties by **September 15, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **September 1, 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 **October 26, 2016**. A change in the seriousness of the deficiencies on **September 11, 2016**, may result in a change in the remedy.

Tiffany Goin, Administrator  
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The remedy, which will be recommended if substantial compliance has not been achieved by **October 26, 2016** includes the following:

Denial of payment for new admissions effective **October 26, 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 non-compliance, 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, 2017**, 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, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **October 26, 2016** 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:

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

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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 22, 2016**. If your request for informal dispute resolution is received after **August 22, 2016**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor  
Long Term Care

DS/lj  
Enclosures

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

PRINTED: 09/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF LEWISTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>325 WARNER DRIVE LEWISTON, ID 83501</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	INITIAL COMMENTS  The following deficiencies were cited during the Federal Recertification survey conducted at the facility from July 25, 2016 to July 28, 2016.  The surveyors conducting the survey were:  Brad Perry, BSW, LSW, Team Coordinator Ophelia McDaniels, RN Angelia Newsome, RN Theresa Griffith, Generalist  Survey Definitions:  C. diff = Clostridium difficile CNA = Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record PPE = Personal Protective Equipment PTA = Physical Therapy Assistant RCM = Resident Care Manager	F 000			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff demonstrated respect for residents' private space when entering residents' rooms without knocking	F 241	1. This deficient practice affects residents #4, #21, and #22. The residents listed reside on the Special Care Unit and were assessed for any negative psychosocial	8/31/16	

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

TITLE

(X6) DATE

Electronically Signed

08/19/2016

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 241	Continued From page 1 on their doors. This was true for 1 of 17 (#4) sampled residents and 2 (#21 & #22) random residents. This failed practice had the potential to negatively affect residents' psychosocial well-being. Findings include:  On 7/25/16 from 1:55 pm to 1:58 pm, CNA #5 was observed entering Resident #4's room without first knocking on the door. Resident #4 was in bed and when CNA #5 approached. Resident #4 said, "uh" and visibly moved back on her bed. After a few seconds, CNA #5 left the room and told the surveyor who was outside the room that she had startled Resident #4. CNA #5 then walked into Resident #21's room without knocking, checked on Resident #21, who was in bed and then left the room. CNA #5 then crossed the hallway and entered Resident #22's room without knocking, checked on Resident #22, who was in bed and then left the room.  On 7/25/16 at 1:58 pm, CNA #5 said she might not have knocked on the room doors in question.	F 241	well-being. These residents have a diagnosis of dementia and could not recall the incident. No adverse effects noted.  2. Other residents are at risk from this deficient practice.  3. Inservice on respect for residents' private space will be provided to facility staff members about knocking on resident room doors and announcing their name or department prior to entering.  4. DON or designee will perform audits twice a week for three weeks through September 2, 2016. Then weekly times 4 weeks through September 30, 2016. Audits will be taken and reviewed at monthly QA for 3 months for ongoing education needs.		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		8/31/16	

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F 328	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, it was determined the facility failed to ensure proper respiratory care was provided to 1 of 25 sampled residents (Resident #17). This deficient practice placed the resident at risk of respiratory distress. Findings include:</p> <p>Resident #17's current plan of care and physician orders for July 2016 documented a diagnosis of COPD and that she was to receive oxygen at 2 liters per minute continuously via nasal cannula for COPD.</p> <p>Resident #17 was observed during the initial tour of the facility on 7/25/16 at 1:45 pm sitting in a wheelchair near Room 321. She had an oxygen cylinder attached to her wheelchair and a nasal cannula in both nostrils. The gauge on the oxygen cylinder indicated the cylinder was empty.</p> <p>During an interview with Resident #17 at that time, she stated, "I have COPD and need oxygen." As she was explaining her oxygen needs, CNA #2 approached her and asked if she required assistance. CNA #2 observed the oxygen cylinder gauge and confirmed the gauge indicated the cylinder was reading as empty. CNA #2 stated, "I know this is not the best way to determine if the cylinder is actually empty, but I am going to remove your nasal cannula and place the cannula near my cheek to see if I can feel air flowing out." CNA #2 confirmed no oxygen was flowing. LN# 1 approached and</p>	F 328	<ol style="list-style-type: none"> <li>1. Resident #17 was hooked up to oxygen concentrator in room upon discovery of empty oxygen cylinder. O2 sats were immediately taken and within normal limits.</li> <li>2. Residents with O2 orders are at risk of this deficient practice. A 100% audit was completed of all residents with oxygen orders at time of discovery and 100% in compliance.</li> <li>3. Inservice will be provided to nursing and therapy on checking O2 cylinders frequently throughout the day to ensure proper O2 capacity is sufficient.</li> <li>4. DON or designee will perform audits twice a week for three weeks through September 2, 2016. Then weekly times 4 weeks through September 30, 2016. Audits will be taken and reviewed at monthly QA for 3 months for ongoing education needs.</li> </ol>		

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F 328	Continued From page 3 asked if she could be of assistance. Resident #17 stated, "I have COPD and I don't feel any oxygen coming out." CNA #2 reported to LN #1, "The resident's tank is empty. The gauge is pointing to empty and no oxygen is flowing from the cannula." LN #1 assessed the oxygen cylinder and confirmed the cylinder was empty. LN #1 and CNA #2 wheeled Resident #17 to her room and began to administer oxygen at 2 liters per minute by means of an oxygen concentrator.  During an interview with LN #1 on 7/25/16 at 4:00 pm, she reported nurses were to give a report to each shift on the status of each resident who received oxygen therapy to prevent this type of occurrence. LN #1 said education was scheduled and the Unit Manager and DON would be informed of the occurrence when they returned to the facility the following day. LN #1 said at 4:14 pm, that Resident #17 was resting comfortably in bed. At 4:27 pm, Resident #17 was observed in no distress waving and smiling in bed with oxygen flowing per nasal cannula through her oxygen concentrator.	F 328			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		8/31/16	

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F 441	<p>Continued From page 4</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure a) implementation of its infection control policies and procedures, b) development of a system of communication that informed staff of initiation of transmission-based precautions, and c)effectively provide staff with infection control education. This was true for 1 of 20 sampled residents (Resident #14) and had the potential to affect visitors, staff, and all residents in the</p>	F 441	<p>1. Resident #14 was removed from contact isolation on July 27th, 2016 and discharged from the facility on August 10th, 2016.</p> <p>2. No other residents in facility with contact isolation precautions at the time of the findings through current date.</p> <p>Visitors, staff, and residents in the facility</p>		

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F 441	<p>Continued From page 5 facility. These deficient practices created the potential for residents, staff, and visitors to contract infections which may lead to serious negative outcomes. Findings include:</p> <p>Resident #14 was admitted to the facility on 7/25/16 at 1:30 pm, with diagnoses which included diarrhea and colitis (inflammation of the colon). Resident #14 had a positive culture for C. diff (a spore-forming bacteria residing in feces which causes an infectious diarrhea that is very contagious and spreads those who are infected to others through touch and contact with contaminated objects or surfaces such as over-bed tables, water glasses, equipment and other objects).</p> <p>Upon admission to the facility, a cart was placed outside Resident #14's room containing isolation and PPE used to help stop the spread of infection from one person to another. A sign reading, "Contact Precautions," procedures was on top of the cart. The PPE included gowns, gloves and other equipment designed to protect the wearer from infection. PPE should be used when providing care and services to a resident with a disease transmittable by contact.</p> <p>During an observation on 7/25/16 at 2:50 pm, Resident #14 was in bed in her room with 2 visitors sitting in chairs. CNA #1 was also in Resident #14's room taking her blood pressure. CNA #1 was not wearing PPE. After assessing Resident #14's blood pressure, CNA #1 took the portable blood pressure machine into the room of the resident across the hallway, with intent to take the other residents blood pressure. CNA #1 was stopped and interviewed in the presence of</p>	F 441	<p>have the potential to be affected by this deficient practice.</p> <p>3. Infection control nurse has been inserviced on the necessary signage about isolation precautions needed and the guidelines to follow.</p> <p>Inservice will be provided to facility staff members on use of Personal Protective Equipment when providing care and services to a resident with a disease transmittable by contact.</p> <p>Facility staff members will be inserviced on Contact isolation policy and procedures.</p> <p>4. DON or designee will perform audits twice a week for three weeks through September 2, 2016. Then weekly times 4 weeks through September 30, 2016. Audits will be taken and reviewed at monthly QA for 3 months for ongoing education needs.</p>		

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F 441	<p>Continued From page 6</p> <p>RCM #1. CNA #1 stated, "I did not see the cart. I should have gloved up." When asked about notification of staff of a resident with a diagnosis requiring the use of transmission-based precautions, CNA #1 stated, "The other CNAs will tell me during shift change and the nurse will tell me. I was not told about [Resident #14]."</p> <p>There was no sign in clear view outside Resident #14's room informing visitors and staff of the isolation precautions needed, or the guidelines to follow. There was no signage instructing anyone entering the room who may touch Resident #14 or objects in the room to wash their hands.</p> <p>The Infection Control Nurse was interviewed on 7/26/16 at 11:00 am. When queried regarding communicating initiation and discontinuation of transmission-based precautions, she stated, "I personally let them know and I put the isolation cart out." The Infection Control Nurse was not in the facility the day Resident #14 was admitted.</p> <p>The facility's Infection Control policy for Contact Isolation Procedures included:</p> <ol style="list-style-type: none"> <li>(1) 'Stop' sign on door.</li> <li>(2) PPE: Wear a gown and gloves on room entry.</li> <li>(3) Visitors are instructed to wash hands when entering and leaving room.</li> <li>(4) Patient care equipment - Reserve noncritical patient care equipment for use with a single patient when possible.</li> </ol> <p>During an observation on 7/28/16 at 11:30 am, PTA #1 was in Resident #14's room without PPE. She was putting Resident #14's socks and shoes on her. Afterward, she placed a resident gown on Resident #14. RCM #1 was summoned to</p>	F 441			

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F 441	Continued From page 7 observe the situation. RCM #1 informed PTA #1 she should be wearing gown and gloves.  CNA #3 was interviewed on 7/26/16 at 9:30 am and CNA #4 was interviewed on 7/26/16 at 9:45 am. The CNAs confirmed they received infection control education "1-2 months ago." CNA #3 stated, "We get papers that you have to read through, sign and give to the Infection Control Nurse." CNA #4 stated, "On payday the Infection Control Nurse brings reading material and we sign and give it to her after we have read it."	F 441		



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August 24, 2016

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

Provider #: 135128

Dear Ms. Goin:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center Of Lewiston. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007174**

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 25, 2016 to July 28, 2016.

Call lights were observed throughout the survey. Staff members were observed providing care throughout the survey. Fall supervision was observed for six residents with a history of falls. Multiple residents were observed for cleanliness and grooming.

The medical record of two identified residents were reviewed for Quality of Care concerns. The medical records of six other residents were reviewed for Quality of Care concerns. The facility's Grievance file from September 2015 to July 2016 was reviewed. Staffing numbers were reviewed for an identified week and three weeks prior to the survey. The facility's bathing policy was reviewed. The facility's Incidents and Accidents from September 2015 to July 2016 were reviewed.

Five individual residents were interviewed regarding Quality of Care concerns. Nine residents in the Group Interview were asked about Quality of Care concerns. Several staff members were interviewed regarding Quality of Care concerns. The Director of Nursing and the Administrator were interviewed regarding staffing.

**Allegation #1:** The Reporting Party said an identified resident and other residents in the facility had not received showers consistently.

**Findings #1:** The identified resident was observed to be properly bathed and groomed. Multiple other residents were observed to be properly bathed and groomed.

The identified resident's medical record was reviewed for bathing and no concerns were identified. Several other residents' medical records were reviewed for bathing and no concerns were identified. The facility's bathing policy was reviewed and no concerns were identified. The facility's Grievance file from September 2015 to July 2016 was reviewed and no bathing concerns were identified.

Five individual residents did not have a concern regarding bathing frequency. Nine residents in the Group Interview said there was not a concern regarding bathing frequency. Several CNAs said residents were bathed per their care plan and when residents needed them.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** There are not enough staff to meet the resident needs, including those who need mechanical lift assistance.

**Findings #2:** Call lights were observed throughout the survey and no concerns were identified. Staff members were observed providing care for all residents throughout the survey, including those requiring a mechanical lift and no concerns were identified.

Staffing numbers were reviewed for an identified week and three weeks prior to the survey and no concerns were identified.

Five individual residents said there was not a concern about the amount of staff. Nine residents in the Group Interview said there was not a concern about the amount of staff. Several staff members, including CNAs and nurses said there were enough staff to meet the residents' needs. The Director of Nursing and the Administrator said there were enough staff to meet the residents' needs and the facility takes into account the acuity of the residents when staffing schedules were assigned.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** An identified resident did not receive appropriate supervision for a fall and sustained significant injuries.

**Findings #3:** The identified resident was no longer residing in the facility at the time the complaint was investigated.

Fall supervision was observed for six residents with a history of falls and no concerns were identified.

The medical record of the identified resident was reviewed and no supervision concerns were identified. The medical records of six other residents with a history of falls were reviewed and no concerns were identified. The facility's Incident and Accident investigations from September 2015 to July 2016 were reviewed and there were no concerns regarding supervision identified.

Four individual residents with a history of falls said they received appropriate fall prevention interventions and supervision. Several staff members were interviewed regarding fall precautions and supervision and they said residents received appropriate fall supervision.

Based on observation, record review, resident and staff interviews, it was determined the allegation could not be substantiated.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** Family members of an identified resident provided treatment when he/she sustained an injury, rather than deferring to the resident's physician.

**Findings #4:** The medical record of the identified resident was reviewed, including the resident's choice of medical providers and no concerns were identified. Two other residents' records were reviewed for medical provider choice and no concerns were identified.

The Director of Nursing said residents had their choice of medical providers and the appropriate paperwork regarding their choices were documented in residents' clinical record.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

Tiffany Goin, Administrator  
August 24, 2016  
Page 4 of 4

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW". The signature is written in dark ink and is positioned above the typed name.

NINA SANDERSON, LSW, Supervisor  
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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August 24, 2016

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

Provider #: 135128

Dear Ms. Goin:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center Of Lewiston. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007226**

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 25, 2016 to July 28, 2016.

Call lights were observed throughout the survey. Staff members were observed providing care throughout the survey. Medication pass was observed. Multiple residents were observed for wet incontinent briefs.

The medical record of the identified resident was reviewed for Quality of Care concerns. The medical records of 12 other residents were reviewed for Quality of Care concerns. The facility's Grievance file from September 2015 to July 2016 was reviewed. The facility's Resident Council minutes from June 2016 to July 2016 were reviewed. Staffing records for the identified days were reviewed.

Five individual residents were interviewed regarding Quality of Care concerns. Nine residents in the Group Interview were asked about Quality of Care concerns. Several staff members were interviewed regarding Quality of Care concerns. The Director of Nursing and the Administrator were interviewed regarding staffing and Quality of Care concerns.

**Allegation #1:** The Reporting Party said an identified resident was left in a wet incontinence brief for a long period of time.

**Findings #1:** The identified resident was no longer in the facility at the time the complaint was investigated.

Multiple residents were observed for wet incontinent briefs and no concerns were identified.

The medical record of the identified resident was reviewed and no concerns were identified. The medical record of nine other residents with incontinence were reviewed and no concerns were identified. The facility's Grievance file from September 2015 to July 2016 was reviewed and no concerns regarding incontinence care was identified.

Four individual residents with incontinence were interviewed and they had no concerns regarding their care. Nine residents in the Group Interview did not voice a concern regarding incontinence care. Several staff members said residents received appropriate incontinence care. The Director of Nursing said residents received appropriate care.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The call light was turned off several times in a row by staff and without assisting the resident.

**Findings #2:** Call lights were observed throughout the survey and staff were observed to assist the residents with no concerns identified.

The facility's Grievance file from September 2015 to July 2016 did not document an issue with call lights. The facility's Resident Council minutes from June 2016 to July 2016 did not document an issue with call lights.

Five individual residents were interviewed and they said there were no issues with call lights. Nine residents in the Group Interview said there were no issues with call lights. Several staff members were interviewed and they said call lights were answered in a timely manner and the residents' needs were addressed.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The resident's pain was not managed well and was ineffective.

**Findings #3:** Medication pass was observed and pain medication for residents was effective.

The medical record of the identified resident was reviewed for pain effectiveness and no concerns were identified. The medical records of 11 other residents were reviewed for pain control and no concerns were identified.

Four individual residents were interviewed regarding Quality of Care concerns and pain control was not identified as an issue. Nine residents in the Group Interview said pain control was not an issue. Several nurses said they address residents' pain according to the physician orders.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The facility did not have enough staff to meet the residents' needs.

**Findings #4:** Call lights were observed throughout the survey and no concerns were identified. Staff members were observed providing care for all residents throughout the survey and no concerns were identified.

Staffing schedules were reviewed for an identified week and three weeks prior to the survey and no concerns were identified.

Five individual residents said there was not a concern about the amount of staff. Nine residents in the Group Interview said there was not a concern about the amount of staff. Several staff members, including CNAs and nurses said there were enough staff to meet the residents' needs. The Director of Nursing and the Administrator said there were enough staff to meet the residents' needs and the facility takes into account the acuity of the residents when staffing schedules were assigned.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #5:** Facility staff were afraid to notify the resident's physician during the night due to the resident's unresolved pain issues.

Tiffany Goin, Administrator  
August 24, 2016  
Page 4 of 4

**Findings #5:** The medical record of the identified resident was reviewed and physician notice was not identified as a concern. The medical records of 12 other residents were reviewed and physician notice was not identified as a concern.

Several nurses said they would not be afraid to notify the physician of residents' change of condition or unresolved pain, regardless of the time of day.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #5:** 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.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (LSW)".

NINA SANDERSON, LSW, Supervisor  
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF  
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August 24, 2016

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

Provider #: 135128

Dear Ms. Goin:

On **July 28, 2016**, an unannounced on-site complaint survey was conducted at Life Care Center Of Lewiston. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00007318**

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 25, 2016 to July 28, 2016.

The medical record of the identified resident was reviewed. Two other discharged residents records were reviewed. The facility Grievance file from September 2015 to July 2016 were reviewed. The identified resident's trust fund account was reviewed.

Nine residents in the group interviewed. A Resident Care Services Representative was interviewed regarding discharge issues. The Business Office Manager was interviewed regarding residents' funds.

**Allegation #1:** The Reporting Party said an identified resident did not receive appropriate discharge notification.

**Findings #1:** The identified resident was no longer residing in the facility at the time the complaint was investigated.

The identified resident's medical record regarding discharge was reviewed and no issues were identified. Two other discharged residents' records were reviewed and no issues were identified.

A Resident Care Services Representative was interviewed and said the resident received the appropriate discharge notification.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The facility discharged an identified resident in retaliation due to the resident's frequent complaints.

**Findings #2:** The Grievance file was reviewed and no complaints were found for the identified resident. The identified resident's medical record was reviewed and no retaliation concerns were found. Two other residents' records were reviewed regarding discharge status and no concerns were identified.

A Resident Care Services Representative said the resident was not discharged due to retaliation and the facility would never discharge a resident for that reason.

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The facility did not provide the identified resident his/her personal funds for a particular month.

**Findings #3:** The identified resident's facility trust fund was reviewed and no concerns were identified.

Nine residents in Group Interview said there were no concerns regarding their personal funds kept for them in the facility's trust fund. The Business Office Manager said the resident received his/her funds on the last day of the previous month, since the first day of the month in question was a holiday. The Business Office Manager said the facility dispersed all the resident's remaining personal funds back to the resident at discharge.

Tiffany Goin, Administrator  
August 24, 2016  
Page 3 of 3

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

**Conclusion #3:** 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.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (NS)".

NINA SANDERSON, LSW, Supervisor  
Long Term Care

NS/pmt