



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – 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
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August 11, 2018

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

Provider #: 135128

Dear Ms. Goin:

On **July 27, 2018**, 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, 2018
Page 2

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 21, 2018**. Failure to submit an acceptable PoC by **August 21, 2018**, may result in the imposition of penalties by **September 13, 2018**.

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 **August 31, 2018 (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 25, 2018**. A change in the seriousness of the deficiencies on **September 10, 2018**, may result in

Tiffany Goin, Administrator
August 11, 2018
Page 3

a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 25, 2018** includes the following:

Denial of payment for new admissions effective **October 27, 2018**. [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 27, 2019**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 27, 2018** 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:

Tiffany Goin, Administrator
August 11, 2018
Page 4

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

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

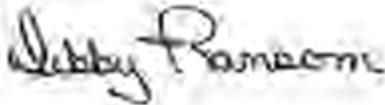
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 21, 2018**. If your request for informal dispute resolution is received after **August 21, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/

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

PRINTED: 09/27/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 325 WARNER DRIVE LEWISTON, ID 83501		
(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 and complaint survey conducted at the facility from July 23, 2018 through July 27, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Teresa Kobza, RDN, LD Cecilia Stockdill, RN Teri Hobson, RN Survey Abbreviations: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligrams PRN = as needed RCM = Resident Care Manager	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		8/31/18	

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

TITLE

(X6) DATE

Electronically Signed

08/21/2018

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 550	<p>Continued From page 1</p> <p>her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect when staff placed clothing protectors on residents without their permission and when staff did not address residents by their preferred name. This was true for 3 of 3 (#2, #40 and #42)</p>	F 550	<p>1. This deficient practice affected Resident #2, #40, and #42. The residents listed reside on the Special Care Unit and were assessed for any negative psychosocial well-being. These residents have a diagnosis of dementia and could not recall the incident. No adverse effects were noted.</p>		

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F 550	<p>Continued From page 2</p> <p>residents sampled for dignity and had the potential to affect all residents who resided in the facility's Special Care Unit. This practice created the potential for psychosocial harm if residents experienced embarrassment or a lack of self-esteem due to their appearance or how they were addressed. Findings include:</p> <p>The facility's Dignity and Meal Service policy, dated 6/7/08, directed staff to provide residents with clothing protectors when needed and to focus on residents as individuals when speaking to them.</p> <p>1. Clothing protectors were placed on residents without first asking their permission, as follows:</p> <p>a. Resident #42 was admitted to the facility on 9/21/16 with multiple diagnoses, including dementia with behavioral disturbances.</p> <p>Resident #42's current care plan directed staff to use a clothing protector at all meals, per family wishes.</p> <p>On 7/24/18 at 12:05 PM, during lunch in the facility's Secured Unit dining room, CNA #2 placed a clothing protector on Resident #42 without asking her permission.</p> <p>On 7/25/18 at 9:05 AM, CNA #2 said she thought since Resident #42's clothing protector was addressed her care plan she did not need to ask the resident's permission and the resident would probably not really respond if she was asked.</p> <p>b. Resident #40 was admitted to the facility on 7/9/14 with multiple diagnoses, including</p>	F 550	<p>2. Other residents are at risk from this deficient practice.</p> <p>3. Inservice on resident rights and dignity will be completed with all staff. Staff will be educated to address residents by their preferred name.</p> <p>Staff will be inserviced to offer residents a cloth napkin in lieu of the clothing protector at each meal. A clothing protector will only be placed at the request of the resident. If the resident is unable to make the determination staff will refer to the care plan.</p> <p>4. DON or designee will perform audits through observation twice a week for three weeks through September 21, 2018. Then weekly times 4 weeks through October 19,2018. Results of audits will be reviewed at QAPI for trending and ongoing education and compliance.</p>		

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F 550	<p>Continued From page 3 Alzheimer's disease.</p> <p>Resident #40's current care plan directed staff to promote dignity, stated she could answer yes and no questions, and wore a clothing protector with meals, per family request.</p> <p>On 7/24/18 at 12:07 PM, CNA #3 assisted Resident #40 in her wheelchair in the Secured Unit hallway and stopped near the dayroom. CNA #3 told Resident #40 that he would go and get a clothing protector. CNA #3 then picked up a clothing protector on a shelf in the dining room, brought it back, and placed it on Resident #40 without asking her permission.</p> <p>On 7/25/18 at 11:11 AM, CNA #3 said he did not ask Resident #40 if she wanted a clothing protector because Resident #40's care plan said she used one.</p> <p>On 7/26/18 at 9:01 AM, the DON said staff should ask residents if they wanted clothing protectors. The DON said even if residents' care plans directed staff to use clothing protectors, the residents still had a choice to use them or not.</p> <p>2. On 7/24/18 at 11:57 AM, while near the facility's Secured Unit dayroom, CNA #3 assisted Resident #2 with hand sanitizer and told the resident to, "rub your hands together Sweetie." CNA #3 then said to Resident #2, "Come on Sweetheart, lets walk down to lunch."</p> <p>On 7/25/18 at 11:08 AM, CNA #8 said he called all the female residents "Sweetie" and the male residents "big boy" or something similar.</p>	F 550			

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F 550	Continued From page 4 On 7/26/18 at 9:05 AM, the DON said staff should call residents by their preferred name and not to use terms of endearment when addressing residents.	F 550			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it	F 661		8/31/18	
			1. Resident #80 discharged from the		

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F 661	<p>Continued From page 5</p> <p>was determined the facility failed to ensure appropriate information was documented in the resident's record and provided to the resident upon discharge. This was true for 1 of 3 residents (#80) reviewed for discharge from the facility. This failure created the potential for harm and inappropriate care due to incomplete documentation related to the resident's discharge. Findings include:</p> <p>1. Resident #80 was admitted to the facility on 4/14/18 with diagnoses which included muscle weakness and nondisplaced spiral fracture of the left tibia (largest bone in lower leg). Resident #80 was discharged from the facility on 4/25/18.</p> <p>A Nurse's Progress Note, dated 4/25/18 at 10:27 AM, documented Resident #80 was discharged home and her left leg was wrapped with ace bandages. The note documented Resident #80 was instructed to leave the bandage in place until her appointment with a physician in May 2018.</p> <p>When asked to provide a discharge summary for Resident #80, the facility provided a packet that included the following documentation: physician orders, recapitulation of stay, and a Discharge and Transition Form.</p> <p>The Discharge Summary, dated 4/25/18, documented Resident #80 was discharged on 4/25/18. The form did not include information of a physician's visit scheduled following discharge from the facility and did not provide the resident with contact information of the physician. The summary documented if her leg swelled then home health may be an option for Resident #80.</p>	F 661	<p>facility on 4/25/18.</p> <p>2. Other residents who discharge from the facility are at risk from this deficient practice.</p> <p>3. Inservice will be provided to social services and RCMs on the proper completion of the discharge summary to include a post discharge plan of care with physician follow up and contact information, if applicable.</p> <p>4. DON or designee will perform audits on all pending discharges to ensure compliance prior to resident discharging from facility. The discharge summary for all resident discharges will be reviewed weekly times 7 weeks through October 19,2018. Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance.</p>		

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F 661	Continued From page 6 On 7/26/18 at 9:37 AM, the DON stated the information provided was all the information she could find regarding Resident #80's discharge. On 7/26/18 at 3:48 PM, the DON stated Resident #80 chose not to use home health services. The DON stated she did not know why the discharge summary documented home health for the leg wrap. The DON stated the physician's appointment was not on the discharge paperwork.	F 661			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, review of the facility's Wound Care Resource Manual, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 18 residents (#70 and #231) reviewed for standards of practice. Resident #70's leg wound treatments were provided without physician orders. Resident #231's Nitroglycerin patch order was changed without a physician's order and the physician's order was not followed. These failed practices had the potential to adversely affect or harm residents whose care and services were	F 684	1. A treatment order for Resident #70 right lower leg was obtained from the physician. An order was obtained for Resident #231 Nitroglycerin patch to be applied at 9PM and removed at 9AM. On 8/14/18 Resident #231 discharged from facility. 2. All residents are at risk from this deficient practice. 3. Inservice will be provided to all licensed	8/31/18	

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F 684	<p>Continued From page 7</p> <p>not delivered according to accepted standards of clinical practices. Findings include:</p> <p>1. Resident #231 was admitted to the facility on 7/17/18 with diagnoses which included sepsis, chest pain, heart failure, and hypertension.</p> <p>Resident #231's care plan did not address her heart failure or hypertension.</p> <p>Resident #231's Physician orders included an order dated 7/17/18, for her to receive Nitroglycerin one time a day 0.2 mg per hour for 12 hours via a patch for extreme high blood pressure. The patch was to be applied at 9:00 AM and removed at 9:00 PM .</p> <p>On 7/24/18 at 9:45 AM, LPN #1 was observed as she brought a new Nitroglycerin patch to place on Resident #231's chest. LPN #1 removed a button to expose where the patch was placed on Resident #231's chest and saw a patch was still in place from the previous day. LPN #1 stated, "Oh, the previous shift must have forgotten to remove the patch." LPN #1 removed the patch from the day before and began to place the new patch. Resident #231's family member was present at the bedside and asked the nurse to please not place the new patch on the resident. Resident #231's family member requested the Nitroglycerin patch be applied at night and removed in the morning. LPN #1 stated she would correct the order.</p> <p>Resident #231's 7/18/18 through 7/25/18 MAR documented her Nitroglycerin patch was administered. Resident #231's Nitroglycerin patch order was documented on the MAR. The</p>	F 684	<p>nurses on medication and treatment orders, whether new, changes in orders, time changes, etc, all must have an order from physician. Tool guide for pressure and non-pressure ulcers will be reviewed with all licensed nurses.</p> <p>4. DON or designee will perform audits weekly times 7 weeks on each unit and review the medication and treatments for the week to ensure orders are in place with proper physician notification through October 19,2018. Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance.</p>		

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F 684	<p>Continued From page 8</p> <p>MAR documented "apply" at 9:00 AM and it was crossed out with a hand-written word "remove." The "remove" was crossed out and "apply" was hand written in for 9:00 PM. No time was documented as to when the change was made.</p> <p>Resident #231's Physician orders included an order dated 7/26/18, for her to receive Nitroglycerin one time a day 0.2 mg per hour for 12 hours via a patch, for extreme high blood pressure. The patch was to be applied at 9:00 PM and removed at 9:00 AM.</p> <p>On 7/26/18 at 11:59 AM, the DON stated the Nitroglycerin patch should be changed per physician orders. The DON stated she would ask about an order for changing the administration time of the Nitroglycerin patch. The DON stated the nurse should not have attempted to place a new patch on when the previous patch was in place.</p> <p>On 7/26/18 at 3:12 PM, RCM #1 stated she started the process to change the administration time of the Nitroglycerin patch on 7/26/18, not on 7/24/18. RCM #1 stated the other nurse (LPN #1) should have initiated the order change on 7/24/18.</p> <p>2. The facility's Interdisciplinary Team Approach from the Wound Care Resource Manual, dated 2/25/15, documented "All disciplines focus on assessment, planning, and implementing, and documenting care."</p> <p>The facility's Evaluations, Screenings, and Assessments from the Wound Care Resource Manual, dated 11/2017, documented the</p>	F 684			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2018
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F 684	<p>Continued From page 9 following:</p> <ul style="list-style-type: none"> * All residents receive a weekly skin check by licensed staff. * Appropriate disciplines are notified of skin breakdown or the resident's risk of skin breakdown. * Nursing coordinates the response to resident's skin needs by the following means: implementing appropriate prophylactic measures when there is an identified risk, referring the resident to restorative and therapeutic programs when medically directed, and medically directed treatment for existing skin problems. <p>Resident #70 was admitted to the facility on 3/16/15 with multiple diagnoses, including muscle weakness and other abnormalities of gait and mobility.</p> <p>Resident #70's care plan, dated 3/30/15, directed staff to complete a weekly skin assessment, monitor per the treatment record, document positive results in the nurse's notes, and notify the family/physician. Staff were directed to complete all treatments per the physician orders and notify the physician if additional treatment orders were needed.</p> <p>Resident #70's quarterly MDS assessment, dated 4/6/18, documented the following:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment. * Skin tear(s) was present. * There was application of nonsurgical dressings. <p>Resident #70's quarterly MDS assessment, dated 7/3/18, documented the following:</p>	F 684			

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F 684	<p>Continued From page 10</p> <ul style="list-style-type: none"> * She was cognitively intact. * There were no skin problems. * There was application of nonsurgical dressings. <p>Resident #70's physician orders, dated July 2018, documented the following was ordered on 3/16/15: "If new skin issues noted fill out [the] appropriate skin sheets."</p> <p>Resident #70's TAR (Treatment Administration Record), dated July 2018, documented the following:</p> <ul style="list-style-type: none"> * Treatment orders for a skin tear to the right shin from 3/4/18 were noted as "Resolved" and initialed by a staff member. * On 7/24/18: "Right shin-clean with NS, cover with Mepitel One- leave in place- change non-adherent pad secured with paper tape daily until resolved. Change PRN loose or soiled." <p>Resident #70's Weekly Skin Integrity Data collection documented the following:</p> <ul style="list-style-type: none"> * On 4/29/18: Skin tear on right shin, 0.25 by 0.2 improved, leave open to air, and resolved. * On 7/7/18: Skin intact. * On 7/24/18: New maceration (softening of the skin from contact with moisture) from dressing, new treatment on that day. <p>On 7/24/18 at 10:14 AM, Resident #70 had a Band-aid dressing that was dated 7/20/18 on her right lower leg with redness noted in the right lower extremity. Resident #70 said she must have bumped into something. There was no documentation in Resident #70's clinical record</p>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 11 regarding a Band-aid or wound being present on the right lower extremity on 7/20/18. On 7/24/18 at 10:29 AM Resident #70 said she did not remember what happened to her right lower leg. RCM #1 removed the Band-aid, and a shallow open area was present on the right shin area. RCM #1 said she would apply a Mepitel and gauze dressing with paper tape and she would write an order for the dressing. RCM #1 said there was not an order for the Band-aid and she was not aware of Resident #70 having a Band-aid in place. RCM #1 said she would have the physician look at the wound and sign the order the next time she came in, and the physician was expected to come in later that day. RCM #1 applied the dressing as she previously described. On 7/25/18 at 1:43 PM, RCM #1 said a nurse applied the Band-aid to Resident #70's right lower leg as a preventive measure in case the resident bumped it. RCM #1 said the nurse should not have applied the Band-aid without obtaining an order. RCM #1 said she thought Resident #70 had a skin tear in the same area a long time ago, and she thought the current wound was a macerated area over an old skin issue.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate	F 689		8/31/18	

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F 689	<p>Continued From page 12 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy and procedure review, and resident record review, it was determined the facility failed to ensure adequate supervision of residents to prevent falls and that fall prevention measures were followed. This was true for 1 of 4 sampled residents (#70) reviewed for falls when a resident experienced multiple falls in the facility. This failure created the risk for harm should residents sustain injuries from falling. Findings include:</p> <p>The facility's undated policy and procedure for Fall Risk Management documented the following:</p> <ul style="list-style-type: none"> * The admitting nurse completes the initial Fall Risk Assessment within 24 hours of admission. * If the score is 10 or greater on the Falls Risk Assessment or if the resident has a history of falling prior to admission, the resident is at high risk for falls. The admitting nurse will initiate the care plan regarding the resident's current status and the initial interventions to minimize the potential for falls and injury. * A Fall Risk Assessment is completed after a fall with serious injury, significant change, quarterly, and as needed. * If the score is greater than 10 on subsequent Fall Risk Assessments, the care plan is updated to show the resident's current status and the necessary interventions. The care planned interventions are communicated to staff members by inservices, orientation, shift reports, care plan meetings, and/or staff meetings. 	F 689	<ol style="list-style-type: none"> 1. Resident #70 care plan and interventions were reviewed with additional approaches added to minimize the potential for falls and injury. Non-skid strips were added next to Resident #70 bedside. RCM and social services met with resident and responsible party. Resident wishes to maintain independence. Socks were removed from the facility. Accidents and Incidents are reviewed daily by the IDT with a weekly follow-up review to ensure appropriate interventions are implemented and care plan is updated. 2. Other residents who have multiple falls have the potential to be affected. Current resident care plans were reviewed to ensure fall prevention interventions were present and complete. 3. Nursing staff will be inserviced on accident and incident investigation to determine root cause, implement new interventions to prevent reoccurrence, and update care plan as needed. 4. The fall committee will review Accidents and Incidents daily to ensure appropriate interventions are in place. DON or designee will audit all Accident & Incidents weekly x 7 weeks through 		

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F 689	<p>Continued From page 13</p> <p>Resident #70 was admitted to the facility on 3/16/15 with multiple diagnoses, including muscle weakness and other abnormalities of gait and mobility.</p> <p>Resident #70's quarterly MDS assessment, dated 4/6/18, documented the following:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment. * One person physical assist when walking in corridor and locomotion off unit. * Not steady, but able to stabilize without human assistance with moving from seated to standing and surface to surface transfers. * Not steady, only able to stabilize with human assistance with walking, turning around and facing the opposite direction while walking, and moving on and off the toilet. * Use of a walker and wheelchair. * Two or more falls with no injury since admission or the prior assessment. * One fall with injury (except major) since admission or the prior assessment. <p>Resident #70's quarterly MDS assessment, dated 7/3/18, documented the following:</p> <ul style="list-style-type: none"> * She was cognitively intact. * One person physical assist when walking in corridor. * Not steady, but able to stabilize without human assistance with moving from seated to standing and surface to surface transfers. * Not steady, only able to stabilize with human assistance with walking, turning around and facing the opposite direction while walking, and moving on and off the toilet. * Use of a walker and wheelchair. 	F 689	<p>October 19, 2018 to ensure completion of investigation with updated care plan and interventions. Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 14</p> <p>* One fall with no injury since admission or the prior assessment.</p> <p>Resident #70's physician orders, dated July 2018, documented the 4 P's (pain, potty, positioning, placement of personal items) were to be completed hourly between 6:00 PM and 6:00 AM. The order was dated 3/12/18.</p> <p>Resident #70's current care plan directed staff to:</p> <ul style="list-style-type: none"> * Perform a Fall Risk Assessment upon admission, quarterly, and upon incident. * Ensure the resident was aware of her call light location. * Ensure the bed was at the appropriate height for transfers. * If declines or falls occurred, assess for injuries, level of consciousness, signs/symptoms of infection, review medications, check vital signs, review recent lab results, request a urine culture if a urinalysis was ordered, and notify the physician of abnormalities. * Document falls in the nurses' notes per the facility protocol. * Ensure footwear was properly fitted and was non-skid when out of bed. * 4 P's from 6:00 PM to 6 AM. <p>Resident #70's Fall Risk Evaluations documented the following:</p> <ul style="list-style-type: none"> * "When [the] resident's total score is 10 or more, interventions should promptly be put in place." * On 2/3/18 the fall risk score was 13. * On 3/12/18 the fall risk score was 15. * On 4/18/18 the fall risk score was 18. * On 7/20/18 the fall risk score was 9. 	F 689			

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F 689	Continued From page 15 An Accident and Incident (A and I) report, dated 2/3/18 at 11:00 AM, documented Resident #70 fell in her room. She was found sitting on the floor next to her bed and stated she slipped while attempting to get out of bed. The slippers were removed, which had slick soles, and the bed was at the appropriate height. Interventions in place prior to the fall included bilateral cane rails, increased staff assistance, non-skid footwear, education about falls, an x-ray of the elbow, bed against the wall, continue to ensure non-skid slippers were on, and frequent checking. Current intervention were to include removing slippers that did not have a gripping surface, continue to monitor for slick or plain footwear, encourage non-skid footwear, alert charting and neuro checks. A therapy screening was completed, which indicated the resident was not appropriate for skilled therapy interventions. An A and I report, dated 3/12/18 at 4:15 AM, documented Resident #70 fell in her room. She was found sitting on the floor in stocking feet after she was heard banging on the closet door. "She was on a one person assist to [the] wheelchair. She stated she slipped out of [the] w/c (wheelchair)/bed and landed on the floor." Interventions in place prior to the fall included bed at the appropriate height, locked wheelchair, non-skid socks, frequent checks at night, and anticipate needs. Current interventions were to include having the wheelchair nearby, non-skid socks or slippers, monitor for self transfers, add the 4 P's, licensed nurse to round every hour from 6 PM to 6 AM, alert charting, and neuro checks per protocol. A therapy screening was completed, which indicated the resident was not	F 689			

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F 689	<p>Continued From page 16 appropriate for skilled therapy interventions.</p> <p>An A and I report, dated 4/18/18 at 3:30 AM, documented Resident #70 fell in her room by her bed. A nurse walked by and heard the resident calling out for help, and she was lying on her right side by the night stand with one shoe on and one shoe off. The resident stated she fell when trying to put her shoe on. Interventions in place prior to the fall included bed at the appropriate height, non-skid footwear, call light within reach, hourly checks, wheelchair brakes locked, and wheelchair next to bed. Current interventions were to include alert charting and neuro checks, monitor for pain and changes, send in a urinalysis to check for a urinary tract infection, and assessment for use of one bed cane rail per the resident's request. The bed cane rail was installed on 4/24/18. A therapy screening was completed, which indicated the resident may have benefited from skilled therapy interventions, and an order for occupational therapy was waiting for signature.</p> <p>A Progress Note, dated 7/20/18 at 12:02 AM, documented Resident #70 was found on the floor by her bed. The resident stated she slid off the bed, and she was wearing socks from home. She was assisted off the floor to her wheelchair and assisted to the restroom. Non-skid socks were provided.</p> <p>A Progress Note, dated 7/20/18 at 12:15 PM, documented slick socks were discussed with Resident #70's family member, and "all socks except non-skid is a good intervention for these kinds of falls."</p>	F 689			

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F 689	<p>Continued From page 17</p> <p>On 7/26/18 at 10:05 AM, Therapy Staff #1 said Resident #70 had been ambulating with a front-wheeled walker with assistance from CNAs. Therapy Staff #1 said an occupational therapy assessment was last performed on 6/27/18, and there were no current referrals for therapy.</p> <p>On 7/26/18 at 10:49 AM, the Therapy Director said Resident #70 last received physical therapy on 3/15/18.</p> <p>On 7/26/18 at 4:28 PM, the Therapy Director said Resident #70 was not involved in therapy beyond the initial evaluation because there had not been much change in her status. The Therapy Director said the resident liked fuzzy slippers, and the resident and her family were educated about the socks and about obtaining assistance to get up.</p> <p>On 7/27/18 at 7:53 AM, RCM #1 said Resident #70 had fallen more this year, mainly because she was more active and was walking more. RCM #1 said the main cause of Resident #70 falling was her socks, and it mostly happened at night. RCM #1 said the resident would use her call light at times, perhaps 50% of the time she would call for help, and staff looked in when they walked by and would intervene if they saw something happening. RCM #1 said Resident #70's family member continued to bring in slippery socks, facility staff previously talked to the family about the socks, and she was going to talk with the family again. RCM #1 said the CNAs applied Resident #70's socks, and the resident liked regular socks. RCM #1 said the only other option to help prevent Resident #70 from falling was a one-to-one staff assignment, but she was not sure how practical that would be for the</p>	F 689			

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F 689	Continued From page 18 resident's privacy and needs. RCM #1 said the 4 P's were initiated for Resident #70 on 7/6/18. The A and I report, dated 3/12/18 at 4:15 AM, included documentation the 4 P's were to be added as a intervention following Resident #70's fall on that date. Resident #70's physician orders, dated July 2018, documented the 4 P's (pain, potty, positioning, placement of personal items) were ordered on 3/12/18, and were to be completed hourly between 6:00 PM and 6:00 AM. The 4's were added to Resident #70's care plan on 7/6/18, 3 months and 24 days after ordered by the physician. On 7/27/18 at 7:53 AM, a copy of the A and I report was requested from RCM #1 regarding Resident #70's fall on 7/20/18. The facility did not provide a copy of the A and I report.	F 689			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure a method for evaluating the effectiveness of residents' pain management plans was in place for 2 of 3 residents (#1 and #231) sampled for pain. This failure created the potential for harm if residents	F 697	1. Resident #231 discharged from facility on 8/14/18. Resident #1 pain assessment was completed and care plan was updated to include pain.	8/31/18	

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F 697	<p>Continued From page 19</p> <p>experienced ongoing severe pain or increased pain and the facility did not identify it. Findings include:</p> <p>1. Resident #231 was admitted to the facility on 7/17/18 with diagnoses which included sepsis, chest pain, heart failure, and hypertension.</p> <p>The care plan area addressing Resident #231's pain, dated 7/18/18, documented staff were to evaluate the effectiveness of pain interventions and provide pain medications as ordered.</p> <p>Resident #231's physician order, dated 7/17/18, documented Resident #231 was to receive a 1000 mg tablet of acetaminophen orally three times a day for chronic pain.</p> <p>A Fax Order Request, dated 7/22/18, documented Resident #231 was currently receiving acetaminophen for back pain due to her kyphosis (curvature in upper portion of the back), and she stated the pain medication was not providing adequate pain control.</p> <p>Resident #231's 7/17/18 through 7/26/18 MAR documented acetaminophen was administered and her pain level was assessed. Resident #231's pain levels on the 7/17/18 through 7/23/18 evening shift documented her pain levels were rated at five and six. Resident #231's pain level on the 7/23/18 night shift was rated at a level 8. Resident #231's pain level on the 7/24/18 morning shift was rated at a level 10. Resident #231's pain level on the 7/25/18 morning shift was rated at a level 8, and on the morning shift of 7/26/18 her pain was rated at a level 9.</p>	F 697	<p>2. Other residents that experience pain are at risk from this deficient practice.</p> <p>3. Facility will implement a pain monitor for each resident that will be completed every shift and documented on the MAR to ensure facility is providing appropriate pain relief or trying other non-pharmacological interventions. All licensed nurses will be inserviced on the completion of the new pain assessment tool.</p> <p>4. DON or designee will perform audits twice a week for three weeks through September 21, 2018. Then weekly times 4 weeks through October 19, 2018. Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance.</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2018
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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F 697	<p>Continued From page 20</p> <p>On 7/23/18 at 4:33 PM, Resident #231 was complaining of severe back pain and wanted to lay down. Resident #231 stated she was miserable and her pain was a 10 out of 10.</p> <p>On 7/24/18 at 9:24 AM, Resident #231 was sitting in the therapy room in her wheelchair with her head bent over her chest and appeared asleep. The therapist was observed asking Resident #231 to please stand up with her walker. Resident #231 stood up and sat down quickly in her wheelchair from exhaustion. Resident #231 complained of pain in her back and dizziness.</p> <p>On 7/24/18 at 9:34 AM, Resident #231 stated she had severe pain of 10 out of 10 in her back.</p> <p>On 7/24/18 at 9:40 AM, LPN #1 provided Resident #231 with acetaminophen and Resident #231 stated her pain was at a 10 out of 10.</p> <p>On 7/24/18 at 9:57 AM, Resident #231 stated the acetaminophen was not working for the pain control. Resident #231 stated she told staff members about the pain control issue and it had not been resolved yet.</p> <p>A 7/24/18 physician order documented Resident #231 was to receive 50 mg of Tramadol orally twice daily PRN for back pain.</p> <p>On 7/24/18 at 11:45 AM, RCM #1 stated she was not aware of the increased pain Resident #231 was experiencing until 7/24/18. RCM #1 stated the physician was called about her increased pain and an order for Tramadol was received on 7/24/18. RCM #1 stated she had not thought</p>	F 697			

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F 697	<p>Continued From page 21</p> <p>about other non-pharmacological interventions tried such as massage, heat, and cooling. RCM #1 stated she would speak with Resident #231 and the staff about utilizing those options. RCM #1 stated she spoke with Resident #231's family about trialing different positions while in bed and ensuring Resident #231 was positioned out of bed during meals. RCM #1 stated they would utilize additional pillows for Resident #231's positioning to try and help with pain control. RCM #1 stated she could not find documentation of other nonpharmacological interventions that the facility tried. RCM #1 stated she was not sure why there was a delay of two days from the date of the faxed order request (7/22/18) and the receipt of the physician's order for Tramadol (7/24/18).</p> <p>A Progress Note, dated 7/24/18 at 11:48 AM, documented Resident #231 was interviewed regarding her pain level. The note documented her pain level on 7/23/18 "all day" was a "10/10." The note documented Resident #231's family was contacted regarding her increased pain, and her family stated Resident #231 was 'hunched over' in bed while she was there. The note documented non-pharmacological heat or cold per resident preferences was suggested.</p> <p>On 7/26/18 at 9:52 AM, the DON stated Resident #231 had kyphosis and she was receiving the maximum dose of acetaminophen. The DON stated staff should evaluate residents' pain levels and determine if the current medication was working timely.</p> <p>2. Resident #1 was admitted to the facility on 10/21/17 with diagnoses which included pain in</p>	F 697			

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F 697	<p>Continued From page 22 the right knee and muscle weakness.</p> <p>A quarterly MDS assessment, dated 4/18/18, documented Resident #1 had a severe cognitive impairment and received PRN pain medications. The MDS assessment documented Resident #1 had frequent pain.</p> <p>Resident #1 did not have a care plan regarding pain.</p> <p>Resident #1's physician orders documented Resident #1 was to receive the following pain medications:</p> <ul style="list-style-type: none"> * 650 mg of acetaminophen tablet orally four times daily PRN for pain, ordered 10/21/17. * 50 mg of Tramadol every 4 hours PRN for pain ratings 3-5 out of 10, ordered 10/21/17. * 100 mg of Tramadol every 4 hours PRN for pain ratings of 6-10 out of 10, ordered 10/21/17. <p>Resident #1's orders did not include a daily pain assessment.</p> <p>A Pain Assessment, dated 5/22/18, documented Resident #1 was not experiencing pain.</p> <p>On 7/24/18 at 10:22 AM, Resident #1 stated she was in pain and pointed to her joints when asked where it hurt.</p> <p>Resident #1's clinical record did not contain a daily pain assessment on the MAR or in her record to assess her pain level.</p> <p>On 7/26/18 at 10:38 AM, the DON and RCM #2 stated Resident #1 did not require scheduled</p>	F 697			

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F 697	Continued From page 23 pain medications and RCM #2 stated Resident #1's pain was present in her knee when she walked. RCM #2 stated Resident #1 did not request pain medications very often and she did not have very much pain present. The DON stated nurses assess residents for pain when providing all medications and it was just not documented.	F 697			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents receiving a psychoactive	F 757	1. Facility obtained order to decrease Resident #1 Lexapro to 10mg one time a day for depression. Resident's mood is	8/31/18	

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F 757	<p>Continued From page 24</p> <p>medication had an appropriate indication for use of the medication. This was true for 1 of 5 (#1) sampled residents who received psychoactive medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include:</p> <p>Resident #1 was admitted to the facility on 10/21/17 with diagnoses which included depression, single episode.</p> <p>A quarterly MDS assessment, dated 4/18/18, documented Resident #1 had a severe cognitive impairment and no signs and symptoms of depression.</p> <p>The care plan area addressing Resident #1's Mood and Behavior, initiated 11/10/17, documented Resident #1 had depression as evidenced by angry outbursts related to functional limitation.</p> <p>Resident #1's physician order, dated 11/28/17, documented Resident #1 was to receive 5 mg of Lexapro one time a day for depression.</p> <p>Resident #1 did not have a Behavior Monitoring flowsheet for November 2017.</p> <p>Resident #1's December 2017 Behavior Monitoring flowsheet documented no behaviors or signs of depression.</p> <p>Resident #1's physician order, dated 1/18/18, documented Resident #1 was to receive 10 mg of Lexapro one time a day for depression.</p>	F 757	<p>monitored on the Behavior Monitor Flowsheet. No adverse effects from the decrease have been identified.</p> <p>2. All residents receiving psychopharmacological medications are at risk from this deficient practice.</p> <p>3. Social services and nursing will be inserviced on justification for the use of medications and monitoring in place to support the medications. The Behavior Management Team will review at weekly meeting all new psychopharmacological medications ordered or any changes in dosage to ensure justification and proper monitoring is in place.</p> <p>4. DON or designee will perform audits weekly times 7 weeks through October 19, 2018. Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance.</p>		

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F 757	<p>Continued From page 25</p> <p>Resident #1's January 2018 MAR documented she was administered her 5 mg and 10 mg of Lexapro as ordered.</p> <p>Resident #1's 1/1/18 through 5/2/18 Behavior Monitoring flowsheets documented no behaviors or signs of depression.</p> <p>A Physician's Progress Note, dated 4/27/18, documented Resident #1 was sleeping well with a good appetite and good energy. The note documented Resident #1 was started on Lexapro for depression and anxiety and was doing much better after the initiation of the medication. The note documented Resident #1 was participating in physical therapy more and not calling her family as much.</p> <p>Resident #1's physician order, dated 5/2/18, documented Resident #1 was to receive 20 mg of Lexapro one time a day for depression.</p> <p>Resident #1's 5/3/18 through 7/25/18 Behavior Monitoring flowsheet documented one episode of depression on 5/4/18.</p> <p>Resident #1's 5/1/18 through 7/25/18 MAR documented Lexapro 10 mg and 20 mg was administered as ordered.</p> <p>On 7/26/18 at 10:08 AM, the DON stated Resident #1 seemed more cheerful and she was depressed towards the ends of last year. RCM #2 stated Resident #1's family spoke with her physician about her depression. RCM #2 stated the family told the physician that Resident #1 still had signs and symptoms of depression and that she needed an increase in her depression</p>	F 757			

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F 757	Continued From page 26 medication. RCM #2 stated Resident #1 was not present when Resident #1's family spoke with the physician. RCM #2 stated Resident #1 had not exhibited signs and symptoms of depression that the staff had identified. RCM #2 stated Resident #1's normal activity was to stay in her room and visit with her family when they came to visit her. RCM #2 stated the family was requested to let the facility know when Resident #1 exhibited signs of depression.	F 757			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		8/31/18	

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F 761	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure expired medications and stool culture kits were not available for use or administration to residents. This was true for 1 of 4 medication storage rooms reviewed for expired medications and biological products. This failed practice had the potential to effect 22 of 22 sampled residents (#1, #2, #4, #8, #13, #15, #17, #22, #40, #48, #49, #52, #53, #59, #62, #65, #66, #70, #72, #74, #231, #233) who resided in the facility, who could receive expired medications and/or biological products. This failed practice created the potential for harm should residents receive expired medications and/or biological products with decreased efficiency. Findings include:</p> <p>A Laboratory Supplies policy undated, documented the DON expected staff to check expiration dates prior to using expired laboratory tests.</p> <p>On 7/26/18 at 11:42 AM, an unopened bottle of multi dose antacid liquid was found with an expiration date of 2/2018.</p> <p>On 7/26/18 at 12:25 PM, two Zinc-PVA/ Formulation O&P collection Kits (stool culture), were found to be expired with an expiration date of 3/2018,</p> <p>On 7/26/18 at 3:30 PM, the DON stated she expected her staff to check expiration dates on all pharmaceuticals and biological products before use and on a regular basis.</p>	F 761	<ol style="list-style-type: none"> 1. The 22 out of the 22 sampled residents did not receive expired medications or biological products with decreased efficiency. The unopened bottle of antacid and 2 stool culture kits were disposed of. 2. All residents are at risk from this deficient practice. 3. Inservice will be completed to all licensed nurses and pharmacy consultant and central supply to ensure expired medications are removed from facility. 4. DON or designee will audit medication treatment carts and medication room for any expired medications or laboratory supplies twice a week for three weeks through September 21, 2018. Then weekly times 4 weeks through October 19, 2018. Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance. 		
F 880	Infection Prevention & Control	F 880		8/31/18	

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F 880 SS=E	Continued From page 28 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 880			

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F 880	<p>Continued From page 29</p> <p>infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents were assisted to perform standard hand hygiene measures, staff performed hand hygiene, and catheter tubing was kept off the ground to reduce the risk of infection. This was true for 5 of 21 (#2, #4, #26,</p>	F 880	<p>1. Resident #2, #26, #36, and #131 were assessed and did not show any signs or symptoms of possible infection. During the course of survey Resident #4 foley catheter was in a privacy bag at all times and measures were taken to secure the foley tubing once identified to prevent</p>		

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F 880	<p>Continued From page 30 #36, and #131) residents sampled for infection control. This failure created the potential for more than minimal harm by exposing residents to the risk of infection and cross-contamination. Findings include:</p> <p>The facility's Hand Washing policy, dated 2/12/16, documented when hands were visibly soiled or came into contact with bodily fluids to use soap and water. If hands were not visibly soiled, then use an alcohol-based cleaning product before direct contact with patients and after contact with patients' medical equipment.</p> <p>1. On 7/23/18 at 5:27 PM, during the dinner meal in the facility's Secured Unit dining room, Resident #2 was observed to bend over, scoop up a white food substance off the floor with her right hand and licked it off her fingers. CNA #4 had her back to Resident #2 during this time, then turned around, noticed the residue on the resident's fingers and used a napkin to wipe off the resident's fingers. CNA #4 then directed Resident #2 to the table where the resident began to eat her meal while using her fingers and her utensils. Approximately one minute later, RMC #2 wiped up the remaining white food substance off the floor.</p> <p>On 7/23/18 at 6:06 PM and on 7/24/18 at 10:35 AM, CNA #4 said she used a dry napkin to wipe off whipped cream from Resident #2's hand and she assumed the whipped cream was from the resident's meal.</p> <p>On 7/26/18 9:16 AM, the DON said staff should have sanitized Resident #2's hands when staff were not sure where the food came from.</p>	F 880	<p>infection. Resident was assessed and no signs or symptoms of infection noted.</p> <p>2. All residents are at risk from this deficient practice.</p> <p>3. Handwashing and proper hand hygiene inservice will be provided to all staff. Inservice will be provided to all staff on the proper placement of catheter tubing.</p> <p>4. DON or designee will audit residents with foley catheters for proper placement twice a week for three weeks through September 21, 2018. Then weekly times four weeks through October 21, 2018.</p> <p>DON or designee will audit staff for proper hand hygiene through observation twice a week for three weeks through September 21, 2018. Then weekly times four weeks through October 21, 2018.</p> <p>Results of audits will be reviewed at monthly QAPI for trending and ongoing education and compliance.</p>		

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F 880	Continued From page 31 2. On 7/24/18 at 12:36 PM, Resident #131 had just left a table in the Secured Unit's dining room and was ambulating toward the dayroom in her wheelchair. Resident #131's lunch plate was on the floor right side up with some remaining food on it. CNA #3 picked up the plate with his left hand, touching the portion of the plate which came into contact with the floor, and placed the plate back on the table where the resident had been sitting. CNA #3 then grabbed Resident #131's wheelchair handles and assisted her into the dayroom. CNA #3 then placed a gait belt on Resident #26 and physically assisted her into a dayroom chair, took off the gait belt and then grabbed Resident #26's walker to move it out of the way. CNA #3 then grabbed Resident #36's wheelchair handles and assisted him into the dayroom. CNA #3 used his hands to lock Resident #36's wheelchair brakes, placed the gait belt on the resident and physically assisted him into a dayroom chair. CNA #3 did not wash his hands or use hand sanitizer during these observations. On 7/24/18 at 12:44 PM and 7/25/18 at 11:12 AM, CNA #3 said Resident #131 had finished her meal and placed her plate on the ground. CNA #3 said he should not have placed the plate back on the table and should have used hand sanitizer after that and between assisting each of the residents. On 7/26/18 at 9:09 AM, the DON said she would expect staff to pick up the plate with a napkin or sanitize hands after picking the plate off the ground and to place the plate in the dirty dishes bin. The DON said staff were to sanitize their	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2018
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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F 880	<p>Continued From page 32</p> <p>hands after performing resident cares, including after transfers.</p> <p>3. The facility's policy and procedure for Foley Catheter Insertion, Removal, and Maintenance, dated 9/12/17, documented the following:</p> <ul style="list-style-type: none"> * "Secure the catheter to prevent movement and/or irritation and to decrease the risk of infection." * "Do not leave the drainage bag laying on the floor." * "A sterile, continuously closed drainage system should be maintained." <p>Resident #4 was admitted to the facility on 4/28/17 with multiple diagnoses, including retention of urine and hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke) affecting the left non-dominant side.</p> <p>Resident #4's annual MDS assessment, dated 4/16/18, documented she was cognitively intact, required one person physical assistance with personal hygiene, and had an indwelling catheter.</p> <p>Resident #4's physician orders, dated July 2018, documented an order for Foley catheter care every shift by the licensed nurse three times a day.</p> <p>Resident #4's care plan, dated 4/28/17, documented the licensed nurse was to monitor every shift for signs and symptoms of infection, urinary retention, or changes in output from the Foley catheter.</p>	F 880			

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

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F 880	<p>Continued From page 33</p> <p>On 7/24/18 at 11:02 AM and on 7/25/18 at 9:28 AM, Resident #4 was sitting outside in the courtyard area. A section of the Foley catheter tubing was resting on the concrete surface of the ground.</p> <p>On 7/25/18 at 9:30 AM, CNA #1 said the Foley catheter bag or tubing should not be on the ground.</p> <p>On 7/25/18 at 9:33 AM, RN #1 said the Foley catheter bag and tubing should not be on the ground or contact the ground, and that it was an infection control issue.</p> <p>On 7/25/18 at 9:35 AM, RCM #1 said the Foley catheter bag and tubing should always be off the floor and staff were educated about that. RCM #1 said it was not a good idea for the Foley catheter tubing to be on the ground. Approximately 30 minutes later, RCM #1 said she looked at Resident #4's Foley catheter tubing and it was on the ground, and they would secure it so it did not touch the ground.</p>	F 880			