

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

PRINTED: 07/09/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135145</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/26/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>ADVANCED HEALTH CARE OF LEWISTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2852 JUNIPER 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	
E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare &amp; Medicaid Services (CMS) on June 17, 2020 onsite at Advanced Health Care of Lewiston.</p> <p>The facility was found to be in substantial compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>Facility Resident Census 19 . Resident sample 6</p> <p>The CMS Team: Barbara Daggy RN, Health and LSC surveyor</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

07/02/2020

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 000	<p><b>INITIAL COMMENTS</b></p> <p>A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare &amp; Medicaid Services (CMS) on June 17, 2020 onsite at Advanced Health Care of Lewiston with record review completed on June 26, 2020.</p> <p>The facility was found to be in substantial compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p> <p>Facility Resident Census 19. Resident sample 6.</p> <p>The CMS Team: Barbara Daggy RN, Health and LSC surveyor</p> <p>Federal surveyors can be reached at: US Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313 206.615.2088 (Fax)</p>	F 000			

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