STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility procedure, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected medications received for three residents (Resident (R)6, R4, and R22) out of a total sample of 19 residents. These failures created potential for an incomplete or ineffective plan of care related to medication effectiveness and side effects.Findings include:1. Review of R6's admission Record located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke) and major depressive disorder.Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/25 and located under the MDS tab of the EMR revealed he was coded as receiving anticoagulant medication (slows or inhibits the clotting of blood), receiving antidepressant medication, and as not receiving antiplatelet medication (prevents blood platelets from clumping together).Review of R6's Order Summary Report for active orders as of 05/21/25 and located under the Orders tab of the EMR revealed orders for clopidogrel bisulfate (an antiplatelet medication) 75 milligrams (mg) daily for blood clot prevention and Lexapro (an antidepressant) 5mg daily for depressive disorder. The report indicated R6 had no orders for anticoagulant medication.Review of the Medication Administration Record (MAR) dated 05/01/25 to 05/31/25 and located under the Orders tab of the EMR revealed R6 received clopidogrel daily and received no anticoagulant medication. R6's Lexapro was coded as 10 each day from 05/15/25 to 05/21/25 which referred the reviewer to see progress notes.Review of R6's Orders-Administration Notes dated 05/15/25 to 05/21/25 located under the Progress Notes tab of the EMR revealed his Lexapro was not available.During an interview on 07/31/25 at 10:05 AM, MDS Coordinator (MDSC2) reported she was unsure whether clopidogrel bisulfate was coded as an anticoagulant or antiplatelet on the MDS. She checked on the coding guidance and stated that clopidogrel bisulfate was an antiplatelet medication. MDSC2 stated R6's MDS dated [DATE] was incorrectly coded because the clopidogrel was documented as an anticoagulant and not as an antiplatelet. In addition, MDSC2 stated an MDS reflected only medications received during the seven-day look-back period. She reviewed R6's MAR from 05/15/25 to 05/21/25 and reported she needed to correct the MDS since R6 did not receive his antidepressant medication.2. Review of the admission Record located in the EMR under the Profile tab revealed R4 was admitted to the facility on [DATE] and had diagnoses including history of transient ischemic attack (TIA) and cerebral infarction (stroke).Review of the quarterly MDS with an ARD of 05/15/25 in the EMR under the MDS tab revealed R4 was coded as receiving anticoagulant medication and as not receiving antiplatelet medication.Review of R4's Order Summary Report for active orders as of 05/15/25 and located under the Orders tab of the EMR revealed orders for clopidogrel bisulfate (an antiplatelet medication) 75mg daily for anticoagulant. R4 had no orders for any anticoagulant medication. During an interview on 07/31/25 at 10:05 AM, MDSC2 reported she had coded R6's clopidogrel as an anticoagulant since the order stated, for anticoagulant. MDSC2 then stated since clopidogrel was supposed to be coded as an antiplatelet, she needed to modify R6's MDS to show that she received an antiplatelet medication and not an anticoagulant medication.3. Review of the admission Record located in the EMR under the Profile tab revealed R22 was admitted to the facility on [DATE] and had diagnoses including gastroparesis.Review of R22's quarterly MDS with an ARD of 07/07/25 in the EMR under the MDS tab revealed he was coded as not receiving any antibiotic medication.Review of R22's Order Summary Report for active orders as of 07/07/25 and located under the Orders tab of the EMR revealed an order dated 10/01/24 for erythromycin (an antibiotic) 250mg capsule before meals for gastroparesis prevention.Review of R22's MAR dated 07/01/25 to 07/31/25 and located under the Orders tab of the EMR revealed he received the antibiotic medication daily.During an interview on 07/31/25 at 10:05 AM, MDSC2 reported she missed that R22 received antibiotic medication and that she planned to correct the MDS right away to reflect the medication.During an interview on 08/01/25 at 11:25 AM, the Director of Nursing (DON) stated he expected medications to be coded correctly on the MDS.Review of the facility's Certification of Accuracy of the MDS policy, revised 04/22/25, revealed, The assessment must accurately reflect the resident's status. The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The observation period [also known as the look-back period] is the time frame over which the resident's condition or status is captured by the MDS assessment .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure one of three residents (Resident (R) 11) reviewed for falls was assessed for injury by a licensed nurse prior to being moved by the Certified Nurse Aides (CNAs). This failure had the potential to contribute to exacerbated injury upon movement prior to assessment.Findings include:Review of R11's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, adult failure to thrive, osteoarthritis, osteoporosis, and anxiety. Review of R11's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/25 and located under the MDS tab of the EMR, revealed she was unable to complete the Brief Interview for Mental Status (BIMS) and she was assessed with memory problems and severely impaired cognition. R11 was dependent on assistance from staff with bed mobility, transfers, and locomotion.Review of R11's Event Note, dated 07/05/25 and located under the Progress Notes tab of the EMR, revealed, RN [Registered Nurse] summoned to residents [sic] room. Resident noted within bed at this time. CNA explained that while providing cares when rolling resident towards her, resident rolled OOB [out of bed] onto CNA. CNA was able to maneuver 'out from underneath' resident and to locate another CNA to assist with returning resident to bed with mechanical lift. Review of R11's Incident Report, dated 07/05/25 and provided on paper, revealed she had rolled out of bed while a CNA was providing care, and another CNA was summoned and assisted with putting the resident back to bed. The RN was then summoned to assess R11 and found R11 already in bed. During an interview on 07/31/25 at 10:41 AM, RN13 stated when she was summoned to R11's room, the resident was already in bed. RN13 conducted an assessment and noted abrasions to R11's forehead and knee but no other injuries were noted. RN13 stated the CNAs should have summoned her to conduct an assessment prior to moving the resident off the floor in case of serious injury. RN13 reported CNA6 and CNA7 were involved in the incident.During an interview on 07/31/25 at 12:05 PM, CNA7 stated CNA6 had called her into R11's room after the resident had fallen. She stated upon entering, she found R11 on the floor and assisted CNA6 to move the resident from the floor to the bed using the mechanical lift. CNA7 stated after R11 was put back into bed, RN13 was alerted of the fall and came to assess the resident. CNA7 did not see any assessment of R11 occur prior to moving her back to bed but noted the resident did not have any signs or symptoms of injury. CNA7 stated she was not aware the resident should be assessed prior to being moved off the floor prior to this incident, but was given verbal education by the nurse that R11 should have remained on the floor until she was assessed by the RN. During an interview on 07/31/25 at 12:40 PM, CNA6 stated while she was providing incontinence care to R11, the resident rolled off the bed and on top of the CNA. After R11 fell, CNA6 got out from under R11, turned on the call light, and found CNA7 to help. CNA6 stated she and CNA7 transferred R11 back to bed using a mechanical lift, then alerted RN13 of the fall. CNA6 stated she had been educated several times by the facility on the need to leave a resident on the floor until an assessment was completed by the RN. She stated in this case, no assessment had been conducted prior to transferring R11 back to bed; however, she noticed the resident was not crying, grimacing, or acting like she was in pain and had no visible injuries. CNA6 stated she was stressed by the situation and worried about getting the resident cleaned up and she did not follow her usual protocol. During an interview on 07/31/25 at 12:50 PM, the Administrator stated CNA6 and CNA7 had received verbal counseling by RN13 on not moving a resident before an assessment by the licensed nurse, but there was no documentation of the education. Review of CNA7's training records, provided on paper, revealed she received training on the Incident & [and] Reportable Event Management policy, which directed staff not to move a resident after a fall before an assessment by a licensed nurse, on 05/21/25. Evidence of CNA6's training on the Incident & Reportable Event Management policy was not provided prior to survey exit.During an interview on 08/01/25 at 12:06 PM, the Director of Nursing (DON) stated professional standards dictate a resident be assessed for injury by a licensed nurse prior to being moved after a fall, even if there were no overt signs of injury.Review of the policy titled, Incident & Reportable Event Management, dated 09/25/24, revealed, The licensed nurse should evaluate the resident and render first aide if needed. The nurse evaluation should be completed prior to moving a resident who has fallen, to determine presence of injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure there was no delay in treatment of a newly identified pressure ulcer for one of two residents (Resident (R) 10) reviewed for pressure ulcers. This failure had the potential to slow healing or lead to wound infection.Findings include:Review of R10's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including alcoholic polyneuropathy, malnutrition, muscle wasting, quadriplegia, multiple contractures, two stage III pressure ulcers, and one stage IV pressure ulcer. Review of R10's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/25 and located under the MDS tab of the EMR, revealed he scored nine out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. He had one stage II pressure ulcer that was facility-acquired and two pressure ulcers that were present on admission.Review of R10's Care Plan, dated 06/06/25, documented, Has break in skin integrity, pressure injury to right hip and right buttock, Scrotum and MASD [moisture-associated skin damage] to groin. The approaches included, Treatment as ordered. Notify MD [physician] if change in tx [treatment] is indicated. Review of R10's Wound Healing and Ostomy Clinic note, dated 07/21/25 and provided on paper, revealed, Wound Care Physician (WCP), dated 07/21/25 and provided on paper, revealed a new right inferior hip wound measuring 1 centimeter (cm) long, 1.5 cm wide, and 0.05 cm deep . There is a wound distal to the right trochanter/posterior thigh that is full thickness that tracks so will continue with current measures here also. The note contained orders for treatment of the right trochanter wound; however, there was no order addressing the inferior right hip wound.Review of R10's Wound Observation Tool, dated 07/21/25 and located under the Assessments tab of the EMR, revealed R10 acquired a new pressure ulcer to the right inferior hip at stage III on 07/21/25. The wound was 1 cm long, 1.5 cm wide, and 0.05 cm deep with moderate red drainage. The assessment documented, Initial Assessment - No wound history to compare. However, the assessment also documented, Resident is assessed weekly by RCM [Resident Care Manager] and seen monthly by [WCP] this date. Measurements show this week that tunneling is deeper but the outside diameter of the wound is unchanged . Treatment to remain the same: Irrigate with Vashe, apply skin prep to peri wound, lightly fill/pack with Iodoform, and cover gauze and secure transparent dressing. Review of R10's July 2025 Treatment Administration Record (TAR), located under the Orders tab of the EMR, revealed from 07/21/25 through 07/28/25, there were no treatment orders addressing the right inferior hip wound. Review of R10's 07/25/25 Skin/Wound Note, dated 07/25/25 and located under the Progress Notes tab of the EMR, revealed, [WCP] noted a new wound to R [right] hip but it is unclear what the wound is or the specifics of this wound. This RCM will contact [WCP] on Monday to follow up as she is out of the office today. Did not open a wound obs [observation] for this wound as it is unclear how to proceed. Review of R10's EMR under the Orders tab revealed the physician's order, dated 07/29/25, R inferior hip wound: Cleanse with Vashe cleanser aggressively, pat dry, apply skin prep to peri wound, apply silver med to wound bed, cover with gauze and secure with transparent film to be completed every Monday and Thursday. During an interview on 08/01/25 at 9:33 AM, RCM2 stated the WCP noted a new wound inferior to the older wound on R10's right hip on 07/21/25. She stated R10 went out to see the WCP on 07/21/25 and came back with paperwork that documented a new wound and its measurements; however, no new orders were noted. RCM2 stated she did not get a hold of the WCP until 07/29/25 to clarify the treatment orders for the new wound. RCM2 stated she was unable to find any documentation indicating wound treatment orders were obtained and wound treatments were implemented between 07/21/25 and 07/29/25. RCM2 stated typically, a resident would come back with paperwork with new orders for wound care and the orders would be entered into the EMR and carried out; however, the paperwork for R10 from the WCP did not have clear orders for treatment and needed to be clarified before they could be entered in the system and carried out. She stated it took a long time to get the order clarified, as the WCP was hard to get a hold of. RCM2 stated she had documented the current order for the superior wound on the 07/21/25 Wound Observation Tool because she did not have any orders to implement for the inferior wound.A call was placed to the WCP on 08/01/25 at 11:24 AM; however, no contact was made.Review of the policy titled, Skin Integrity & [and] Pressure Ulcer/Injury Prevention, dated 08/25/21, revealed, When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and manufacturer's instructions for use of the resident bed, the facility failed to ensure the brakes on the bed were locked for one of three residents (Resident (R) 11) reviewed for falls. This failure caused a fall with minor injury for R11 and had the potential to cause injury from falls.Findings include: Review of R11's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, adult failure to thrive, osteoarthritis, osteoporosis, and anxiety.Review of R11's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/25 and located under the MDS tab of the EMR, revealed she was unable to complete the Brief Interview for Mental Status (BIMS) and she was assessed with memory problems and severely impaired cognition. R11 was dependent on assistance from staff with bed mobility, transfers, and locomotion. Review of R11's EMR under the Profile tab revealed, Special Instructions: Mechanical lift for transfers. High fall risk.Review of R11's Care Plan, dated 07/22/25 and located under the Care Plan tab of the EMR, revealed, [R11] is at risk for falls r/t [related to] impaired strength, standing tolerance, balance, activity tolerance. Dementia with Impaired safety awareness, use of antidepressant medication. The approaches included, Keep her bed in appropriate position with safety mat at bedside and When laying resident in bed, make sure resident body is in the center of the bed.Review of R11's Event Note, dated 07/05/25 and located under the Progress Notes tab of the EMR, revealed, CNA explained that while providing cares when rolling resident towards her, resident rolled OOB [out of bed] onto CNA.Review of R11's Incident Report, dated 07/05/25 and provided on paper, revealed, CNA stated that the brake on one or more of the wheels was not locked. This then caused the bed to shift when rolling the resident to the side of the bed.During an interview on 07/31/25 at 12:40 PM, CNA6 stated she had been providing incontinence care for R11. The bed was unlocked, and R11 rolled too far towards the edge of the bed, the bed rolled away, and R11 fell on top of CNA6. CNA6 stated she had unlocked the bed to move the mechanical lift into position, as there was not a lot of room on the side of the bed, and had forgotten to lock it again. During an interview on 07/31/25 at 12:50 PM, the Administrator stated CNA6 had received verbal counseling on locking the bed before providing care; however, there was no documentation of the education. Review of the Mandatory CNA and NA [Nurse Aide] Clinical Meeting record, dated 07/16/25, revealed, Make sure the bed wheels are locked and that the bed is in the lowest position, parallel to the floor. However, CNA6 had not attended this training. Review of CNA6's training records, provided on paper, revealed she received training on locking the bed prior to providing care on 03/27/25.During an interview on 08/01/25 at 12:06 PM, the Director of Nursing (DON) stated the staff were expected to double-check to ensure the bed brakes were locked before providing care, and this was something taught in CNA curriculum and at the facility.Review of the undated Joerns EasyCare Bed Platform User-Service Manual revealed, Warning: Possible Injury or Death. Floor locks increase bed stability and resident safety. Make sure the bed is in a locked position with respect to the floor by ensuring the casters are off the floor or if equipped, the UltraLock is in the locked position before attempting any resident transfers. Failure to do so could result in injury or death . For best practices, the UltraLock feature should be locked at all times, except when the bed is being moved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility procedure, the facility failed to ensure a medication was available to administer as ordered for one resident (Resident (R)6) out of a total sample of 19 residents. This failure created potential for the resident to have side effects.Findings include:Review of R6's admission Record located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including major depressive disorder.Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/25 and located under the MDS tab of the EMR revealed he scored an 11 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated moderate cognitive impairment. R6 reported feeling down and having little interest in doing things for several days out of the previous two weeks on the PHQ-2 to 9 interview.Review of R6's Order Recap Summary for orders 03/06/25 to 07/31/25 and located under the Orders tab of the EMR revealed orders for Lexapro (an antidepressant) 5mg daily for depressive disorder from 03/20/25 to 05/27/25.Review of the Medication Administration Records (MAR) dated 04/01/25 to 04/30/25 and 05/01/25 to 05/31/25 and located under the Orders tab of the EMR revealed R6's Lexapro was coded as 10 each day but one from 04/28/25 to 05/27/25 which referred the reviewer to see progress notes.Review of R6's Orders-Administration Notes dated 04/28/25 to 05/27/25 located under the Progress Notes tab of the EMR revealed his Lexapro was not available.Further review of the Progress Notes tab of the EMR from 04/28/25 to 05/27/25 revealed no documentation of why R6's Lexapro was unavailable, communication with the pharmacy, or communication with the physician or nurse practitioner. A Behavior Note dated 05/15/25 documented, Resident reviewed in [behavior meeting] with [social services, resident care managers] and pharmacist. Resident has order for Lexapro 5 mg [daily] for depression, however recent has not taken the medication for over a week. The resident reports that he is feeling well and does not have any concerns, resident's behavior monitor shows no signs or symptoms of depression. Resident placed on alert charting to monitor further. Resident will continue to be monitored in [behavior meeting] going forward next month.Review of R6's Documents tab of the EMR revealed one, undated, communication to the provider stating, Resident has not been taking Lexapro 5mg for 1+ weeks and feels stable without medications. Can we [discontinue] Lexapro order with a response dated 05/27/25 to discontinue the medication. Review of R6's Care Plan tab of the EMR revealed an intervention revised on 07/29/25: Resident has a [diagnosis] of depression but prefers not to take medication at this time. He feels his mental health is well managed without pharmaceutical intervention. During an interview on 07/29/25 at 11:37 AM, R6 denied any concerns with his mood.During an interview on 07/31/25 at 8:08 AM, Registered Nurse (RN) 12 stated medications were re-ordered through the EMR. The pharmacy delivered daily. If a medication was not available, there was a pyxis (emergency supply of medications) and a local pharmacy delivery was able to be arranged for important medications. Sometimes medications were on back-order and not available so RN12 called the doctor to see if another medication was able to be substituted. During an interview on 07/31/25 at 11:50 AM, Licensed Practical Nurse (LPN) 9 recalled R6's Lexapro was unavailable. LPN9 believed it was something to do with insurance. When the doctor was notified R6 was not taking the medication, it was discontinued. During an interview on 08/01/25 at 9:59 AM, the Medical Director stated he ordered Lexapro when R6 clinically seemed depressed. R6 was tearful and did not want to participate in his care. The Medical Director stated he was made aware that R6 was not receiving the Lexapro, but he was unable to recall when he was notified and how long R6 went without the Lexapro before the notification. The Medical Director expected both a notification from the pharmacy as well as an SBAR (situation, background, assessment, recommendation) notification from nursing if medication was not available. Both were expected to be documented in the EMR, but the Medical Director saw no evidence in R6's EMR. During an interview on 08/01/25 at 10:44 AM, Resident Care Manager (RCM) 1 was made aware during a behavior meeting on 05/15/25 that R6 was not receiving his Lexapro. There was an insurance issue, and pharmacy did not contact the facility about it. Nurses were led to believe by the pharmacy that the medication was coming. RCM1 notified R6's physician/nurse practitioner that he had not received his Lexapro, and it was discontinued. The facility's protocol when medications were not available was for nursing to order it online. If it did not arrive, nurses called the pharmacy or asked the RCM1 to call the pharmacy. If a medication was available in the pyxis, it was retrieved from it. If it was not available, the physician was to be notified within two to three days. During an interview on 08/01/2025 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135128	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Lewiston	325 Warner Drive Lewiston, ID 83501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure staff donned (put on) the appropriate personal protective equipment (PPE) required for contact isolation precautions for one of three residents reviewed for transmission-based precautions (Resident (R) 16) as well as failed to ensure one out of one resident (R53) catheter bag was not resting on the floor. This failure had the potential to lead to spread of infection throughout the facility.Findings include:1. Review of R16's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE].Review of R16's Order Note, dated 07/29/25 and located under the Progress Notes tab of the EMR revealed, New order received for po [oral] Valtrex [an antiviral medication] for 14 days and for Prednisolone [an anti-inflammatory medication] to right eye tid [three times a day] until directed to stop. Resident reports that she has shinges [sic] in eyeReview of R16's Skilled Note, dated 07/30/25 and located under the Progress Notes tab of the EMR, revealed, Resident is now Contact Isolation precautions r/t having shingles in her right eye. Resident is in a single room with no roommate. All services are being provided within her room.Review of R16's EMR under the Profile tab revealed, Special Instructions: Contact precautions r/t [related to] shingles.During an observation on 07/30/25 at 8:44 AM, R16's room door had a sign announcing, Contact Isolation and directing all staff to perform hand hygiene and don a gown and gloves prior to room entry. The MDS Coordinator (MDSC) entered R16's room carrying a bottle of milk. She did not perform hand hygiene or don a gown or gloves before entering. In an interview on 07/30/25 at 8:47 AM, the MDSC confirmed she did not wear a gown or gloves and stated the floor nurse, Registered Nurse (RN) 12, had told her that the gown and gloves were not required since she was just dropping something off in the room. In an interview on 07/30/25 at 8:59 AM, RN12 stated R16 was on contact precautions due to a case of shingles in her eye. She stated upon entering her room, everyone should don a gown and gloves. In an interview on 07/30/25 at 9:22 AM, the Director of Nursing (DON) stated the MDSC should have donned gown and gloves before entering R16's room, and he had provided re-education to the MDSC regarding proper PPE use for contact precautions. The DON stated he also would be providing re-education to all staff. During an observation on 07/31/25 at 8:12 AM, Certified Nurse Aide (CNA) 5 entered R16's room with a meal tray in her hands. She did not perform hand hygiene or don a gown and gloves prior to entering. CNA 5 touched R16's overbed table and items in room. In an interview on 07/31/25 at 8:12 AM, CNA 5 stated R16 was on contact precautions for shingles in her eye, and staff were to wear a gown and gloves only for high-contact care, such as toileting or personal hygiene.During an observation on 07/31/25 at 8:44 AM, Activity Assistant (AA) entered R16's room with a stack of daily newsletters. The AA did not sanitize her hands or don a gown and gloves prior to entering the room. While in the room, the AA kneeled on floor to speak with R16.In an interview on 07/31/25 at 8:44 AM, the AA confirmed she had not donned PPE and stated she had not yet been given any information on the need for contact precautions in R16's room. She stated for contact precautions, staff were required to wear a gown and gloves if coming in contact with the resident. The AA was unsure if contact with the floor while kneeling was an activity that required PPE use.In an interview on 08/01/25 at 11:35 AM, the DON stated every time a staff member entered a room where Contact Precautions were in place, they should don the appropriate PPE, even if it was just to drop something off or talk and there was no direct contact with the resident. Review of the facility's policy titled, Transmission-based Precautions and Isolation Procedures, dated 07/02/25, revealed, Contact precautions are intended to prevent transmission of pathogens that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves before or upon entering (i.e., before making contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves before entering (i.e. before making contact with the resident or resident's environment) the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed, and hand hygiene is performed.2. Review of R53's admission Record located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses including obstructive and reflux uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine.Review of R53's Order Summary Report located under the Orders tab of the EMR revealed an order for catheter care every shift. Keep catheter bag placed below the level of the bladder, dated 04/08/25.Review of R53's Care Plan tab revealed he had a chronic foley catheter in place, revised