



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

September 23, 2015

Mindy Christopher, Administrator  
Royal Plaza Health & Rehabilitation  
2870 Juniper Drive  
Lewiston, ID 83501-4720

Provider #: 135116

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Ms. Christopher:

On **September 16, 2015**, a Facility Fire Safety and Construction survey was conducted at **Royal Plaza Health & Rehabilitation** by the Department of Health & Welfare, 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 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 6, 2015**. Failure to submit an acceptable PoC by **October 6, 2015**, may result in the imposition of civil monetary penalties by **October 26, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **October 21, 2015**, (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 21, 2015**. A change in the seriousness of the deficiencies on **October 21, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 21, 2015**, includes the following:

Denial of payment for new admissions effective **December 16, 2015**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **March 16, 2016**, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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 **September 16, 2015**, 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:

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<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 **October 6, 2015**. If your request for informal dispute resolution is received after **October 6, 2015**, 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, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

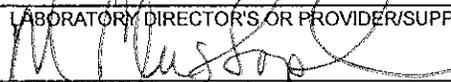
MPG/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135116</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>ROYAL PLAZA HEALTH &amp; REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2870 JUNIPER DRIVE LEWISTON, ID 83501</b>
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(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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(111) construction built in 1964 and is protected by a full automatic fire extinguishing system. It has a fire alarm/smoke detection system throughout. There is an attached Residential Care Facility. The facility is currently licensed for 56 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 16, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction (PoC) is submitted as required under Federal and State regulations applicable to long term care providers. The submission of the plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>Please accept this PoC as our credible allegation of compliance.</p> <p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>OCT - 5 2015</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p>	
K 025 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the</p>	K 025	<p><b>RESIDENT SPECIFIC</b></p> <p>1. There were no individual residents identified.</p> <p><b>OTHER RESIDENTS</b></p> <p>1. A facility wide audit (walk through) was conducted to assess for any similar issues. None were identified.</p>	9-29-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE <i>9.29.15</i>
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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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K 025	<p>Continued From page 1</p> <p>facility failed to maintain smoke barrier doors in attic spaces. Failure to maintain smoke barriers would allow smoke, fire and dangerous gases to communicate between smoke compartments increasing the potential for fires to develop beyond incipient stages. This deficient practice affected 14 residents, staff and visitors on the date of the survey. The facility is licensed for 56 SNF/NF beds and had a census of 50 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 16, 2015 from 2:30 PM to 3:30 PM, an above the ceiling inspection of smoke barrier walls in the attic space revealed the following:</p> <p>a) The self-closing door in the smoke barrier wall above rooms 27/28 would not completely close, leaving a gap of approximately 1-1/2" between the face of the door and the frame. Further inspection of this wall revealed two (2) unsealed penetrations from cables installed through this wall.</p> <p>b) The self-closing door in the smoke barrier wall above rooms 20/21 would not completely close, leaving a gap of approximately 3-1/2" between the face of the door and the frame. Further inspection revealed an approximately one inch unsealed penetration from cabling installed through this wall.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a</p>	K 025	<p><b>SYSTEMS</b></p> <ol style="list-style-type: none"> <li>1. The identified doors were adjusted and the penetration hole was filled per regulation.</li> <li>2. A walk through will be completed by the Maintenance Director after any sub-contractor has been to the facility to complete work to ensure that all self-closing doors close appropriately and that there are no penetration holes in smoke barrier walls.</li> <li>3. A walk through of the above ceiling attic space was included in the Maintenance Director's monthly rounds to ensure that all self-closing doors close appropriately and that there are no penetration holes in smoke barrier walls.</li> </ol> <p><b>MONITORING</b></p> <ol style="list-style-type: none"> <li>1. Maintenance department to make monthly rounds throughout the facility (including attic space) to assess for compliance.</li> <li>2. Administrator to monitor for quality assurance and compliance via monthly reports and daily walking rounds.</li> </ol>	

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K 025	<p>Continued From page 2</p> <p>fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.</p> <p>Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p><b>8.3 SMOKE BARRIERS</b> 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p>	K 025		