



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 4155

September 26, 2014

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

Provider #: 135116

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Christopher:

On **September 17, 2014**, 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 a widespread deficiency 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 and a similar State Form 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 you allege that each

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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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 9, 2014**. Failure to submit an acceptable PoC by **October 9, 2014**, may result in the imposition of civil monetary penalties by **October 29, 2014**.

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 22, 2014**, (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 22, 2014**. A change in the seriousness of the deficiencies on **October 22, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

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October 22, 2014, includes the following:

Denial of payment for new admissions effective **December 17, 2014**.
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 17, 2015**, 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 17, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFa>

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[ilities/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 9, 2014**. If your request for informal dispute resolution is received after **October 9, 2014**, 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,

A handwritten signature in black ink, appearing to read 'MPG', followed by a long horizontal line that ends in a small arrowhead pointing to the right.

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: 135116	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA RETIREMENT CENTER LEWIS		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER 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
K 000	<p>INITIAL COMMENTS</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 17, 2014. 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 align="center">DISCLAIMER CLAUSE</p> <p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.</p> <p align="right">RECEIVED OCT - 8 2014 FACILITY STANDARDS</p> <p>Please accept this POC as our Credible Allegation of Compliance.</p>	
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and</p>	K 029	<p>K029</p> <p>RESIDENT SPECIFIC</p> <p>1. There were no individual residents identified.</p> <p>OTHER RESIDENTS</p> <p>1. A facility wide audit (walk through) was conducted to assess for any similar issues. Self-Closing door closures were installed where appropriate.</p>	10-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *M. Burbank* TITLE *Ex. Director* (X6) DATE *10.6.14*

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 029	<p>Continued From page 1</p> <p>interview, the facility failed to ensure hazardous areas were protected with a self-closing door. Failure to ensure hazardous area doors are equipped with self-closing devices could allow smoke and dangerous gases to pass freely into corridors and affect egress capabilities. This deficient practice affected all residents, staff and visitors occupying the Physical Therapy Gym on the date of the survey. The facility is licensed for 56 SNF/NF beds and had a census of 52 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 17, 2014 from 12:30 PM to 5:30 PM, observation and operational testing of the door to the electrical room located inside the Therapy Gym found it was not equipped with a self-closing device. Further investigation revealed this room was approximately ten feet by ten feet (100 square feet) and also housed combustible storage in addition to the electrical subpanels. This storage was not obstructing access to the referenced subpanels. Inspection of the door from the Therapy Gym to the corridor found it had formerly been equipped with a self-closing device, but this device had been removed. When asked, the Maintenance Director stated he was unsure why this self-closing device had been removed.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or</p>	K 029	<p>SYSTEMS</p> <ol style="list-style-type: none"> 1. The Maintenance Director and/or designee will complete monthly walking rounds to assess for self-closing doors in areas deemed "Hazardous areas." <p>MONITORING</p> <ol style="list-style-type: none"> 1. The Maintenance Director will submit the results of the monthly walking rounds to the Executive Director for review. 2. The Executive Director will monitor for quality assurance and compliance via monthly reports and walking rounds. 3. The monthly reports will be reviewed in the Quality Assurance Performance Improvement (QAPI) meetings. 	

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K 029	Continued From page 2 corrosive materials; or heat-producing appliances. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029			
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average	K 075	K075 RESIDENT SPECIFIC 1. Resident in room #41 was discharged from the facility.	10-9-2014	

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K 075	<p>Continued From page 3</p> <p>density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure highly combustible materials were stored in a safe manner. Failure to provide proper protection of hazardous storage would result in smoke and dangerous gases passing freely through corridors during a fire, hindering egress capabilities. This deficient practice affected 37 residents in 1 of 4 smoke compartments on the date of the survey. The facility is licensed for 56 SNF/NF beds and had a census of 52 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on September 17, 2014 from 12:30 PM to 5:30 PM, observation and operational testing of the doors to room 16 and room 41 found (2) 32 gallon soiled linen/trash storage receptacles stored inside. Further investigation found the doors to these rooms were not equipped with a self-closing devices. When asked, the Maintenance Director stated this storage was due to infection control for these rooms.</p>	K 075	<p>2. The soiled linen and trash receptacle in room #16 were replaced with ones that meet the NFPA standard.</p> <p>OTHER RESIDENTS</p> <p>1. A facility wide audit (walk through) was conducted to assess for any similar issues.</p> <p>SYSTEMS</p> <p>1. All soiled linen and trash receptacles used for Infection Control in resident rooms that exceed the NFPA standard were removed from the facility property.</p> <p>2. The Maintenance Director and/or designee will complete monthly walking rounds to assess for NFPA standards in relation to soiled linen and trash receptacles.</p> <p>MONITORING</p> <p>1. The Maintenance Director will submit the results of the monthly walking rounds to the Executive Director for review.</p> <p>2. The Director of Nursing and/or Executive Director will monitor for quality assurance and compliance via monthly reports and walking rounds.</p> <p>3. The monthly reports will be reviewed in the Quality Assurance Performance Improvement (QAPI) meetings.</p>	

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

Printed: 09/25/2014
FORM APPROVED
OMB NO. 0938-0391

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K 075	<p>Continued From page 4</p> <p>2) During the facility tour conducted on September 17, 2014 from 12:30 PM to 5:30 PM, observation and operational testing of the door to the Janitor closet abutting room 43 found (2) 32 gallon soiled linen receptacles and (1) 32 gallon trash receptacle stored inside. Further investigation found this door was not equipped with a self-closing device. Interview of the Maintenance Director indicated he was not aware this door was required to self-close.</p> <p>Actual NFPA standard:</p> <p>19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft² (20.4 L/m²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.</p>	K 075		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</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 17, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to following tags on federal CMS</p>	C 226	Please see K029 + K075 for POC.	

RECEIVED
OCT - 8 2014
FACILITY STANDARDS

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

TITLE

Ex. Director

(X6) DATE

10-6-14

Bureau of Facility Standards

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C 226	Continued From Page 1 2567: K 029 Hazardous areas K 075 Combustible storage	C 226		