



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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May 5, 2017

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

Provider #: 135116

Dear Ms. Christopher:

On **April 20, 2017**, a survey was conducted at Royal Plaza Health & Rehabilitation 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 an isolated 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. 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.

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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 **May 15, 2017**. Failure to submit an acceptable PoC by **May 15, 2017**, may result in the imposition of penalties by **June 10, 2017**.

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 **May 26, 2017 (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 **July 19, 2017**. A change in the seriousness of the deficiencies on **June 4, 2017**, 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 **July 19, 2017** includes the following:

Denial of payment for new admissions effective **July 19, 2017**. [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 **October 17, 2017**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **July 19, 2017** 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/NursingFacilities/tabid/434/Default.aspx>

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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 **May 15, 2017**. If your request for informal dispute resolution is received after **May 15, 2017**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 05/25/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2017
NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA HEALTH & REHABILITATION			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	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility on April 17, 2017 to April 20, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Edith Cecil, RN Abbreviations: DNS = Director of Nursing GDR = Gradual Dose Reduction IDT = Interdisciplinary Team LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mcg = Micrograms mg = Milligrams	F 000			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for	F 279		5/26/17	

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

TITLE

(X6) DATE

Electronically Signed

05/15/2017

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 279	<p>Continued From page 1</p> <p>each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p>	F 279			

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F 279	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a resident-specific care plan was developed for a resident with a diagnosis of depression, who received antidepressant medication, and whose MDS assessments documented the presence of depression. This was true for 1 of 8 residents (Resident #7) sampled for care plan development. The deficient practice created the potential for harm if Resident #7 experienced continued depression or a deterioration in his mood state, because the facility did not implement a care plan for the resident's mental health needs. Findings included: Resident #7 initially admitted to the facility on 2/6/17, readmitted on 2/27/17, and again on 4/14/17. Resident #7 had multiple diagnoses which included depression. A physician's order, dated 2/28/17, documented escitalopram 10 mg daily. Escitalopram is an antidepressant medication used for the treatment of depression. Resident #7's MDS (Minimum Data Set) assessments documented the following: * Resident #7's Admission MDS assessment, dated 2/13/17, documented a mood severity score of 9, indicating minimal depression.	F 279	F279 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? •Resident #7 is no longer in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken? •Residents with a current diagnosis of Depression or physician orders for an antidepressant had their care plans reviewed and updated accordingly. Measures the facility will take or the systems it will alter to endure that the problem does not recur. •The IDT was in-serviced on the facility policy for care planning psychoactive medications. •Residents Psychoactive Drug and Behavior Medication Review assessment and care plans will be reviewed and updated accordingly Q 3 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance		

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F 279	Continued From page 3 * Resident #7's Admission MDS assessment, dated 3/6/17, documented a mood severity score of 2, indicating mild depression. * Resident #7's 14 day MDS assessment, dated 3/16/17, documented a mood severity score of 4 indicating mild depression. * Resident #7's 30 day MDS dated 3/31/17 documented a mood severity score of 0, indicating no depression. The Admission MDS assessment, dated 3/6/17, documented Resident #7 use of a psychotropic drug [Escitalopram] and that it would be addressed in care plan. A care plan for depression was not found in Resident #7's medical record. On 4/20/17 at 11:00 am, the Director of Nursing (DNS) provided a Depression Care Plan for Resident #7. It was dated 4/20/17. The DNS stated the Licensed Social Worker (LSW) completed the Care Plan, behavior monitoring flowsheets, and other documentation on psychoactive medications; however, she had been out of the facility. The DNS stated this was "missed" by the facility's Interdisciplinary Team.	F 279	program will be put into place? •The IDT will review during the daily Clinical meeting to identify any Residents with psychoactive medications that were new admissions, changes in current residents and newly initiated psychoactive medications and ensure that care plans were initiated and/or updated as appropriate. •DNS and/or their designee will monitor via weekly audits X 4 weeks, monthly audits X 2 months and PRN thereafter. •The ED and DNS and/or their designee will review during the monthly QAPI meeting.		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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-- (1) In excessive dose (including duplicate drug	F 329		5/26/17	

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F 329	<p>Continued From page 4 therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview, it was determined the facility failed to ensure residents who received psychotropic medications were effectively monitored to assess the effectiveness of the medications and to</p>	F 329	<p>F329 What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>		

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F 329	<p>Continued From page 5</p> <p>determine if gradual dose reductions should be initiated. This was true for 3 of 8 sampled residents receiving psychotropic medications (Residents #2, #7, and #8). This deficient practice created the potential for more than minimal harm if residents received medications that may result in negative outcomes, without evidence the benefits of the medication outweighed the risks associated with the use of the medications. Findings include:</p> <p>1. Resident #7 admitted to the facility on 2/6/17, readmitted on 2/27/17, and again on 4/14/17. Resident #7 had multiple diagnoses, which included depression.</p> <p>A Physician order, dated 2/28/17, documented Resident #7 was to receive escitalopram 10 mg (milligrams) daily. Escitalopram is an antidepressant medication used for the treatment of depression.</p> <p>Resident #7's MDS (Minimum Data Set) assessments documented the following:</p> <ul style="list-style-type: none"> * Resident #7's Admission MDS assessment, dated 2/13/17, documented a mood severity score of 9, indicating minimal depression. * Resident #7's Admission MDS assessment, dated 3/6/17, documented a mood severity score of 2, indicating mild depression. * Resident #7's 14 day MDS assessment, dated 3/16/17, documented a mood severity score of 4 indicating mild depression. * Resident #7's 30 day MDS dated 3/31/17 	F 329	<ul style="list-style-type: none"> •Residents #7 & #8 are no longer in the facility. Resident #2 was reviewed and assessed by the IDT during the weekly Psychoactive Drug and Behavior Medication Review meeting and changes were made as appropriate to the assessment. <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken?</p> <ul style="list-style-type: none"> •Residents on psychoactive medications records were reviewed for care plan completion and all appropriate monitoring systems i.e., behavior monitor flow sheets or sleep monitors <p>Measures the facility will take or the systems it will alter to endure that the problem does not recur.</p> <ul style="list-style-type: none"> •The IDT was in-serviced on the facility policy for care planning and behavior monitoring of residents who take psychoactive medications. •The admitting nurse will initiate the behavior flow sheets and/or sleep monitor flow sheets and Psychoactive Drug and Behavior Medication Review Assessments upon admission. Residents Psychoactive Drug and Behavior Medication Review assessment and care plans will be reviewed and updated accordingly Q 3 months. 		

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F 329	<p>Continued From page 6</p> <p>documented a mood severity score of 0, indicating no depression.</p> <p>The MAR (Medication Administration Record) for March 2017 and April 2017 documented the escitalopram was provided to Resident #7 daily. Staff also documented daily on the MAR, the presence or absence of side effects.</p> <p>Resident #7's medical record did not include the type and frequency of data necessary to evaluate the efficacy of the Escitalopram he used to manage his depressive symptoms. Specific behaviors that may represent Resident #7's depressive symptoms, were not identified to ensure consistent monitoring by all staff.</p> <p>On 4/20/17 at 11:00 am, the DNS (Director of Nursing) stated there was not a behavior monitoring flow sheet or other documentation process in place to monitor Resident #7's depressive symptoms. The DNS stated the LSW (Licensed Social Worker) completed the Care Plan, behavior monitoring flow sheets, and other documentation related to psychoactive medications; however, the LSW had been out of the facility. The DNS stated this was "missed" by Resident #7's IDT (Interdisciplinary Team).</p> <p>2. Resident #8 was admitted to the facility on 2/17/15, with multiple diagnoses, including depression.</p> <p>Resident #8's Physician Order Sheet for April 2017, documented she was to receive Paxil 10 mg daily. Paxil is an antidepressant medication used for the treatment of depression.</p>	F 329	<p>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?</p> <ul style="list-style-type: none"> •The IDT will review during the daily Clinical meeting to identify any Residents with psychoactive medications that were new admissions, changes in current residents and newly initiated psychoactive medications and ensure that care plans were initiated and/or updated as appropriate. •DNS and/or their designee will monitor via weekly audits X 4 weeks, monthly audits X 2 months and PRN thereafter. •The ED and DNS and/or their designee will review during the monthly QAPI meeting. 		

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F 329	<p>Continued From page 7</p> <p>Resident #8's MDS assessments, dated 1/19/17 and 3/20/17, documented a mood severity score of 2, indicating mild depression.</p> <p>A care plan, dated 8/23/16, documented Resident #8 was on a psychoactive medication [Paxil] related to depression. Interventions directed staff to:</p> <ul style="list-style-type: none"> * Report new behaviors and worsening or violent behaviors, to the nurse and MD (Medical Doctor), as needed. * The IDT and MD were to review for reduction of dosage of Resident #8's Paxil every 3 months, beginning 8/1/16. <p>The Behavior Monitoring Flowsheet for 2/2017 directed staff to document on the flowsheet episodes of crying, tearfulness, and self-isolation that were identified as the depressive symptoms Resident #8 may exhibit. Staff were also to document on an undated flowsheet. There was no documentation in Resident #8's medical record of a review of her medication and depressive symptoms, as noted in her care plan, to determine if a gradual dose reduction should be initiated.</p> <p>On 4/19/17 at 3:30 pm, Resident #8 stated she was happy and had no complaints. She stated her son visited and made sure she had everything she needed.</p> <p>On 4/20/17 at 11:00 am, the DNS stated she did not find documentation of a dose reduction for the antidepressant medication. She stated she did not find behavior monitoring data for previous months, other than those referenced above. The</p>	F 329			

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F 329	<p>Continued From page 8</p> <p>DNS stated the LSW completed the care plans, behavior monitoring flowsheets, and other documentation related to psychotropic medications; however, the LSW had been out of the facility. The DNS stated the IDT had missed some things.</p> <p>3. Resident #2 was admitted to the facility on 8/31/15, with multiple diagnoses including insomnia and depression.</p> <p>Resident #2's quarterly MDS assessment, dated 3/8/17, documented Resident #2 experienced mild depression.</p> <p>The April 2017 Physician Order Sheet, documented Resident #2 received Trazodone 25 mg daily for insomnia, beginning 6/29/16.</p> <p>Resident #2's current care plan, with an onset date of 3/22/16, documented a problem of, "Resident #2 had trouble staying asleep, insomnia" and a goal of, "Resident will report adequate rest daily." Interventions directed staff to monitor sleep status every shift, and every 3 months the IDT and Physician would review to determine if a GDR should be initiated.</p> <p>The Behavior Medication Review Form, dated 3/29/17, documented Resident #2 was started on Trazodone 25mg daily for insomnia on 6/29/16. No further GDR documentation for Trazodone was found in Resident #2's clinical record.</p> <p>Resident #2's April MAR, documented Resident #2 received Trazodone 25 mg daily at bedtime, beginning 6/29/16. The clinical record did not include documentation of the number of hours</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA HEALTH & REHABILITATION			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	
F 329	Continued From page 9 Resident #2 slept, to evaluate the medication's effectiveness. On 4/19/17 at 8:20 am, Resident #2 was observed sleeping in bed. On 4/19/17 at 10:10 am, Resident #2 was observed sleeping in bed when a staff member knocked on Resident #2's door, entered the room, and offered Resident #2 a morning snack. Resident #2 said, "No, thank you, I just want to go back to sleep." On 4/19/17 at 11:10 am, Resident #2 was observed out in the common area, participating in an activity. Resident #2 appeared alert and engaged with the activity. On 4/19/17 at 11:55 am, Resident #2 was observed eating ice cream and said she slept well. On 4/20/17 at 11:30 am, the DNS said there was a behavior monitoring flowsheet for the use of an antidepressant, rather than a hypnotic for Resident #2. The DNS said Resident #2's medical record did not include current sleep monitoring data or documentation the Trazodone was reviewed for a GDR.	F 329			
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 332		5/26/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2017
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F 332	<p>Continued From page 10</p> <p>by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a medication error rate less than 5 percent. This was true for 2 of 34 medications (5.8%) administered during medication pass and effected 2 of 7 residents (#14 and #15) observed during medication pass. This failed practice placed residents at risk of not receiving medications as ordered by the physician and had the potential to lessen the effectiveness of the medications administered. Findings include:</p> <p>The Nursing 2017 Drug Handbook for administration of Levothyroxine documented, "give Levothyroxine at same time each day on an empty stomach, preferably 30 minutes to 1 hour before breakfast."</p> <p>1. Resident #14 was admitted to the facility on 9/21/16 with multiple diagnoses, including hypothyroidism.</p> <p>Resident #14's Physician Order Sheet, dated April 2017, documented the resident was to receive the medication, Levothyroxine 125 mcg (micrograms) tablet daily to be administered on an empty stomach.</p> <p>On 4/18/17 at 9:15 am, LPN #3 (Licensed Practical Nurse) was observed as she administered Resident #14's morning medications including Levothyroxine, after Resident #14 had eaten. Resident #14's April MAR, documented the Levothyroxine was to be administered in the "AM". LPN #3 said the night nurse should have given the Levothyroxine before leaving her shift at 6:00 am.</p>	F 332	<p>F332 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? "Resident #15 is no longer in the facility. Resident #14 medications and administration times were reviewed for clinical appropriateness and adjusted as indicated.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken? "Resident's physicians order sheets were reviewed for clinical administration directions and administration times. Changes were made to the Medication Administration Records to match the Physician Order Sheets as indicated.</p> <p>Measures the facility will take or the systems it will alter to endure that the problem does not recur. "The identified LN was provided education on medication administration. "LN's were in-serviced on medication administration and completed a corresponding test.</p> <p>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? "LN's will be in-serviced Q month X 3</p>		

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F 332	<p>Continued From page 11</p> <p>2. Resident #15 was admitted to the facility on 4/15/17 with multiple diagnoses, including hypothyroidism.</p> <p>Resident #15's Physician Order Sheet, dated 4/15/17, documented the resident was to receive the medication Levothyroxine 88 mcg daily and it was to be administered prior to breakfast.</p> <p>On 4/18/17 at 9:20 am, LPN #3 was observed as she administered Resident #15's morning medications including Levothyroxine. Resident #15's April MAR, documented the Levothyroxine was to be administered "AMAC" [in the morning before meal]. LPN #3 said she should have given the Levothyroxine prior to Resident #15's breakfast, which the resident had at 8:30 am.</p> <p>On 4/19/17 at 11:30 am, the Director of Nursing said the Levothyroxine should have been administered prior to breakfast on an empty stomach.</p>	F 332	<p>months medication administration.</p> <p>"RCM□s will audit the physician□s orders Q month during the month-end change over process.</p> <p>"DNS and/or their designee will monitor via weekly audits X 4 weeks, monthly audits X 2 months and PRN thereafter.</p> <p>"The ED and DNS and/or their designee will review during the monthly QAPI meeting.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2017
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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state re-licensure survey conducted at the facility on April 17, 2017 to April 20, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Edith Cecil, RN</p> <p>Abbreviations:</p> <p>AHIMA = American Health Information Management Association</p>	C 000		
C 880	<p>02.203.01 Responsible Staff</p> <p>01. Responsible Staff. The administrator shall designate a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Records Administrator (RRA) or an Accredited Records Technician (ART), consultation from such a qualified individual shall be provided periodically to the designated staff person.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the staff member responsible for the accurate maintenance of medical records periodically received consultation from a qualified individual. This affected 12 of 13 (#1-#12) sampled residents and had the potential to affect all residents who resided in the facility. Findings</p>	C 880	<p>C880 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? "There were no negative outcomes to the facility resident□s as a result of this.</p>	5/26/17

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
05/15/17

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/20/2017
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NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501
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C 880	Continued From page 1 included: On 4/17/17 at 1:15 pm, the Administrator was asked for a copy of their current AHIMA [American Health Information Management Association] credentials for the Medical Records staff. The Administrator said the Medical Record consultant's last day was 3/31/17 and the facility had not been able to fill the position yet.	C 880	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken? "There were no negative outcomes to the facility resident□s as a result of this. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. "The facility will locate and contract with a qualified individual to provide consultation to the medical records department. "The ED will facilitate a relationship with the state AHIMA organization to develop continuing relationships. 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? "The ED will review the facility contracts on an annual basis and renew as indicated.	