



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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

November 7, 2017

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 **October 25, 2017**, 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 **November 20, 2017**. Failure to submit an acceptable PoC by **November 20, 2017**, may result in the imposition of civil monetary penalties by **December 10, 2017**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by , (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 . A change in the seriousness of the deficiencies on , 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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includes the following:

Denial of payment for new admissions effective .
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 , 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **October 25, 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:

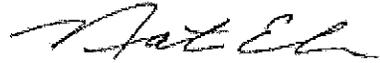
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **November 20, 2017**. If your request for informal dispute resolution is received after **November 20, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 11/07/2017
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 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2017
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
K 000	INITIAL COMMENTS 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 with a two hour separation. The facility is currently licensed for 56 SNF/NF beds. The following deficiencies were cited at the above facility during the annual fire/life safety code survey conducted on October 25, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 483.80 and 42 CFR 483.65. The survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction NFPA 101 General Requirements - Other	K 000	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. Please accept this PoC as our credible allegation of compliance. RECEIVED NOV 20 2017 FACILITY STANDARDS	
K 100 SS=F	General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to develop and implement a water management plan. Failure to develop and implement a facility specific water management plan could increase risk of growth and spread of Legionella and other opportunistic pathogens in	K 100	K100 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this. A Water Management Program was implemented.	11-20-17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE 11-17-17

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 100	Continued From page 1 building water systems. This deficient practice could potentially affect all residents, visitors and staff on the date of the survey. The facility is licensed for 56 SNF/NF residents and had a census of 49 on the day of the survey. Findings include: During the review of facility records on October 25, 2017, from approximately 8:30 AM to 10:30 AM, no records were available demonstrating the facility had completed or implemented a water management plan, which included a risk assessment and testing protocols for the prevention of waterborne pathogens such as Legionella. When asked about the missing documentation, the interim Maintenance Director stated he was not aware of the requirement for such a plan. CFR standard: 42 CFR 483.65 § 483.65 Infection control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Additional reference: Center for Medicaid/Medicare Services S & C letter 17-30	K 100	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? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this. A Water Management Program was implemented. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. <ul style="list-style-type: none">The facility completed a Legionella Risk Assessment and identified the water system process and testing requirements that were needed per facility policy. The Water Management Program will be reviewed on a quarterly basis during the monthly QA meeting. 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? <ul style="list-style-type: none">The ED and QA Committee will review the quarterly water supply testing results during the monthly QA meeting.The ED and the QA Committee will review the Waste Management Program on an annual basis and make changes as necessary.	
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR)	K 325		

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K 325	Continued From page 2 ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed, could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected 49 residents, staff and visitors on the date of the survey. The facility is licensed for 56 SNF/NF residents and had a census of 49 on the day of the survey.	K 325	K325 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this. An Alcohol Based Hand Sanitizer (ABHS) refill and testing process was implemented. 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? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this. An Alcohol Based Hand Sanitizer (ABHS) refill and testing process was implemented. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. <ul style="list-style-type: none">The facility numbered all wall mounted ABHS. The housekeeping department created a Hand Sanitizer Documentation form that they will utilize each time they refill and test a wall mounted ABHS.	11-20-17

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K 325	<p>Continued From page 3</p> <p>Findings include:</p> <p>During the review of facility inspection records on October 25, 2017 from approximately 8:30 AM to 10:30 AM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Maintenance Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of</p>	K 325	<ul style="list-style-type: none"> This form will be turned into the Director of the Safety Committee every month for review during the monthly meeting. <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 ED and QA Committee will review the monthly Safety Committee meeting minutes in regards to ABHS issues. 	

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K 325	<p>Continued From page 4</p> <p>alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100</p>	K 325		

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K 325	Continued From page 5 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.	K 325		
K 353 SS=D	NFFA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFFA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFFA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 353	K353 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this. 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? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this.	11-20-17

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K 353	<p>Continued From page 6</p> <p>failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected residents using the dining room, staff and visitors on the date of the survey. The facility is licensed for 56 SNF/NF beds and had a census of 49 on the day of the survey.</p> <p>Findings include:</p> <p>Observation during the facility tour on October 25, 2017, from approximately 10:30 AM to 12:00 PM, revealed two of the sprinkler heads in the dining room, close to the front entry, had paint on them. When asked, the Maintenance Director stated the facility was not aware that the sprinklers had been painted.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element</p>	K 353	<p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <ul style="list-style-type: none"> The maintenance department completed a facility audit of all sprinkler heads to assess for other sprinkler heads with paint on them. None were identified. Simplex Grinnell replaced the two identified sprinkler heads on 11-16-17. <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 ED, DNS and/or Director of Maintenance will complete a bi-annual visual inspection of all sprinkler heads and will report issues and POC to the QA committee. The ED, DNS and/or Director of Maintenance will ensure that a post-painting or post-construction visual inspection is completed in all areas with recent painting or construction.

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K 353	Continued From page 7 (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storage Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923	<p>K923</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> There were no negative outcomes to the facility resident's as a result of this. <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"> There were no negative outcomes to the facility resident's as a result of this. <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <ul style="list-style-type: none"> The ED, DNS and Maintenance Director assessed the storage location of the oxygen tanks and designed a plan for designated "Full" and "Empty" oxygen tank storage. The "Full" storage location will be identified with a large green sign stating "FULL" and the "empty" storage location will be identified with a large red sign stating "EMPTY." The plan was implemented. 	11-20-17

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

PRINTED: 11/07/2017
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 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2017
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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K 923	<p>Continued From page 8</p> <p>considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full cylinders has the potential of confusing staff causing the incorrect cylinder(s) to be used during an emergency requiring supplemental oxygen. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 56 SNF/NF beds and had a census of 49 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 25, 2017 from approximately 10:30 AM to 12:00 PM, observation of the oxygen storage area, revealed two storage racks with approximately nine (9) E-size oxygen cylinders in each rack. There were no signs or indicators as to whether or not the stored cylinders were empty or full. Further observation of these storage racks revealed that both full and empty cylinders were stored in each rack. When asked, the Maintenance Director stated the facility was not aware they had to be separated.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions, Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that</p>	K 923	<p>All Staff were in serviced on the policy for storage of "Full" and "Empty" oxygen tanks.</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?</p> <ul style="list-style-type: none"> The ED, DNS and/or their designee will complete weekly visual inspections of the oxygen storage locations X 4 weeks, then monthly X 2 months and PRN thereafter.

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K 923	Continued From page 9 cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		
K 926 SS=D	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the handling and use of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect 7 residents using oxygen on the date of the survey. The facility is licensed for 56 SNF/NF residents and had a census of 49 on the day of the survey. Findings include: During the review of facility training records	K 926	K926 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? <ul style="list-style-type: none">There were no negative outcomes to the facility resident's as a result of this. 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? <ul style="list-style-type: none">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. <ul style="list-style-type: none">Current Staff will be provided in-service education and training on the risks associated with the handling, safety guidelines and usage requirements of medical gases.	11-20-17

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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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K 926	Continued From page 10 conducted on October 25, 2017 from approximately 8:30 AM to 10:30 AM, no records were available indicating that the facility maintains an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Administrator stated the facility was not aware of the requirement for medical gas training. Actual NFPA Standard: NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926	<ul style="list-style-type: none"> New staff will be provided in-service education and training on the risks associated with the handling, safety guidelines and usage requirements of medical gases during new employee orientation. The SDC will provide the staff competency to the DNS for review/initial prior to anniversary date of annual evaluation. The SDC and/or designee will provide on-going education and training on a PRN basis. <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 ED and DNS and/or designee will review staff competency summaries during the monthly QA meeting. 	