



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

December 6, 2018

Mindy Shepard, 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. Shepard:

On **November 27, 2018**, 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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Mindy Shepard, Administrator
December 6, 2018
Page 2 of 4

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 **December 19, 2018**. Failure to submit an acceptable PoC by **December 19, 2018**, may result in the imposition of civil monetary penalties by **January 10, 2019**.

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 **January 1, 2019**, (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 **February 25, 2019**. A change in the seriousness of the deficiencies on **January 11, 2019**, may result in a change in the remedy.

Mindy Shepard, Administrator
December 6, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **January 1, 2019**, includes the following:

Denial of payment for new admissions effective **February 27, 2019**.
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 **May 27, 2019**, 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 **November 27, 2018**, 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:

Mindy Shepard, Administrator
December 6, 2018
Page 4 of 4

<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:

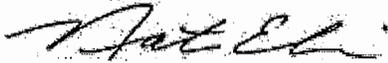
BFS Letters (06/30/11)

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

This request must be received by **December 19, 2018**. If your request for informal dispute resolution is received after **December 19, 2018**, 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

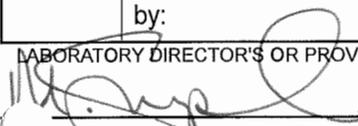
NE/lj
Enclosures

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 11/27/2018
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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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(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>INITIAL COMMENTS</p> <p>The facility is a single story, Type V(111) building, originally constructed in 1964. The facility is protected by an automatic fire extinguishing system, with an interconnected fire alarm/smoke detection system throughout. There is an attached Residential Assisted Living Facility which is separated by a two-hour fire wall. Emergency power is provided by a spark-ignited Emergency Electrical System (EES) generator. The facility is located in a municipal fire district with both county and state EMS services available. Currently the facility is licensed for 63 SNF/NF beds and had a census of 45 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 27, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70 and 483.80.</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;">RECEIVED DEC 19 2018 FACILITY STANDARDS</p>	
K 100 SS=D	<p>General Requirements - Other CFR(s): NFPA 101</p> <p>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 REQUIREMENT is not met as evidenced by:</p>	K 100	<p>K100 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. • A Facility Specific Risk Assessment was completed. 	12-19-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12-18-18
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A 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	<p>Continued From page 1</p> <p>Based on record review and interview, the facility failed to develop a water management program to prevent the transmission of waterborne pathogens. Failure to develop a risk assessment and monitor related control measures, along with implementing corrective actions when those controls are not met, has the potential to limit the facility's ability to mitigate and correct areas found to be outside established parameters due to insufficient data. This deficient practice affected 45 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records conducted on 11/27/18 from 8:45 - 10:00 AM, records revealed the following:</p> <p>The information shown on page 1 and identified as "Legionella Risk Assessment" did not indicate a facility risk assessment had been conducted, but was found to be a copy of page 2 in the CDC toolkit labeled "Identifying Buildings at Increased Risk". Further review of the CDC toolkit document demonstrated this page is used to establish if a facility needs to incorporate a water management program and is not a site-specific risk assessment for the actual facility.</p> <p>Documentation provided on page 2 of 3 revealed an area labeled "Decontamination of Water Sources". Both Item number 1 and 2 showed methods of chemical controls implemented by the facility. Further interview with the Maintenance Director revealed documentation of the monitoring of these controls and whether they were meeting or failing to meet any established parameters, was not available.</p> <p>Under the section labeled "Risk Areas for Legionella Growth" found on page 2 of 3, the list</p>	K 100	<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. • A Facility Specific Risk Assessment was completed. <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 facility completed a Legionella Risk Assessment and a Facility Specific Risk Assessment and identified the water system process and testing requirements that were needed per facility policy. • The Maintenance Director will complete monthly Water Management Preventative maintenance checks. <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 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 	

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K 100	Continued From page 2 was found to provide information on generic areas of risk and not specific risks identified by a risk assessment. Interview of the Maintenance Director established that five of the areas identified in this list did not exist in the facility. Documentation of monitoring of the temperature of water heaters was provided and demonstrated that water heater temperatures were set at a known temperature of 120 degrees to prevent scalding of the residents. Interview with the Maintenance Director revealed he was aware this temperature setting increased the risk of exposure to waterborne pathogens such as Legionella, however no mitigating practice or procedure was in place to reduce exposed risks. CFR standard: 42 CFR 483.80 § 483.80 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 QSO letter 17-30	K 100			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211	K211 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 residents as a result of this.• The paddle latch was disabled immediately after identification of this issue.	12-19-18	

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K 211	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure means of egress were maintained in accordance with NFPA 101. Failure to maintain egress doors free of obstructions has the potential to hinder resident evacuation during a fire or other emergency. This deficient practice affected residents using the front dining room, staff and visitors in 1 of 4 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/27/18 from 10:00 AM to 1:00 PM, operational testing of facility egress doors revealed the following impediments to immediate use:</p> <p>The front door paddle latch would not unlatch the door when the lock was activated. Interview of the Maintenance Director and the Administrator established management staff carried keys, but the door was not locked during or after business hours.</p> <p>The exit door from the dining room to the east was blocked by a dietary cart. This cart was observed parked at this location at 8:15 AM, 11:00 AM and 1:00 PM. Further observation revealed this cart blocked 24 inches of the 48 inch wide egress door.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2 Means of Egress Requirements. 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</p>	K 211	<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 residents as a result of this. • The paddle latch was disabled immediately after identification of this issue. <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 Director completed a facility walk through/audit of all egress doors to ensure that all other egress doors were functioning properly. No other issues were identified. • An outside contractor was contacted to inspect the paddle latch and replacement parts were ordered. The paddle latch was repaired and is functioning properly. • The Maintenance Director will complete a facility walk through/audit of all egress doors to ensure that all other egress doors were functioning properly on a monthly basis. 	

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K 211	Continued From page 4 19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following: (1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width. (2)*Where corridor width is at least 6 ft (1830 mm), noncontinuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted. (3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted. (4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)*The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment (5)*Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) The fixed furniture is securely attached to the floor or to the wall. (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830	K 211	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 Maintenance Director will provide a copy of the monthly egress door inspections to the ED for review in the monthly QA meeting. The ED and the QA Committee will review the current PoC on an annual basis and make changes as necessary. 	

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

Printed: 12/05/2018
FORM APPROVED
OMB NO. 0938-0391

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K 211	Continued From page 5 mm), except as permitted by 19.2.3.4(2). (c) The fixed furniture is located only on one side of the corridor. (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft ² (4.6 m ²). (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm). (f)*The fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. NFPA 101 Chapter 7 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. 7.2.1.5.10.2 The releasing mechanism shall open the door leaf with not more than one releasing operation, unless otherwise specified in 7.2.1.5.10.3, 7.2.1.5.10.4, or 7.2.1.5.10.6.	K 211			
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code,	K 511	K511 – See Next Page		

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K 511	Continued From page 7 Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed. 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the	K 511	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 residents as a result of this. The RPTs were removed from the staff breakroom and room 25. 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 residents as a result of this. The RPT's were removed from the staff breakroom and room 25. 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 Maintenance Director completed a facility walk through/audit for inappropriate use of RPT units. No other issues were identified. The Maintenance Director will complete a facility walk through/audit for inappropriate use of RPT units on a monthly basis. 	12-19-18	

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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 511	<p>Continued From page 6</p> <p>electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with their listed assemblies and those requirements under NFPA 70. Use of relocatable power taps (RPTs) outside of those defined in the referenced standard, UL 1363, has the potential to expose residents to risks of electrocution and arc fires. This deficient practice affected 16 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/27/18 from 10:00 AM to 12:00 PM, observation of installed electrical systems revealed the following:</p> <p>The staff breakroom was using a RPT to supply power to a full-sized refrigerator/freezer. Room number 25 was using a RPT plugged into a 3-1 multiple plug adapter, connected in series (daisy-chained).</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p>	K 511	<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 Maintenance Director will provide a copy of the monthly RPT inspections to the ED for review in the monthly QA meeting. The ED and the QA Committee will review the current PoC on an annual basis and make changes as necessary. 		

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 11/27/2018
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 511	Continued From page 8 listing or labeling.	K 511		
K 522 SS=D	<p>Additional reference: UL 1363 XBYS.GuideInfo Relocatable Power Taps</p> <p>HVAC - Any Heating Device CFR(s): NFPA 101</p> <p>HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure wall mounted electric heating units were maintained free of combustible materials as specified by manufacturer's safety guidelines. Failure to maintain spaces between electric wall heating units and combustible storage, potentially increases the risk of resident exposure to fires and forced evacuations. This deficient practice affected 16 residents, staff and visitors in 1 of 4 smoke compartments on the date of the survey.</p> <p>Findings include: During the facility tour conducted on 11/27/18 from 10:30 AM - 12:00 PM, observation of the Central supply office revealed the electric wall heating unit had a cardboard box placed approximately eight inches from the face of the</p>	K 522	<p>K522</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 residents as a result of this. • The boxes were removed from in front of the electrical wall heating unit. <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 residents as a result of this. • The boxes were removed from in front of the electrical wall heating unit. <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 Director completed a facility walk through/audit for other electrical wall heating units. No other heating units were identified. 	12-19-18

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K 522	Continued From page 9 heating unit. Operational testing of this unit revealed the unit was active and producing heat. Further observation of the unit revealed the safety sticker on the face frame which indicated these units were to be free of combustible obstructions. Actual NFPA standard: 19.5.2.2* Any heating device, other than a central heating plant, shall be designed and installed so that combustible material cannot be ignited by the device or its appurtenances, and the following requirements also shall apply: (1) If fuel-fired, such heating devices shall comply with the following: (a) They shall be chimney connected or vent connected. (b) They shall take air for combustion directly from the outside. (c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 522	<ul style="list-style-type: none"> The Maintenance Director placed caution tape on the floor in front of the electrical wall heating unit to designate the area to keep clear of combustible items. All staff were provided an in-service education regarding the safety issues of NOT placing combustible items near the electrical wall heating units/ inside the caution tape on the floor. The Central Supply Director will observe for items placed inside of this area and will remove if identified. <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/or their designee will complete a visual inspection of the area in front of the electrical wall heating unit during their weekly rounds. The ED and the QA Committee will review the current PoC on an annual basis and make changes as necessary. 	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or	K 761	K761 – See Next Page	

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K 761	<p>Continued From page 10 experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, observation and operational testing, the facility failed to ensure means of egress were maintained in accordance with NFPA 80 and NFPA 101. Failure to maintain egress doors and test fire rated assemblies annually, has the potential to hinder operation of these components and affect resident evacuation during a fire or other emergency. This deficient practice affected 16 residents, staff and visitors in 1 of 4 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility maintenance and inspection records conducted on 11/27/18 from 8:45 - 10:00 AM, records did not indicate annual testing in accordance with NFPA 80 of the fire rated assembly separating the Skilled Nursing Facility (SNF) from the Residential Assisted Living Facility (RALF) had been conducted.</p> <p>2) Operational testing of the west (left) leaf of the fire rated doors separating the SNF from the RALF, revealed the door would not fully close and latch as designed when activated.</p> <p>NFPA 101</p> <p>19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p>	K 761	<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 residents as a result of this. • The west (left) leaf of the fire rated door was adjusted to ensure proper closure and latch. <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 residents as a result of this. • The west (left) leaf of the fire rated door was adjusted to ensure proper closure. <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 Director completed a facility walk through/audit for other fire rated door closures. No other issues were identified. • The Maintenance Director will complete a monthly inspection of all fire rated doors to ensure proper closure and latch. 	12-19-18

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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 761	<p>Continued From page 11</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6</p> <p>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</p> <p>NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.</p> <p>NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.</p>	K 761	<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 Maintenance Director will provide a copy to the ED of the monthly fire rated door inspection results. The ED and/or designee will test the fire rated door closure and latch during their weekly rounds. The ED and the QA Committee will review the current PoC on an annual basis and make changes as necessary. 	
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923	K923 – See Next Page	

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K 923	Continued From page 12 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 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 923	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 residents as a result of this. The empty O2 bottles were removed from the rack marked for full bottles. 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 residents as a result of this. The empty O2 bottles were removed from the rack marked for full bottles. 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"> Additional Oxygen storage racks were purchased to accommodate more O2 bottles. Staff were provided an in-service education regarding O2 storage specifically to NOT co-mingle full and empty tanks. 	12-19-18

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K 923	<p>Continued From page 13</p> <p>failed to ensure medical gas cylinders were maintained in accordance with NFPA 99. Failure to segregate full and empty oxygen cylinders in storage areas has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 11/27/18 from 11:00 AM - 1:00 PM, observation of the oxygen storage room abutting room 15, revealed two sections with oxygen storage, one marked "Full" and one marked "Empty". When asked how staff determined which cylinders were empty, the Director of Nursing (DON) stated they would use the racks as labeled, or identify the level by looking at the gauges. Further observation revealed five (5) cylinders whose gauges indicated "Empty", placed in the rack marked "Full".</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 cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p> <p>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.</p>	K 923	<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 DNS and/or Designee will complete an audit of the O2 storage 1 X per week for 4 weeks, and monthly thereafter. • The ED and the QA Committee will review the current PoC on an annual basis and make changes as necessary. 		



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

December 20, 2018

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

Provider #: 135116

RE: **PLAN OF CORRECTION ACCEPTANCE**

Dear Ms. Shepard:

On **November 27, 2018**, a Facility Fire Safety and Construction survey was conducted at your facility. You have alleged that the deficiencies cited on that survey will be corrected. We are accepting your Plan of Correction.

If you have any questions, please contact Nate Elkins, Supervisor, Facility Fire Safety and Construction at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

FILE COPY



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FAX 208-364-1888

December 6, 2018

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

Provider #: 135116

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Shepard:

On **November 27, 2018**, an Emergency Preparedness survey was conducted at Royal Plaza Health & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

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NE/lj
Enclosures

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

Printed: 12/04/2018
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 11/27/2018
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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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(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
E 000	<p>Initial Comments</p> <p>The facility is a single story, Type V(111) building, originally constructed in 1964. The facility is protected by an automatic fire extinguishing system, with an interconnected fire alarm/smoke detection system throughout. There is an attached Residential Assisted Living Facility which is separated by a two-hour fire wall. Emergency power is provided by a spark-ignited Emergency Electrical System (EES) generator. The facility is located in a municipal fire district with both county and state EMS services available. Currently the facility is licensed for 63 SNF/NF beds and had a census of 45 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on November 27, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.