



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

November 1, 2019

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

Provider #: 135116

Dear Ms. Shepard:

On **October 18, 2019**, 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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.

Mindy Shepard, Administrator
November 1, 2019
Page 2 of 4

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 **November 12, 2019**. Failure to submit an acceptable PoC by **November 12, 2019**, may result in the imposition of penalties by **December 4, 2019**.

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 **November 22, 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 **January 18, 2020**. A change in the seriousness of the deficiencies on **December 2, 2019**, may result in a change in the remedy.

Mindy Shepard, Administrator
November 1, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **January 18, 2020** includes the following:

Denial of payment for new admissions effective **January 18, 2020**. [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 **April 18, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, 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 **January 18, 2020** 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>

Mindy Shepard, Administrator
November 1, 2019
Page 4 of 4

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 12, 2019**. If your request for informal dispute resolution is received after **November 12, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 12/20/2019
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 10/18/2019
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 from October 15, 2019 through October 18, 2019. The surveyors conducting the survey were: Cecilia Stockdill, RN Team Coordinator Jenny Walker, RN Susette Mace, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing MDS = Minimum Data Set RCM = Resident Care Manager RN = Registered Nurse SSD = Social Services Designee	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		11/20/19	

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

TITLE

(X6) DATE

Electronically Signed

11/11/2019

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 550	<p>Continued From page 1</p> <p>must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure resident dignity was maintained during dining. This affected 1 of 12 residents (Resident #1) observed for dignity during dining. This deficient practice placed Resident #1 at risk of embarrassment when staff decided to spoon feed him his soup without his consent, to prevent spills onto his shirt. Findings include: The facility's Dining Room Service policy, undated, documented: * If a clothing protector or napkin to protect clothing is beneficial, the resident is asked if they</p>	F 550	<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"> C.N.A. #1 was educated on Resident Dignity and Resident Rights. <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"> Staff were educated on Resident Dignity and Resident Rights and ongoing education is being provided. 		

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F 550	<p>Continued From page 2 would like to use one.</p> <p>* Dining Assistance:</p> <ul style="list-style-type: none"> - Assistance was provided as needed. - Residents were asked if they needed help. - Staff were polite, respectful and maintained the dignity of the resident. <p>This policy was not followed.</p> <p>Resident #1 was admitted to the facility on 2/28/17, with multiple diagnoses including history of traumatic brain injury and weakness.</p> <p>Resident #1's quarterly MDS assessment, dated 7/10/19, documented he required extensive assistance of one person with eating.</p> <p>Resident #1's care plan documented he had dysphagia (difficulty swallowing), he required extensive assistance of one staff, and required extra time to eat.</p> <p>On 10/15/19 at 5:48 PM, Resident #1 was observed using an adaptive spoon to feed himself a bowl of soup. He repeatedly spilled the soup from the spoon onto his shirt. CNA #1 was assisting another resident at the same table. CNA #1 said they were out of clothing protectors as she used a napkin to wipe the front of Resident #1's shirt. CNA #1 threw the soiled napkin onto the table and sat beside Resident #1, who spilled soup from the spoon onto the front of his shirt. CNA #1 again wiped the front of Resident #1's shirt and threw the soiled napkin onto the table. Resident #1 continued to feed himself, spilling soup from the spoon onto the front of his shirt. CNA #1 grabbed the spoon out of Resident #1's hand and stated, "I'm going to</p>	F 550	<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"> • There will be a member of the IDT assigned as Dining Room Monitor to assist during meal times and to monitor staff interactions and adherence with Resident Dignity and Resident Rights. <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 Dining Room Monitor to assess that Residents Rights and Residents Dignity are being honored during meal times. • The DON and/or their designee will monitor via weekly audits x 4 weeks, monthly audits x 2 months and PRN thereafter. • The ED and DON and/or their designee will review issues identified on the Dining Room Monitor reports during the monthly QAPI meeting. 		

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F 550	Continued From page 3 help you, so you don't make a mess." Resident #1 did not respond, and his eyes looked down. Three other residents were at the table with Resident #1. CNA #1 proceeded to spoon feed Resident #1. On 10/18/19 at 8:30 AM, the dining observation of Resident #1 was shared with the facility Administrator. The Administrator provided the facility Dining Room Service policy. The Administrator requested the name of the staff member but did not voice her opinion on the matter.	F 550			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		11/20/19	

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F 578	<p>Continued From page 4</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with the opportunity to complete an advance directive, the residents' records included documentation of this process, or documentation of their decision not to formulate an advance directive. This was true for 1 of 6 residents (Resident #196) who were reviewed for advance directives. The failure created the potential for harm if residents' health care preferences were not documented and honored at the end of life. Findings include:</p> <p>The facility's policy for Advance Directive, updated November 2016, documented the following:</p> <p>* Upon admission, the Admission Director or designee asked each resident, or their</p>	F 578	<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"> The SSD met with resident #196 to re-address his wishes regarding formulating and Advanced Directive. She documented this conversation in the resident's medical record. <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"> Resident's medical records were audited to validate that a current copy of the Advanced Directive was in the chart and/or that assistance to formulate an 		

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F 578	<p>Continued From page 5</p> <p>responsible party, if an advance directive was prepared. If an advance directive was prepared, the resident was asked to provide a copy. Each resident was asked to indicate on the Admission Agreement whether their advance directive was provided to the facility.</p> <p>* If the resident did not have an advance directive and wanted to prepare one, the Admissions Director or designee explained "in general terms" the purpose of the advance directive.</p> <p>* Each resident's advance directive was reviewed and discussed during a care plan conference, and it was documented in the resident's record.</p> <p>This policy was not followed.</p> <p>Resident #196 was admitted to the facility on 10/9/19, with multiple diagnoses including chronic heart failure, presence of a cardiac pacemaker, chronic kidney disease, and hypertension (high blood pressure).</p> <p>Resident #196's care plan documented he wished to receive CPR (cardiopulmonary resuscitation) and to follow his POST (Physician Order for Scope of Treatment) form. The interventions were initiated on 10/9/19.</p> <p>Resident #196's POST form documented his code status was full code with aggressive interventions. He wished to receive IV (intravenous) fluids, antibiotics, and blood products. He did not want to receive a feeding tube. The POST was signed by Resident #196 on 10/13/19.</p>	F 578	<p>Advanced Directive was provided.</p> <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 and Social Services Designee were educated on the regulation and the facility policy for obtaining and/or offering assistance to residents to formulate and Advanced Directive and the required documentation of these conversations. <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 the resident's Advanced Directives during the 72-hour care conference, quarterly, annually and with a significant changes and will offer assistance as needed to create an Advanced Directive. Admissions Department, Medical Records and/or Social Services will audit new admissions Advanced Directives for appropriate copies and/or documented assistance provided to create and Advanced Directives weekly X 4 weeks, monthly X 2 months and PRN thereafter. The ED, DON and/or their designee will review issues identified with Advanced Directives during the monthly QAPI meeting. 		

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F 578	Continued From page 6 A Care Conference note, dated 10/14/19 at 11:00 AM, documented a care conference was held with Resident #196 and his responsible party. The Care Conference note did not document an advance directive was offered or discussed. There was no documentation of an advance directive in Resident #196's record or that he declined to formulate an advance directive. On 10/17/19 at 9:42, the RCM said there were supposed to be two conversations regarding advanced directives; one when the resident was admitted and signed the admission agreement, and one at the initial care conference. The RCM said Social Services usually had the conversation with residents regarding advance directives. On 10/17/19 at 9:45 AM, the SSD said advance directives were discussed with each resident at the 72-hour care conference, and nursing staff reviewed the POST form at that time. The SSD said when residents completed the admission paperwork, she asked if they had an advance directive or Durable Power of Attorney, she documented the appropriate response, and she offered it if they did not have one. The SSD said Resident #196 did not have an advance directive, he was offered one, and he declined it. The SSD said she did not document a note regarding resident's response when they were offered an advance directive.	F 578			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to	F 622		11/20/19	

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F 622	Continued From page 7 remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622			

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F 622	Continued From page 8 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622			

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 10/18/2019
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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F 622	<p>Continued From page 9</p> <p>consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the required documentation was completed and the appropriate information was communicated to the receiving facility when a resident was transferred to the hospital. This was true for 1 of 3 residents (Resident #22) reviewed for transfer/discharge, and had the potential to cause harm if the resident was not treated appropriately due to lack of information. Findings include:</p> <p>The facility's policy for Transfer and Discharge, updated March 2017, documented when residents were transferred, it was documented in the resident's record and appropriate information was communicated to the receiving institution or provider. "At a minimum," the following information was provided: contact information of the practitioner responsible for care of the resident, resident representative information, advance directive information, special instructions or precautions for ongoing care, comprehensive care plan goals, and "other necessary information."</p> <p>This policy was not followed.</p> <p>Resident #22 was admitted to the facility on 8/12/19, with multiple diagnoses including dementia, muscle weakness, unsteadiness on her feet, and hallucinations.</p>	F 622	<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"> Resident #22 no longer resides at the facility. <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"> An audit of the last 7 transfers was completed and any issues identified were addressed as appropriate. <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"> Staff were educated related to the regulation and facility policy related to transferring a resident from the facility to the hospital. <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 all hospital transfers during the daily Clinical Meeting and will address any issues identified as needed. ED, DON and/or their designee will 		

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F 622	Continued From page 10 A nursing note, dated 9/28/19 at 9:30 PM, documented Resident #22's daughter requested transfer of Resident #22 to the hospital due to her altered state. The note documented Resident #22 was sent to the hospital by ambulance, and her daughter called several times asking what medications Resident #22 took and to let the facility know her mother was admitted to the hospital. The note also documented the facility's nurse called the emergency room and spoke to the emergency room nurse. The note did not include what information was provided to the emergency room nurse. Resident #22's record also did not include documentation of information provided to the hospital. On 10/17/19 at 4:26 PM, RN #1 said the only documentation in Resident #22's record regarding her transfer to the hospital was the nursing note about calling report to the emergency room. RN #1 said the facility had a transfer form, but it was not utilized when Resident #22 was transferred to the hospital.	F 622	complete audits of all hospital transfers weekly X 4 weeks, monthly X 2 months and PRN thereafter. • The ED, DON and/or their designee will review issues identified with transfers to the hospital during the monthly QAPI meeting.		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		11/20/19	

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 10/18/2019
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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F 623	<p>Continued From page 11 accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which</p>	F 623			

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F 623	<p>Continued From page 12</p> <p>receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as</p>	F 623			

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F 623	<p>Continued From page 13 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, the facility failed to ensure written notice was provided to the resident or the resident's representative prior to transfer to the hospital. This was true for 1 of 3 residents (Resident #14) reviewed for transfer/discharge to the hospital. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy for Transfer and Discharge, updated March 2017, documented when a transfer was initiated, the resident received written notice using the Resident Notice of Transfer or Discharge. The written notice included the following: the date the notice was given, the effective date of the transfer/discharge, the reason for the transfer/discharge, where the resident was moved, and the contact information for the State Long Term Care Ombudsman.</p> <p>This policy was not followed.</p> <p>Resident #14 was admitted to the facility on 7/30/19, with multiple diagnoses including arthritis and a fracture.</p> <p>Resident #14's "Nursing Home to Hospital Transfer" form, dated 9/29/19 at 12:45 AM, documented she required a transfer to the hospital related to continued back pain after a fall.</p>	F 623	<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"> Resident #14 no longer resides at the facility. <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"> An audit of the last 7 transfers was completed and any issues identified were addressed as appropriate. <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 facility DC/Transfer paperwork was reviewed and updated as appropriate to ensure it met the regulations. Staff were educated related to the regulation and facility policy related to providing written notice prior to transfer to the hospital. <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 all hospital transfers for written notice prior to transfer 		

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F 623	Continued From page 14 On 10/17/19 at 9:50 AM, the Administrator stated, she was not aware a written notice was required when a resident transferred to the hospital. RN #1, also present, said she thought the facility had 30 days to provide a written notice. RN #1 reviewed Resident #14's record and confirmed there was no documentation a written notice was provided to Resident #14 and her representative at the time of transfer to the hospital.	F 623	during the daily Clinical meeting and will address any issues identified as needed. • ED, DON and/or their designee will complete audits of all hospital transfers for written notification of transfer, weekly X 4 weeks, monthly X 2 months and PRN thereafter. • The ED, DON and/or their designee will review issues identified with providing written notification of transfer to hospital during the monthly QAPI meeting.		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		11/20/19	

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 10/18/2019
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F 625	<p>Continued From page 15</p> <p>facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure bed-hold agreements were provided to residents when they were transferred to the hospital. This was true for 1 of 3 residents (Resident #14) reviewed for transfer/discharge. This failed practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's policy for Transfer and Discharge, updated March 2017, documented in the case of an emergency transfer, written notice including the bed-hold policy was sent to the resident/responsible party, or was sent with the resident to the hospital.</p> <p>This policy was not followed.</p> <p>Resident #14 was admitted to the facility on 7/30/19, with multiple diagnoses including arthritis and a fracture.</p> <p>Resident #14's Nursing Home to Hospital Transfer form, dated 9/29/19 at 12:45 AM, documented she required a transfer to the hospital related to continued back pain after a fall.</p> <p>On 10/17/19 at 9:50 AM, the Administrator stated, the facility completed the bed-hold notice on a</p>	F 625	<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"> Resident #14 no longer resides at the facility. <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"> An audit of the last 7 transfers was completed and any issues identified were addressed as appropriate. <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 facility Bed Hold Policy was reviewed and updated as appropriate. Staff were educated related to the regulation and facility policy related to providing written information regarding the facility Bed Hold policy at the time of transfer. <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 all hospital 		

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F 625	Continued From page 16 resident's admission. RN #1, also present, reviewed Resident #14's record and confirmed there was no documentation the bed-hold policy was provided to Resident #14 and her representative when she was transferred to the hospital.	F 625	transfers for written documentation that the facility Bed Hold policy was followed during the daily Clinical Meeting and will address any issues identified as needed. • ED, DON and/or their designee will complete audits of all hospital transfers for adherence to the facility Bed Hold policy weekly X 4 weeks, monthly X 2 months and PRN thereafter. • The ED, DON and/or their designee will review issues identified with adherence to the facility Bed Hold policy during the monthly QAPI meeting.		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of Incident and Accident (I&A) Reports and staff interview, it was determined the facility failed to ensure neurological assessments were completed according to facility policy. This was true for 1 of 4 residents (Resident #198) reviewed for falls. This failure created the potential for harm if residents experienced undetected changes in neurological status. Findings include:	F 684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • Resident #198 no longer resides at 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	11/20/19	

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 10/18/2019
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F 684	<p>Continued From page 17</p> <p>The facility's policy for Neurological Evaluation, updated September 2014, documented the following:</p> <p>* In the event of an unwitnessed fall and/or it was suspected the resident hit their head, neurological evaluations were initiated and continued for 72 hours.</p> <p>* Neurological evaluations were completed at the following time frames: every 15 minutes times 8, every 30 minutes times 4, every hour times 4, and every 8 hours for the remaining 64 hours after the fall.</p> <p>The facility's policy for Fall Evaluation, updated March 2018, documented the following:</p> <p>* The licensed nurse performed neurological assessments for 72 hours after all unwitnessed falls or falls where the resident hit their head.</p> <p>These policies were not followed.</p> <p>Resident #198 was admitted to the facility on 10/7/19, with multiple diagnoses including traumatic subdural hemorrhage (a type of bleeding that occurs outside the brain as a result of a severe head injury) with loss of consciousness, and history of falling.</p> <p>Resident #198's I&A Reports documented she fell on 10/15/19 at 1:15 AM, 10/11/19 at 3:20 AM, 10/9/19 at 7:15 AM, 10/10/19 at 7:30 AM, 10/9/19 at 7:15 AM, 10/8/19 at 6:30 AM, and 10/7/19 at 11:00 PM.</p> <p>Resident #198's Neurological Evaluation forms documented the neurological evaluations were</p>	F 684	<p>taken?</p> <ul style="list-style-type: none"> An audit of the last 7 falls were completed and any issues identified were addressed as appropriate. <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 facility policy on completing Neurological assessments was reviewed and updated as appropriate to ensure it met the regulations. Staff were educated related to the regulation and facility policy on completing Neurological assessments and appropriate documentation. <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 all I & A for completion of Neurological assessments and appropriate documentation during the daily Clinical meeting and will address any issues identified as needed. ED, DON and/or their designee will complete audits of all I & A that require neurological assessments for appropriate assessment and documentation, weekly X 4 weeks, monthly X 2 months and PRN thereafter. The ED, DON and/or their designee will review issues identified with following the facility on completion of Neurological assessments during the monthly QAPI meeting. 		

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F 684	Continued From page 18 incomplete as follows: * On 10/9/19 on night shift, there were no vital signs documented. * On 10/10/19 at 2:15 PM, there were no vital signs documented, and the initials of the assessing nurse were blank. * On 10/11/19 at 3:15 PM: "See Nurses Note." There was no neurological evaluation data entered. * On 10/12/19 at 11:15 PM: "See Nurses Note." There was no neurological evaluation data entered. * On 10/12/19 at 3:15 PM: There was no information documented for Level of Consciousness, Pupil Response, Motor Functions, and Pain Response. On 10/17/19 at 9:11 AM, the RCM said neurological assessments should be done when there was an unwitnessed fall or a witnessed fall where the resident hit their head, and the neurological assessments should be done for 72 hours. The RCM said she expected the nurse to complete the documentation of neurological assessments by the end of their shift, and to complete the neurological assessments according to their schedule.	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		11/20/19	

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F 688	<p>Continued From page 19</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident interview, and staff interview, it was determined the facility failed to ensure residents received restorative therapy consistent with their needs. This was true for 1 of 12 residents (Resident #40) reviewed for restorative therapy. This created the potential for residents to experience a decline in range of motion (ROM). Findings include:</p> <p>The facility's Restorative Program policy, updated March 2019, documented the DON or designee developed a restorative plan of care based on the evaluated restorative needs of the resident with individualized, measurable goals and interventions.</p> <p>This policy was not followed.</p> <p>Resident #40 was admitted to the facility on 10/30/17, with multiple diagnoses including quadriplegia (paralysis of all four extremities) and multiple sclerosis (a potentially disabling disease of the brain and spinal cord).</p>	F 688	<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"> Resident #40's restorative program was reviewed and program was updated as appropriate. <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 with current restorative programs were reviewed and programs updated as appropriate. <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"> New Restorative staff were hired to complete the resident's Restorative program. The facility Restorative policy was 		

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F 688	<p>Continued From page 20</p> <p>Resident #40's annual MDS assessment, dated 9/20/19, documented he was cognitively intact and required the assistance of two persons for bed mobility, transfers, dressing, and toileting. He required the assistance of one person for eating, personal hygiene, and bathing.</p> <p>Resident #40's care plan documented he had a problem with impaired mobility related to decreased ROM. The care plan was initiated on 10/18/18. The goal documented for Resident #40 was he would maintain present muscle strength and endurance through the next quarter. The target date was 12/30/19. The documented interventions included:</p> <p>* A nursing rehabilitative/restorative active range of motion (AROM) program for Resident #40's upper and lower extremities for 6 days per week for 15 weeks, and he could use an arm bike (stationary bicycle using the arms instead of legs to propel the wheel). The intervention was revised on 10/18/18 as follows:</p> <p>A nursing rehabilitative/restorative passive range of motion program (PROM) for Resident #40's upper and lower extremities for 6 days per week for 15 minutes. The intervention was initiated on 10/18/18.</p> <p>The facility's Restorative Book documented Resident #40's restorative services for October 2019 as follows:</p> <p>* AROM UE (upper extremities) for 15 minutes 6 days per week; and he may use an arm bike if available. The number "1" was marked on each day six days a week.</p>	F 688	<p>reviewed and updated as appropriate to ensure it met the regulations.</p> <ul style="list-style-type: none"> Staff were educated related to the regulation and facility Restorative program policy. Education was provided to the Restorative Nurse and the Restorative Aides on the purpose and proper Restorative programs. <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 Physical Therapist and the Restorative Nurse will review resident Restorative programs during the monthly Restorative meeting and will address any issues identified as needed. ED, DON and/or their designee will complete audits of all Restorative programs, documentation and resident feedback weekly X 4 weeks, monthly X 2 months and PRN thereafter. The ED, DON and/or their designee will review issues identified with the Restorative program during the monthly QAPI meeting. 		

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F 688	<p>Continued From page 21</p> <p>* PROM LE (lower extremities) for 15 minutes 3 sets of 10 repetitions 6 days/week for 15 minutes/day. The number "1" was marked for six days in the week to indicate 15 minutes of service was provided.</p> <p>On 10/15/19 at 3:13 PM, Resident #40 stated, he fought "really hard" to control his body from the waist up, and told the facility for two years he needed an exercise program. Resident #40 said the facility told him he had a restorative program, but he said that was not right. Resident #44 said the facility called dressing and showering him a restorative program, but he knew it was not. Resident #40 stated the therapy department was really good, but the restorative program was not.</p> <p>On 10/18/19 at 8:48 AM, the Administrator verified the restorative program for Resident #40 was not an acceptable plan. The restorative program did not include specific instructions to provide range of motion to all joints of the upper and lower extremities. The restorative program also did not include defined goals to measure whether the program was effective. The Administrator said stated she was aware the restorative program was problematic, and the facility was in the process of correcting it.</p> <p>On 10/18/19 at 9:31 AM, the Physical Therapist (PT) verified the restorative program instructions for Resident #40 did not constitute an appropriate restorative program, but were traditional resident care instructions. The PT said a restorative program should have individual instructions for repetitions to each joint of an extremity, it should be a measurable program to determine if it was</p>	F 688			

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F 688	Continued From page 22 effective, and changes should be made as needed. The PT said Resident #40's current restorative program did not meet the facility's expectations	F 688			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and family and staff interview, it was determined the facility failed to ensure interventions were consistently implemented to prevent falls. This was true for 2 of 4 residents (#12 and #198) reviewed for falls, and created the potential for harm if residents experienced injuries from falling. Findings include: The facility's policy for Fall Evaluation, updated March 2018, documented the following: * The licensed nurse performed the Morse Scale (a tool to assess the resident's risk of falling) upon the resident's admission. * If the Morse scale score was greater than 45, the resident was considered a high fall risk and appropriate care plan interventions were implemented.	F 689	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • Resident #12's care plan was reviewed and updated as appropriate. • The C.N.A. involved was provided education on following the resident care plan. • Resident #198 no longer resides at 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 care plans were reviewed updated as appropriate. Measures the facility will take or the	11/20/19	

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F 689	<p>Continued From page 23</p> <p>* If the Morse scale score was less than 45, the resident was at low to moderate risk for falling, and the interdisciplinary team (IDT) determined if other interventions were needed.</p> <p>* The Morse scale was completed with each fall and with significant change in condition.</p> <p>* The Morse scale and resident's care plan were reviewed quarterly and updated as required.</p> <p>1. Resident #198 was admitted to the facility on 10/7/19, with multiple diagnoses including traumatic subdural hemorrhage (bleeding that occurs outside the brain as a result of a severe head injury) with loss of consciousness, and history of falling.</p> <p>Resident #198's care plan documented the following:</p> <p>* On 10/7/19, the Alteration in Mobility care plan documented she required one person assistance with transfers, maximum assistance with bed mobility, two person assistance with ambulation using a front wheel walker, and one person assistance with locomotion using a wheelchair.</p> <p>* The care plan for Risk for Falls, undated, documented the following: Remind Resident #198 to use the call light prior to attempting to self transfer, perform a fall assessment quarterly, as needed, and after falls, use a night light, ensure appropriate footwear at all times, notify the nurse if she refused appropriate footwear, keep the room clean and free from obstacles, ambulate with two person assistance using a front wheel walker, notify the RCM of changes in</p>	F 689	<p>systems it will alter to endure that the problem does not recur.</p> <ul style="list-style-type: none"> The facility policy on following resident care plans was reviewed and updated as appropriate. Staff were educated related to the facility policy on following resident care plans. <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 I & A during the daily clinical meeting and will address any issues identified as needed. ED, DON and/or their designee will complete audits of all I & A documentation and follow up weekly X 4 weeks, monthly X 2 months and PRN thereafter. The ED, DON and/or their designee will review issues identified I & A documentation and follow up during the monthly QAPI meeting. 		

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F 689	<p>Continued From page 24</p> <p>ambulatory status, ensure the bed was at the appropriate height for her to sit on the edge of the bed with her knees bent at a 90 degree angle and feet flat on the floor, and keep the arrangement of items and furniture consistent in her room. On 10/8/19, an intervention was added to use a padded call light and self locking brakes.</p> <p>* The Short Term Care Plan, dated 10/8/19, documented the following: Maintain a safe and clutter-free environment, keep the call light in reach and answer promptly, assess the need for safety devices, encourage Resident #198 to call for assistance if needed, observe for pain, bruising, red areas, and decreased range of motion, review environmental factors that may contribute to falls, resident to be within line of sight when not sleeping and when family was not present, re-educate staff about the call light, and use a padded "pancake" call light. On 10/9/19, it was documented to "Encourage resident to sit in recliner in Day area when drowsy during waking hours." On 10/15/19, it was documented Resident #198 was to be kept in her recliner next to the plant stand, and one on one staffing for safety from 10:00 PM to 6:00 AM.</p> <p>Resident #198's Morse Fall Scale Assessments, dated 10/7/19, 10/8/19, 10/10/19, 10/11/19, and 10/15/19, documented she was at high risk for falling.</p> <p>Resident #198's Incident and Accident (I&A) Reports documented she fell six times from 10/7/19 to 10/15/19 as follows:</p> <p>* On 10/7/19 at 11:00 PM, a nurse heard a noise while getting report for shift change, and</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>Resident #198 was found on the floor in her room at the foot of her bed. It was determined she fell when she attempted to get out of bed without assistance. Resident #198 stated she hit her head, she was alert and oriented, and a neurological assessment was within normal limits. She was assisted to her wheelchair and taken to the common area for vital signs and neurological assessments. The care plan was updated to keep Resident #198 within line of sight when she was awake and a padded call light was added.</p> <p>* On 10/8/19 at 6:30 AM, Resident #198 was found on the floor lying on her right side against the recliner. She was within line of sight prior to the fall, then she was taken to her room per her request so she could go to bed. She was attempting to get dressed and self-transferred out of bed. It was believed her wheelchair rolled away from her. Self-locking brakes were placed on her wheelchair, and she was encouraged to remain within line of sight when her family was not present. It was documented she was very impulsive and had poor safety awareness.</p> <p>* On 10/9/19 at 7:15 AM, Resident #198 was found lying on the floor beside her wheelchair in the day room. Resident #198 was sitting in her wheelchair in the common area, and she fell asleep in her wheelchair. A CNA noticed Resident #198 was leaning forward in her wheelchair but could not reach her before she fell out of her wheelchair. Previous interventions were continued, and Resident #198 was offered a recliner to use in the day area when she was tired or drowsy.</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>* On 10/10/19 at 7:30 AM, Resident #198 was found in her room sitting on the floor next to her bed. She fell before breakfast, after a CNA assisted her with morning cares. Resident #198 was in her wheelchair in her room and attempted to self-transfer. The root cause was determined to be the care plan was not followed when Resident #198 was not within line of sight, as directed by the care plan. The CNA was educated, and the care plan and directives were reviewed.</p> <p>* On 10/11/19 at 3:20 AM, Resident #198 had a witnessed fall. She was sleeping in the recliner, and she suddenly scooted down the chair onto the foot rest. The recliner tipped forward, and Resident #198 slid down the chair onto the floor. A CNA saw her scooting down in the chair, but was unable to reach her in time. An emergency care conference was held with the family, who reported Resident #198 fell frequently at home and often times it was at night when her husband was asleep. The family offered to come in and sit with Resident #198 while she was asleep, all previous interventions were continued, and the care plan and care directives were reviewed.</p> <p>* On 10/15/19 at 1:15 AM, Resident #198 was in her recliner in the day room "sleeping occasionally." She was sitting on the foot rest, the chair flipped up, and she slid onto the floor. A nurse was in the common area and heard a sound, and she saw Resident #198 sitting on the foot rest of the recliner. Before the nurse could reach Resident #198, she fell forward onto the floor. The family had been staying with Resident #198 at night since her previous fall, but they did not notify the facility they would not be coming in</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>that night; therefore, staff placed Resident #198 in the common area in her recliner. After this incident, one to one staffing was initiated for Resident #198 between the hours of 10:00 PM and 6:00 AM, with the family providing the one to one from 10:00 PM to midnight and the facility providing the one to one from midnight to 6:00 AM.</p> <p>On 10/16/19 at 3:30 PM, Resident #198's husband said she was very unstable and would fall if they did not watch her. Resident #198's husband also said she had fallen a couple of times in the facility, and she fell at home and hit her head, resulting in a hospitalization.</p> <p>On 10/17/19 at 10:38 AM, the I&A reports were reviewed with the RCM. The RCM said Resident #198 was admitted to the facility on 10/7/19 in the afternoon, and she came in with a subdural hemorrhage and frequent falls at home. The RCM said Resident #198 experienced falls in the facility. After the first fall, the facility switched to a padded call light because she wasn't remembering to use her call light, and they tried to encourage her to be out in the day area. The RCM said self-locking brakes were put on Resident #198's wheelchair at that time. Regarding the fall on 10/10/19 at 7:30 AM, the RCM said the CNA was not familiar with Resident #198, did not follow the interventions that were in place, and left her alone in her room. Education was provided to the CNA, the care plan and care directives were reviewed, and the nursing staff were educated about care plans and care directives. The RCM said on 10/15/19 at 1:15 AM, Resident #198's family did not come in and did not alert staff they were not coming in that</p>	F 689			

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F 689	<p>Continued From page 28</p> <p>night. Resident #198 was placed in the day area in the recliner. The nurse heard a noise and saw Resident #198 at the end of the foot rest. Resident #198 made it to the floor before the nurse could get there. The RCM said starting on 10/15/19, arrangements were made for one on one care for Resident #198. The one on one care consisted of her family being there from 10:00 PM to 12:00 AM, and the facility provided one one one care from 12:00 AM until 6:00 AM.</p> <p>The facility failed to ensure Resident #198 was provided the supervision necessary to prevent falls.</p> <p>2. Resident #12 was admitted to the facility on 2/17/19, with multiple diagnoses including repeated falls and age-related physical debility.</p> <p>Resident #12's quarterly MDS assessment, dated 8/7/19, documented he was severely cognitively impaired and he had no falls since the prior assessment. He required extensive assistance of two persons for bed mobility and transfers.</p> <p>Resident #12's care plan documented the following:</p> <ul style="list-style-type: none"> * Staff were directed to follow the facility fall protocol and to anticipate and meet his needs. The interventions were initiated on 5/24/19. * Resident #12 required extensive assistance of two staff members to turn and reposition in bed. The intervention was initiated on 5/24/19 and revised on 8/20/19. * Resident #12 had a fall with a skin tear to his 	F 689			

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F 689	Continued From page 29 left forearm, which was discontinued on 10/7/19. Staff were directed to review environmental factors that may have contributed to the fall. Resident #12's Morse Fall scale assessments, dated 6/4/19 and 9/28/19, documented he was at high risk for falls. An I & A report, dated 9/28/19 at 10:35 PM, documented Resident #12 was assisted by one staff member to change his incontinence brief, and his care plan directed two staff members to assist him with bed mobility. He was too close to the edge of the bed and rolled off the bed onto the floor. The I&A documented "This fall occurred as a result of the caregiver not following the resident's prescribed care plan." On 10/16/19 at 4:15 PM, the DON said Resident #12 fell when a CNA was rolling him from side to side providing cares. The DON said Resident #12 was too close to the edge of the bed and fell, and he should have had two-person assistance.	F 689			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		11/20/19	

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F 758	<p>Continued From page 30 resident, the facility must ensure that---</p> <p>§483.45(e)(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>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to</p>	F 758	What corrective action will be accomplished for those residents found to		

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 10/18/2019
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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F 758	<p>Continued From page 31</p> <p>ensure side effects were monitored and documented for residents receiving psychotropic medications. This was true for 1 of 5 residents (Resident #44) reviewed for unnecessary medications. This failure created the potential for harm if residents experienced undetected side effects from psychotropic medications. Findings include:</p> <p>The facility's policy for Behavior Management, updated January 2019, documented the following: "If the resident has an order for psychotropic medications, the side effects are monitored and documented as indicated."</p> <p>The facility's policy for Psychotropic Drugs, updated January 2019, documented psychotropic medications were "any drug that affects brain activities associated with mental processes and behavior." Psychotropic drugs include antidepressant medications.</p> <p>Resident #44 was readmitted to the facility on 5/13/19, with multiple diagnoses including non-Hodgkin lymphoma (cancer of the lymphatic system) and cachexia (weakness and wasting of the body due to severe chronic illness).</p> <p>Resident #44's quarterly MDS assessment, dated 9/24/19, documented he was cognitively intact and received antidepressant medication on 7 of the previous 7 days.</p> <p>Resident #44's physician orders included Mirtazapine (antidepressant medication) 15 mg (milligrams) at bedtime related to abnormal weight loss. The order started on 4/15/19.</p>	F 758	<p>have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #44's medical record and MARS were reviewed for appropriate psychotropic side effect monitoring and updated as appropriate. <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> Residents medical records and MARS were audited for appropriate psychotropic side effect monitoring and updated as appropriate. <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 facility policy on psychotropic side effect monitoring was reviewed and updated as appropriate. Staff were educated on the regulation and the facility policy on monitoring for psychotropic side effects. <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 Social Service and/or their designee will review all new orders for psychotropic medications for appropriate side effect monitoring and will address any issues identified as needed. ED, DON and/or their designee will complete audits of all residents receiving 		

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 10/18/2019
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F 758	Continued From page 32 Resident #44's care plan documented he used antidepressant medication related to poor nutrition. The care plan directed staff to monitor/document/report adverse reactions to antidepressant medication, including: change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in ADL (Activities of Daily Living) ability, continence, lack of voiding (urination), constipation, fecal impaction (inability to pass hard stool) diarrhea, changes in gait, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes. Resident #44's Medication Administration Records (MARs) documented the Mirtazapine was administered each day from 9/1/19 through 10/17/19. Resident #44's record did not include documentation he was monitored for side effects from the antidepressant medication. On 10/17/19 at 2:35, RN #1 said she did not see documentation of side effect monitoring in Resident #44's record related to his psychotropic medication. On 10/18/19 at 8:38 AM, RN #1 said she was unable to locate documentation of side effect monitoring for Resident #44, and it may have been because the medication was ordered for his appetite and was not triggered for side effect monitoring.	F 758	psychotropic medications for appropriate side effect monitoring weekly X 4 weeks, monthly X 2 months and PRN thereafter. • The ED, DON and/or their designee will review issues identified with psychotropic medication side effect monitoring during the monthly QAPI meeting.		

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 10/18/2019
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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F 804 SS=F	<p>Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)</p> <p>§483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, the facility failed to 1) Provide palatable food and the food was held and served at an acceptable temperature. This affected 1 of 12 residents (Resident #32) observed in the dining room, and had the potential to affect the remaining 36 residents in the facility. 2) Prepare pureed foods per the facility recipe to maintain the nutritive value. This had the potential to affect two residents (#6 and #10) who required pureed foods. These failures had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:</p> <p>1. The facility's policy for Food Temperatures, updated October 2017, documented:</p> <p>* Temperatures were taken and documented daily prior to meal service and monitored periodically throughout the meal service.</p> <p>* For potentially hazardous foods on the tray line, the temperature of the food was periodically monitored throughout the meal service to maintain proper hot or cold holding temperatures.</p>	F 804	<p>WE ARE REQUESTING AN IDR</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"> Resident #32 did not eat the chicken and was provided an alternate meal. Resident #6 and #10 were not served the first batch of pureed country fried steak. <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"> The staff stopped serving the chicken and offered alternates. Cook #2 was redirected and reeducated by the company corporate dietician at the time of the preparation of the puree and the first batch was discarded. 	11/20/19	

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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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F 804	<p>Continued From page 34</p> <p>* Corrective action was taken for food temperatures outside of regulatory standards (hot foods should be 140 degrees Fahrenheit (F) or above).</p> <p>During observation of meal service in the main dining room on 10/15/19 at 5:55 PM, Resident #32 yelled, "this chicken is still frozen, I can't eat this." The resident yelled, "I don't want any more of that chicken, give me the egg salad sandwich." Serving staff were asked to check the temperature of the chicken strip served to Resident #32, and it was observed by two surveyors. The temperature was read as 94 degrees F. Dietary Staff #3 was asked to obtain the temperature of the remaining chicken strips on the steam table to be served to other residents, and the temperature was read as 110 degrees F. Other residents who were served the chicken strips had already left the dining room. Five resident plates remained on the table with chicken strips, and on three of the five plates the chicken strips were not eaten.</p> <p>Interview of Dietary Staff #3 confirmed the acceptable temperature to serve hot food was 140 degrees F per the facility's policy. The Server chose to stop serving the chicken strips and made a request to have more chicken strips brought from the kitchen. Upon arrival of the additional chicken strips at 6:15 PM, the temperature obtained by Dietary Staff #3 registered 120 degrees F. The server chose not to serve the chicken strips. Review of the food temperature log documented prior to the beginning of food service the chicken strips temperature was 150 degrees F.</p>	F 804	<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 facility policy on proper food temperatures at the time of cooking, transport and serve out were reviewed and updated as appropriate. Staff were educated on the regulation and the facility policy proper food temperatures at the time of cooking, transport and serve out. The facility policy on following recipes for puree meal preparation were reviewed and updated as appropriate. Staff were educated on the regulation and the facility policy on following recipes. <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 Food Service Manager and/or Dietician and/or their designee will complete audits of food temperatures weekly X 4 weeks, monthly X 2 months and PRN thereafter. The Food Service Manager and/or Dietician and/or their designee will complete audits of puree meal preparation according to recipe weekly X 4 weeks, monthly X 2 months and PRN thereafter. The ED, DON and/or their designee will review issues identified with food temperatures, adherence to recipes and resident feedback the monthly QAPI meeting. 		

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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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F 804	<p>Continued From page 35</p> <p>2. The recipe provided by the facility for pureed chicken fried steak read as follows:</p> <p>Internal Temp: 165 (frozen patties baked in the oven to heat)</p> <p>5 servings Country Fried Steak - 5 portions Chicken Stock: 1/2 cup + 2 tablespoons Food Thickener Bulk: 1 Tablespoon + 3/4 teaspoon</p> <p>1. Prepare According to Regular Recipe 2. Process until smooth adding 1 oz (ounce) slurry per portion 3. Reheat to a minimum temperature of 165 F or higher for 15 seconds, Hold at minimum required temperature or higher for service</p> <p>Note: Amount of thickener required may vary relative to liquid content of cooked product. For best results, alternate thickener, and processing, checking product consistency periodically. Follow Hot-Holding temperature of 135 F or 140 F based on facility policy.</p> <p>The facility did not follow the recipe for pureed chicken fried steak.</p> <p>On 10/16/19 at 11:00 AM, Cook #2 was observed preparing the pureed food for the chicken fried steak, as listed on the menu. Cook #2 dropped five pre-portioned patties of the chicken fried steak into the container and placed the container on the food processor. Cook #2 then obtained a pitcher, put a large spoonful of chicken stock base in the container, and filled it with hot water and mixed the base in the hot water. Cook #2 walked back to the area of kitchen with the food</p>	F 804			

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F 804	Continued From page 36 processor, poured liquid into the container with the five patties of chicken fried steak, and turned the machine on to puree the food. The mixture was very thin. Cook #2 was asked how much liquid was added to the meat patties, and she said "I just eyeball it." Cook #2 began to add thickening product into the mixture of meat and liquid. Cook #2 was asked how much thickener was added to the meat and liquid, and she shrugged and stated, "maybe 1/2 teaspoon." A request was made for a copy of the recipe for pureed chicken fried steak from Dietician #2. The issue was reviewed with facility Dietician #1 on 10/17/19 at 8:54 AM. A request was made for the facility policy on the puree process of food and Dietician #1 said the facility did not have one.	F 804			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		11/20/19	

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 10/18/2019
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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F 812	<p>Continued From page 37</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to store dry foods in a manner to prevent cross contamination. This had the potential to affect all 48 residents in the facility, and created the potential for harm if residents contracted food borne illnesses. Findings include:</p> <p>On 10/15/19 at 2:15 PM, the initial tour of the facility kitchen was performed. A bulk 20 pound box of lentils and a bulk 20 pound box of navy beans were observed opened and uncovered. The tops of the boxes were missing, leaving the bulk supply of lentils and beans open to contamination. Dietary Staff #1 said the lentils and beans should be covered or in a bin with a lid to protect them from dirt and contamination.</p>	F 812	<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 residents effected. <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"> • All residents had the potential to be effected by no residents were effected. <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 facility policy on storage of dry goods was reviewed and updated as appropriate. • Staff were educated on the regulation and the facility policy on storage of dry goods. <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 Food Service Manager and/or Dietician and/or their designee will complete audits of storage of dry goods weekly X 4 weeks, monthly X 2 months and PRN thereafter. 		

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 10/18/2019
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F 812	Continued From page 38	F 812			
F 880 SS=F	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p>	F 880	<ul style="list-style-type: none"> The ED, DON and/or their designee will review issues identified with storage of dry goods during the monthly QAPI meeting. 	11/20/19	

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F 880	<p>Continued From page 39</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to</p>	F 880	<p>What corrective action will be accomplished for those residents found to</p>		

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F 880	<p>Continued From page 40</p> <p>ensure laundry staff handled, processed, and transported residents' personal clothes in a sanitary manner. This was true for 12 of 12 residents (#4, #6, #12, #14, #17, #23, #27, #39, #40, #196, #197, and #198) reviewed for infection control and had the potential to impact the other 36 residents residing in the facility. These failures created the potential for the residents to develop infection from cross-contamination of linens. Findings include:</p> <p>The facility's Soiled Laundry and Bedding policy, dated May 2015, documented staff who handle soiled laundry wore protective gloves and gowns.</p> <p>This policy was not followed.</p> <p>On 10/17/19 at 3:45 PM, the Laundry Supervisor stated the laundry staff had left for the day. The Laundry Supervisor described the laundering process of accepting, separating, cleaning, drying, folding, and returning residents' clothing. The Laundry Supervisor stated staff applied gloves and sorted the clothing, separating dark colors from the white, and sorted the linens, then they transported the dirty laundry to the washer. The Laundry Supervisor stated once the dirty laundry was placed in the washer, staff removed their gloves and washed their hands. After the wash cycle was completed, clean gloves were applied, and the clean laundry was transferred from the washer to the dryer. After the clothing was dried, the Laundry Supervisor stated the laundry was transferred from the dryer to the folding area, where it was folded and hung up. He stated the personal clothing was hung up on an uncovered rack and the cleaned clothing was delivered to the residents' rooms. The Laundry</p>	F 880	<p>have been affected by the deficient practice?</p> <ul style="list-style-type: none"> There were no negative outcomes for residents #4, #6, #12, #14, #17, #23, #27, #39, #40, #196, #197 or #198. <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"> All residents had the potential to be impacted by the deficient practice. <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 facility policy on Infection Control for handling soiled linen was reviewed and updated as appropriate. Staff were educated related to the facility policy on Infection Control for handling soiled linen and the location of the protective aprons. <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 Environmental Services Director and/or the Infection Control Nurse and/or their designee will complete audits of soiled linen processing weekly X 4 weeks, monthly X 2 months and PRN thereafter. The ED, DON and/or their designee will review issues identified with soiled linen processing during the monthly Infection Control Meeting and QAPI 		

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

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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 880	Continued From page 41 Supervisor did not mention the use of gowns when handling dirty laundry and none were observed in the laundry area at that time. On 10/17/19 at 3:50 PM, the Laundry Supervisor stated there should have been gowns in the dirty area for the laundry staff to wear while sorting the dirty laundry. The Laundry Supervisor stated he understood by not wearing a gown, gloves, or covering the clean clothing with a clean barrier during the transferring of laundry, he and the laundry staff were a risk for cross contaminating the personal laundry.	F 880	meeting.		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 21, 2020

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

Provider #: 135116

Dear Ms. Bradley:

On **October 15, 2019** through **October 18, 2019**, an unannounced on-site complaint survey was conducted at Royal Plaza Health & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint o#ID00008198

ALLEGATION #1:

The facility failed to ensure residents were free from neglect.

FINDINGS #1:

Observations of resident care and staff interactions with residents were conducted throughout the survey. Staff were observed interacting with residents and meeting residents' needs appropriately throughout the survey.

Eleven residents, two staff members, and two family members were interviewed and a resident council interview was conducted with 7 residents in attendance. During individual and group interviews with residents and family members, there were no concerns expressed regarding resident neglect.

Grievances and reportable incidents were reviewed for the previous six months. A grievance in May 2019, documented residents had concerns regarding not being assisted back to their rooms from the dining room and not receiving assistance with personal cares.

Another grievance in July 2019, documented a concern regarding a staff member carrying an

Mindy Bradley, Administrator
January 21, 2020
Page 2 of 2

infant when she entered a resident's room. The staff was not willing or able to safely assist the resident. The facility's incident investigation substantiated that the staff member entered the resident's room and attempted to assist the resident to the restroom while holding an infant.

During an interview with the Administrator on 10/18/19 at 9:10 AM, it was confirmed the staff member involved was suspended for 5 days during the investigation of the incident. The Administrator stated there had been concerns from other residents about the staff member regarding her (the staff member's) interactions with residents. The Administrator stated the staff member had previously been on probation for other situations. The Administrator stated the staff member was not abusive, and the investigation ruled out abuse. The incident was appropriately investigated and reported to the State Agency.

It was determined the facility failed to ensure resident care needs were not neglected in July 2019.

Based on the investigative findings, the allegation was substantiated. However, the facility took corrective action and no current deficient practice was identified at the time of the survey.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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March 9, 2020

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

Provider #: 135116

Dear Ms. Bradley:

On **October 15, 2020** through **October 18, 2019**, an unannounced on-site complaint survey was conducted at Royal Plaza Health & Rehabilitation. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008179

ALLEGATION #1:

The facility failed to ensure sufficient numbers of staff were provided to meet the needs of the residents.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, and interviews were conducted with residents and staff.

When asked about staffing, on 10/18/19 at 10:15 AM, the Administrator stated the corporation had a pool of staff they could use if they were short staffed. The Administrator stated the facility had used travel staff in the past and the therapy staff used to be traveling staff. The Administrator stated the facility used agency staff if it was needed.

Daily staff postings for June and July of 2019 were reviewed and an assessment of current staffing numbers was completed during the survey. Concerns related to adequate numbers of staff were not identified.

Mindy Bradley, Administrator
March 9, 2020
Page 2

Observation of 12 residents were made for necessary provision of care to ensure enough staff were available for services. Observations of meals, medication administration, and wound care were completed and observation of call light response times was observed for four days. Concerns related to adequate numbers of staff were not identified during the observations.

A group meeting was conducted with residents. Residents did not express concerns related to staffing and provision of care.

Review of the documentation related to sufficient staff for administration of medication, skin assessments, and weight monitoring was conducted with no concerns identified.

Twelve resident records were reviewed, which included three closed records of discharged residents, and no concerns were identified with a lack of documentation related to medication administration, skin assessments, or residents' weights.

The resident records were also reviewed for significant weight loss and no concerns were identified. During an interview on 10/17/19 at 2:15 PM, the dietician stated she had no concerns with documentation of the weights of residents.

Based on the investigative findings, the allegation could not be substantiated and no deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj