



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

December 16, 2019

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

Provider #: 135116

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Ms. Shepard:

On **December 5, 2019**, a Facility Fire Safety and Construction survey was conducted at **Royal Plaza Health & Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must

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be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 30, 2019**. Failure to submit an acceptable PoC by **December 30, 2019**, may result in the imposition of civil monetary penalties by **January 20, 2020**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 9, 2020**, (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 **March 4, 2020**. A change in the seriousness of the deficiencies on **January 19, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 9, 2020**, includes the following:

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Denial of payment for new admissions effective **March 5, 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 noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 5, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 5, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

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

This request must be received by **December 30, 2019**. If your request for informal dispute resolution is received after **December 30, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

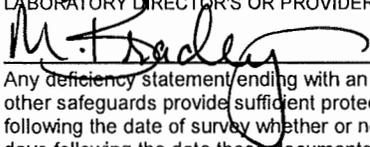
NE/lj  
Enclosures

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

PRINTED: 12/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135116</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROYAL PLAZA HEALTH &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2870 JUNIPER DRIVE LEWISTON, ID 83501</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(111) building, originally constructed in 1964. The facility is protected by an automatic fire extinguishing system, with an interconnected fire alarm/smoke detection system throughout. There is an attached Residential Assisted Living Facility which is separated by a two-hour fire wall. Emergency power is provided by a spark-ignited Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 63 SNF/NF beds and had a census of 42 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 5, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>This Plan of Correction (POC) is submitted as required under Federal and State regulations applicable to long term care providers. The submission of the plan does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>Please accept this POC as our credible allegation of compliance.</p> <p style="text-align: center;"><b>RECEIVED</b> <b>DEC 27 2019</b> <b>FACILITY STANDARDS</b></p>	
K 511 SS=D	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p>	K 511	<p><b>K511</b></p> <p><b>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>• There were no negative outcomes to the facility residents as a result of this.</li> <li>• The RPT was removed from the Salon.</li> </ul>	01-06-2020

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



TITLE

Executive Director

(X6) DATE

12.23.19

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 511	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations were maintained in accordance with NFPA 70 and approved, listed assemblies. Use of relocatable power taps (RPTs) with heat-producing appliances such as hair dryers, has been historically linked to the cause of arc fires and electrical shock. This deficient practice affected residents visiting the facility Salon and staff on the date of the survey.  Findings include:  During the facility tour conducted on 12/5/19 from 11:00 AM - 3:00 PM, observation of the Salon revealed two (2) hand-held curling irons and one (1) hand-held hair dryer using a RPT to supply power from the facility outlet.  Actual NFPA standard:  NFPA 70  110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other	K 511	<b>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?</b>  <ul style="list-style-type: none"> <li>There were no negative outcomes to the facility residents as a result of this.</li> <li>A room to room audit was completed to ensure that there were no other RPT in use.</li> </ul> <b>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</b>  <ul style="list-style-type: none"> <li>The staff were in-serviced on regulations related to use of RPT.</li> <li>The Maintenance Director and/or their designee will complete a facility walk through/audit for inappropriate use of RPT on a monthly basis.</li> </ul>	

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K 511	Continued From page 2 limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment. (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511	<b>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?</b>  <ul style="list-style-type: none"> <li>The Maintenance Director will provide a copy of the monthly RPT audits to the ED for review in the monthly QAPI meeting.</li> <li>The ED and the QAPI committee will review the current POC on an annual basis and make changes as needed.</li> </ul>	
K 712 SS=F	Further reference: UL 1363 XBYS Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712	<b>K712 What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</b>  <ul style="list-style-type: none"> <li>There were no negative outcomes to the facility residents as a result of this.</li> </ul>	1-6-2020

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K 712	<p>Continued From page 3 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure fire drills were performed for each shift each quarter. Failure to conduct quarterly fire drills has the potential to hinder staff response during fire events. This deficient practice affected 60 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided fire drill records conducted on 12/5/19 from 8:30 - 10:00 AM, records failed to demonstrate the facility conducted quarterly fire drills on the following shifts:</p> <ol style="list-style-type: none"> <li>1) No documentation of 2019, first quarter fire drills on all identified shifts.</li> <li>2) No documentation of 2019, second quarter fire drills for the day shift and evening shift.</li> <li>3) No documentation of 2019, third quarter fire drill for the graveyard shift.</li> </ol> <p>Actual NFPA standard:</p> <p>19.7.1 Evacuation and Relocation Plan and Fire Drills.</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p>	K 712	<p><b>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?</b></p> <ul style="list-style-type: none"> <li>• There were no negative outcomes to the facility residents as a result of this.</li> </ul> <p><b>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</b></p> <ul style="list-style-type: none"> <li>• The Maintenance Director will complete monthly fire drills on differing shifts to ensure that there are quarterly fire drills for all shifts.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>• The Maintenance Director will provide a copy of the monthly fire drills to the ED for review in the monthly QAPI meeting.</li> </ul>		

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K 914 SS=F	<p>Electrical Systems - Maintenance and Testing CFR(s): NFPA 101</p> <p>Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility electrical receptacles were maintained in accordance with NFPA 99. Failure to test resident care area electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 42 residents and staff on the date of the survey.</p> <p>Findings include:  During review of provided maintenance</p>	K 914	<p><b>K712 Continued</b></p> <ul style="list-style-type: none"> <li>The ED and the QAPI committee will review the current POC on an annual basis and make changes as needed.</li> </ul> <p>K914 <b>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>There were no negative outcomes to the facility residents as a result of this.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>There were no negative outcomes to the facility residents as a result of this.</li> </ul>	1-6-2020

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K 914	<p>Continued From page 5</p> <p>documents conducted on 12/5/19 from 8:30 - 10:00 AM, no documentation was available demonstrating annual outlet testing had been conducted.</p> <p>When interviewed on 10/16/19 at approximately 10:30 AM, the Maintenance Supervisor stated he had started, but not yet completed the outlet testing for resident care areas.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care Rooms. 6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection. 6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified. 6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device.</p>	K 914	<p><b>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director and/or their designee will complete tension testing on all of the facility outlets.</li> <li>The Maintenance Director and/or their designee will place outlet tension testing on the annual preventative maintenance schedule.</li> </ul> <p><b>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?</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director will provide a copy of the annual tension testing to the ED for review in the QAPI meeting.</li> <li>The ED and the QAPI committee will review the current POC on an annual basis and make changes as needed.</li> </ul>	

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K 914	Continued From page 6 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K 923	<b>K923</b> <b>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</b>  <ul style="list-style-type: none"> <li>• There were no negative outcomes to the facility residents as a result of this.</li> <li>• The empty O2 bottles were removed from the rack marked for full bottles.</li> </ul> <b>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?</b>  <ul style="list-style-type: none"> <li>• There were no negative outcomes to the facility residents as a result of this.</li> <li>• The empty O2 bottles were removed from the rack marked for full bottles.</li> </ul>	1-6-2020

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:  <b>135116</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROYAL PLAZA HEALTH &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2870 JUNIPER DRIVE LEWISTON, ID 83501</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	<p>Continued From page 7</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure storage of medical gas cylinders such as oxygen, were maintained in accordance with NFPA 99. Failure to segregate storage of empty cylinders from full cylinders, has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. This deficient practice affected those residents requiring supplemental oxygen treatment and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/5/19 from 11:00 AM - 3:00 PM, observation of the oxygen storage room revealed the room had two (2) sides of storage that were labeled with signs reading "Full" and "Empty". Further observation revealed storage racks in the facility that were placed on both sections. Inspection of the racks revealed the following:</p> <p>1) The rack located on the south side of the space housed 5 of 6 "E" cylinders stored that were missing the protective plastic cap for the valve connection. 2) The rack located on the north side of the space</p>	K 923	<p><b>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</b></p> <ul style="list-style-type: none"> <li>The O2 storage room was assessed for proper storage racks and adequate number of storage racks for both full and empty O2 tanks. Additional racks were purchased as necessary.</li> <li>Staff in-service was provided on O2 storage specifically not to comingle full and empty O2 tanks.</li> <li>The Employee General Orientation was reviewed and updated to include education on O2 storage specifically not to comingle full and empty O2 tanks.</li> <li>Oxygen use and proper storage will be added to the All-Staff in-service calendar on a quarterly basis.</li> </ul>	

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K 923	<p>Continued From page 8</p> <p>housed 7 of 8 "E" cylinders stored that were missing the protective plastic cap for the valve connection.</p> <p>When asked at approximately 11:30 AM about the determination of which cylinders were considered "Full" and which cylinders were considered "Empty", a nurse on staff at the time stated the absence of the protective cap would indicate "Empty".</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.</p>	K 923	<p><b>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?</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director, DON and/or their designee will complete an audit of the O2 storage 1 X per week for 4 weeks, and monthly thereafter.</li> <li>The ED and the QAPI committee will review the current POC on an annual basis and make changes as needed.</li> </ul>	



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

December 16, 2019

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

Provider #: 135116

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Ms. Shepard:

On **December 5, 2019**, an Emergency Preparedness survey was conducted at Royal Plaza Health & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

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

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

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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E 000	<p>Initial Comments</p> <p>The facility is a single story, Type V(111) building, originally constructed in 1964. The facility is protected by an automatic fire extinguishing system, with an interconnected fire alarm/smoke detection system throughout. There is an attached Residential Assisted Living Facility which is separated by a two-hour fire wall. Emergency power is provided by a spark-ignited Emergency Power Supply System (EPSS) generator. The facility is located in a municipal fire district with both county and state EMS services available. Currently the facility is licensed for 63 SNF/NF beds and had a census of 42 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on December 5, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000			

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

TITLE

(X6) DATE

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.