

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Royal Plaza Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 Juniper Drive Lewiston, ID 83501	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>40733</p> <p>Based on Resident Group interview, Resident Council Meeting minutes review, and staff interview, it was determined the facility failed to ensure resident concerns were addressed. These negative practices placed residents at risk of ongoing frustration and decreased sense of self-worth, as well as, unmet care needs, when issues of concern to them were not promptly addressed by the facility. Findings include:</p> <p>A Resident Group interview was attended by 8 residents on 11/6/24 at 10:00 AM. All the residents voiced concerns related to staffing and long call light response times. The residents stated these issues were an ongoing problem in the facility.</p> <p>The Resident Council minutes from May 2024 through October 2024 documented residents' concerns. Examples include:</p> <ul style="list-style-type: none"> a. Resident Council Minutes, dated 5/2/24, documented residents voiced issues related to staffing continuity and the scheduling of nursing aides. b. Resident Council Minutes, dated 6/18/24, documented, evening [staff] needs more training. The Minutes did not document what actions were taken to address and resolve the concern voiced during the 5/2/24 meeting. c. Resident Council Minutes, dated 8/9/24, documented, A nurse tried to have a resident clean the toilet. Going through resident's things. Aides having bad attitudes. Empty trash cans in rooms. Call lights need answered. The Minutes did not document what actions were taken to address and resolve the concerns voiced during the 6/18/24 meeting. d. Resident Council Minutes, dated 9/10/24, documented, The staff needs to communicate more. Beds need made. Not taking dirty laundry. Not answering call lights. The Minutes did not documented what actions were taken to address and resolve the concerns voiced during the 8/9/24 meeting. e. Resident Council Minutes, dated 10/11/24, documented, some aides aren't taking laundry. Not going around with snack cart. The Minutes did not documented what actions were taken to address and resolve the concerns voiced during the 9/10/24 meeting. <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/07/24 at 05:44 PM, the Administrator and the Activities Director were interviewed together, and the Resident Council Minutes were reviewed in their presence. The Activities Director stated she had been employed in her role since August 2024. She stated the residents' concerns were discussed during staff stand-up meetings, and she would inform each department head of the residents' concerns. The Activities Director stated she did not document the resolutions to the residents' concerns and was unaware that she was required to. When asked for documentation of call light audits for May through October 2024, the Administrator stated there were none.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733</p> <p>Based on policy review, review of grievances, and staff interview, it was determined the facility failed to ensure resident grievances were investigated and resolutions were documented. This deficient practice placed all residents at risk of having unmet needs and poor quality of life when their concerns were not properly addressed. Findings include:</p> <p>A review of the facility's grievances from May 2024 to October 2024 revealed the following grievance continued and unresolved:</p> <p>Resident #14 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including sepsis, urinary tract infection, and quadriplegia (complete or severe loss of motor function in all four limbs).</p> <p>A facility grievance report, dated 7/10/24, documented Resident #14 activated his call light, then a staff member came into his room, turned off his call light, and left his room without assisting him. The report did not document the investigation or actions taken by the facility to address Resident #14's concerns related to the call light.</p> <p>On 11/08/24 at 09:43 AM, the Administrator confirmed the facility did not address Resident #14's grievance related to issues with call light response.</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on record review, and staff interview, it was determined the facility failed to ensure information was provided to the receiving hospital for 3 of 5 residents (#3, #45 and #51) reviewed for transfers. This deficient practice had the potential to cause harm if residents were not treated in a timely manner due to lack of information. Findings include:</p> <p>The State Operations Manual, Appendix PP, revised 02/03/23, documented when the facility transfers or discharges a resident under any of the circumstances, the facility must ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider. Documentation in the resident's medical record must include:</p> <ul style="list-style-type: none"> - The basis for the transfer or discharge. - Contact information of the practitioner(s) responsible for the care of the resident, - Resident representative information and contact information. - Advance Directive information, - All special instructions/precautions for ongoing care, and as appropriate treatments - Comprehensive care plans and goals and - All other necessary information including a copy of the resident's discharge summary and any other documentation to ensure a safe and effective transition of care. <p>1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease, and dementia.</p> <p>A review of records documented Resident #3 was transferred to the hospital on 5/8/24, and 7/24/24.</p> <p>Resident #3's record did not include documentation of medical information was provided to the hospital when she was sent to the hospital on 5/8/24 and 7/24/24, to ensure a safe and effective transition of care.</p> <p>2. Resident #45 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure with hypoxia (low levels of oxygen in your body tissues), chronic obstructive pulmonary disease, and stroke.</p> <p>A review of records documented Resident #45 was transferred to the hospital on 7/18/24, and 7/23/24.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #45's record did not include documentation of medical information was provided to the hospital when she was sent to the hospital on 7/18/24 and 7/23/24, to ensure a safe and effective transition of care.</p> <p>On 11/08/24 at 9:33 AM, the CNO confirmed the facility has not been providing hospital paperwork when a resident is transferred to the hospital. She stated the facility does not have a hospital transfer policy. The CNO confirmed Resident #3 and Resident #45 did not have any documentation of hospital transfer paperwork.</p> <p>36193</p> <p>3. Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including right hemiplegia and hemiparesis (paralysis and weakness) following stroke.</p> <p>A nursing progress notes, dated 6/1/24 at 3:39 PM documented Resident #51 was clammy, afebrile, and wiggled in bed and was not alert as her usual. The progress notes documented her blood sugar was elevated and her blood pressure was low. An order was received to do a stat (immediately) CBC (complete blood count) and CMP (complete metabolic panel).</p> <p>A nursing progress notes, dated 6/1/24 at 4:32 PM documented an order was received to send Resident #51 to the emergency room due to critically BUN (blood urea nitrogen - kidney function test) and high sodium level.</p> <p>Resident #51's record did not include documentation information was provided to the hospital to ensure safe and effective transition of care.</p> <p>On 11/7/24 at 12:49 PM, the CNO when a resident transferred to the hospital, face sheet, MAR, and POST were sent with them. The CNO stated she was unable to find documentation the necessary documents were sent with Resident #51 when she went to the hospital on 6/1/24.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure transfer notices were provided to the ombudsman. This was true for 3 of 5 residents (#3, #45, and #51) reviewed for transfers to the hospital. This deficient practice had the potential for harm if residents were not aware of or able to exercise their rights related to transfers. Findings include:</p> <p>1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease, and dementia.</p> <p>A review of records documented Resident #3 was transferred to the hospital on 5/8/24, and 7/24/24.</p> <p>Resident #3's record did not include transfer notices to the ombudsman regarding the patient hospital transfers on 5/8/24 and 7/24/24 to ensure a safe and effective transition of care.</p> <p>2. Resident #45 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure with hypoxia (low levels of oxygen in your body tissues), chronic obstructive pulmonary disease, and stroke.</p> <p>A review of records documented Resident #45 was transferred to the hospital on 7/18/24, and 7/23/24.</p> <p>Resident #45's record did not include transfer notices to the ombudsman regarding the patient hospital transfers on 7/18/24 and 7/23/24 to ensure a safe and effective transition of care.</p> <p>On 11/08/24 at 9:33 AM, the CNO confirmed the facility this has not been providing ombudsman hospital notifications when a resident is transferred to the hospital. The CNO confirmed the ombudsman's was not notified Resident #3 and Resident #45 were transferred to the hospital.</p> <p>36193</p> <p>3. Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including right hemiplegia and hemiparesis (paralysis and weakness) following stroke.</p> <p>A nursing progress notes, dated 6/1/24 at 3:39 PM documented Resident #51 was clammy, afebrile, and wiggled in bed and was not alert as her usual. The progress notes documented her blood sugar was elevated and her blood pressure was low. An order was received to do a stat (immediately) CBC (complete blood count) and CMP (complete metabolic panel).</p> <p>A nursing progress notes, dated 6/1/24 at 4:32 PM documented an order was received to send Resident #51 to the emergency room due to critically BUN (blood urea nitrogen - kidney function test) and high sodium level.</p> <p>On 11/7/24 at 12:49 PM, the CEO stated the facility did not inform the Ombudsman of Resident #51's discharge to the hospital.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on record review, and staff interview, it was determined the facility failed to ensure a bed-hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 3 of 5 residents (#3, #45, and #51) reviewed for transfer. This deficient 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>1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease, and dementia.</p> <p>A review of records documented Resident #3 was transferred to the hospital on 5/8/24, and 7/24/24.</p> <p>Resident #3's record did not include documentation of a bed-hold being provided to the resident when she was sent to the hospital on 5/8/24 and 7/24/24 to ensure a safe and effective transition of care.</p> <p>2. Resident #45 was admitted to the facility on [DATE], with multiple diagnoses including respiratory failure with hypoxia (low levels of oxygen in your body tissues), chronic obstructive pulmonary disease, and stroke.</p> <p>A review of records documented Resident #45 was transferred to the hospital on 7/18/24, and 7/23/24.</p> <p>Resident #45's record did not include documentation of a bed-hold being provided to the resident when she was sent to the hospital on 7/18/24 and 7/23/24 to ensure a safe and effective transition of care.</p> <p>On 11/08/24 at 9:33 AM, the CNO confirmed the facility this has not been providing bed-hold paperwork to the resident when they are transferred to the hospital. The CNO confirmed Resident #3 and Resident #45 did not have a notice of bedhold provided to them or their representatives.</p> <p>36193</p> <p>3. Resident #51 was admitted to the facility on [DATE], with multiple diagnoses including right hemiplegia and hemiparesis (paralysis and weakness) following stroke.</p> <p>A nursing progress notes, dated 6/1/24 at 3:39 PM documented Resident #51 was clammy, afebrile, and wiggled in bed and was not alert as her usual. The progress notes documented her blood sugar was elevated and her blood pressure was low. An order was received to do a stat (immediately) CBC (complete blood count) and CMP (complete metabolic panel).</p> <p>A nursing progress notes, dated 6/1/24 at 4:32 PM documented an order was received to send Resident #51 to the emergency room due to critically BUN (blood urea nitrogen - kidney function test) and high sodium level.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #51's record did not include documentation that a bed-hold notice was provided to her or to her representative when she was transferred to the hospital.</p> <p>On 11/7/24 at 11:23 AM, the CNO stated she was unable to find documentation a bed-hold notice was provided Resident #51's representative when she was transferred to the hospital.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 1 of 1 resident (Resident #19) reviewed for Pre-Admission Screening and Resident Review (PASARR) level II evaluations. This deficient practice had the potential to cause harm if the residents' specialized services for mental health needs were not evaluated by an appropriate state-designated authority to provide coordinated care. Findings include:</p> <p>The State Operation Manual, Appendix PP revised on 8/8/24, documented if a PASARR level I identifies a major mental illness, an in-depth evaluation, known as a PASARR level II evaluation is completed by the state-designated authority, which must be completed prior to admission to a nursing facility.</p> <p>Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease, bipolar disorder (a major mental illness), major depressive disorder, anxiety disorder, and unspecified psychosis.</p> <p>Resident #19's care plan, created on 3/3/23, documented Resident #19 was prescribed antidepressant medication related to bipolar disorder, depression, and insomnia. She used anti-anxiety medications related to anxiety disorder and anti-psychotic medication related to psychosis.</p> <p>Resident #19's pre-admission PASARR level I screening, dated 3/3/23, did not identify Resident #19's bipolar disorder, major depressive disorder, anxiety disorder, and unspecified psychosis.</p> <p>Resident #19's admission MDS, completed on 3/10/23, documented a Level II PASARR was not completed.</p> <p>A facility PASARR level I, dated 11/2/23, documented Resident #19 had depression, anxiety, and bipolar disorders. The PASARR level I was not forwarded to the Bureau of Long Term Care.</p> <p>On 11/07/24 at 4:51 PM, the Social Services Manager stated, This resident should have had a PASARR level II completed. The preadmission PASARR screening and follow-up PASARR level I paperwork were filled out incorrectly.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603</p> <p>Based on , policy review, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated. This was true for 1 of 18 residents (Resident #19) whose care plans were reviewed. This created the potential for harm if cares and/or services were not provided appropriately due to inaccurate information on the care plan. Findings include:</p> <p>The State Operation Manual, Appendix PP revised on 8/8/24, documented a comprehensive care plan must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease, neuropathy (a nerve problem causing pain, numbness, tingling, and swelling, or muscle weakness in different parts of the body), kidney disease, bipolar disorder (a major mental illness), major depressive disorder, hypertension, anxiety disorder, and unspecified psychosis.</p> <p>Resident #19's care plan for renal failure related to kidney disease, initiated 3/21/24, directed staff to monitor for signs and symptoms of hypo/hypervolemia (a condition where there is not enough/too much fluid in the body, particularly in the blood), and to monitor/report/document to the doctor as needed for signs and symptoms of edema, with gain over 2 lbs. (pounds) per day, neck vein distension, difficulty breathing, increase heart rate, elevated blood pressure, skin temperature, peripheral pulses, level of consciousness, monitor breath sounds for crackles, among other kidney care plan interventions.</p> <p>A review of Resident #19's TAR (treatment administrative record) from 2023 through 2024, did not show monitoring for signs and symptoms related to renal insufficiency as ordered in Resident #19's care plan.</p> <p>A review of Resident #19's record failed to show physician's orders for monitoring signs and symptoms of hypo/hypervolemia (a condition where there is not enough/too much fluid in the body, particularly in the blood), and to monitor/report/document to the doctor as needed for signs and symptoms of edema, with gain over 2 lbs (pounds) per day, neck vein distension, difficulty breathing, increase heart rate, elevated blood pressure, skin temperature, peripheral pulses, level of consciousness, and to monitor breath sounds for crackles.</p> <p>On 11/8/24 on 11:07 AM, the DON confirmed Resident #19's record did not include monitoring related to the kidney interventions as directed by the care plan. The care plan had not been updated after MDS quarterly or annual assessments in relation to the care plan kidney monitoring and interventions.</p> <p>(continued on next page)</p>		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 5:35 PM, the MDS Coordinator stated the kidney protocol selected on the care plan in March 2023 was most likely an error as there were no physician's orders on file in 2023 directing staff to monitor kidney function. She further stated when developing a care plan sometimes interventions for diagnoses are checked off before a doctor's order is placed due to admitting diagnoses. The MDS Coordinator confirmed Resident #19's care plan had not been updated to remove the kidney interventions and monitoring identified in the care plan.		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure medication was administered according to professional standards of practice. This was true for 2 of 2 residents (#55 and #57) reviewed for medication errors. This created the potential for Resident #55 and Resident #57 to experience adverse effects when their medications were not administered according to physician orders. Findings include:</p> <p>1. Resident #57 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and a history of falling.</p> <p>Resident #57's order summary documented an order for hydrocodone 5/325 mg was discontinued on 10/8/24.</p> <p>A nursing progress note, dated 10/9/24 at 2:36 PM, documented Resident #57 received hydrocodone (an opioid pain medication) 5/325 mg when the order was discontinued during the prior shift.</p> <p>An I&A report, dated 10/39/24, documented the nurse gave Resident #57 hydrocodone without checking her EMAR beforehand. After she gave the hydrocodone, the nurse realized the error when she went to document it in Resident #57's EMAR and discovered it was discontinued. Resident #57 was assessed for adverse effects and none were found.</p> <p>On 11/07/24 at 3:05 PM, the CNO confirmed Resident #57 had received hydrocodone when it was discontinued, and stated medications should be remove from the medication cart when discontinued, and the standards of practice were not followed.</p> <p>36193</p> <p>2. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including non-pressure chronic ulcer.</p> <p>A Wound Clinic physician's order, dated 10/28/24, documented Resident #55 was to receive Augmentin (antibiotic) 875 mg orally twice a day for seven days for his venous stasis ulcer (a non-healing open sore that develops when blood pools in the veins of the legs)to his lower leg.</p> <p>A nursing progress note, dated 10/30/24 at 11:45 AM, documented Resident #55 received Amoxicillin (antibiotic) when the order was Augmentin. Amoxicillin was discontinued and Augmentin was initiated.</p> <p>An I&A report, dated 10/30/24 documented Resident #55 received two doses of Amoxicillin when the order for Resident #55 to receive Augmentin. The I&A report documented the Augmentin did not come up in the facility's computer system when the nurse typed Augmentin. Augmentin showed up as Amoxicillin-Potassium Clavulanate. The nurse then typed Amoxicillin and selected it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Royal Plaza Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 Juniper Drive Lewiston, ID 83501	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 3:14 PM, the CNO stated the nurse made a transcription error. The CNO stated the Augmentin did not come up when the nurse entered the Augmentin in their PCC (Point Click Care) and the nurse chose Amoxicillin. The CNO stated the nurse who received the order should have asked another nurse or the RCM to clarify the order.		

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NAME OF PROVIDER OR SUPPLIER Royal Plaza Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2870 Juniper Drive Lewiston, ID 83501	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193</p> <p>Based on record review, review of facility policies and procedure, review of Incidents and Accidents (I&As), and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 1 of 1 resident (Resident #44) reviewed for medication administration. This failure created the potential for Resident #44 to experience hypoglycemia when he was administered insulin which was not according to the physician's order. Findings include:</p> <p>The facility's Medication Management policy and procedure, revised 4/12/22, documented staff who administer medications are responsible for staying proficient in administering medication following evidenced-based practice guidelines. Following the eight rights - right resident, right medication, right dose, right route, right time, right documentation, right reason, and right response.</p> <p>Resident #44 was admitted to the facility on [DATE], with multiple diagnoses including diabetes.</p> <p>The October and November 2024 MAR (Medication Administration Record) documented Resident #44 was to receive 10 units of insulin Lispro as needed between meals when his blood sugar was greater than 360 mg/dl.</p> <p>The October and November 2024 MAR documented he was administered 10 units of insulin Lispro when his blood sugar was less than 360 mg/dl on the following dates:</p> <ul style="list-style-type: none"> - 10/8/24 at 8:00 PM, BG was 338 mg/dl - 10/27/24 at 3:00 PM, BG was 313 mg/dl - 10/27/24 at 8:00 PM, BG was 330 mg/dl -11/2/24 at 3:00 PM, BG was 270 mg/dl - 11/2/24 at 8:00 PM, BG was 237 mg/dl - 11/3/24 at 3:00 PM, BG was 308 mg/dl <p>On 11/6/24 at 10:35 AM, the CNO reviewed Resident #44's record. The CNO stated Resident #44 received 10 units of insulin Lispro on the above dates when his blood sugar was less than 360 mg/dl. The CNO stated Resident #44 should receive insulin Lispro when his blood sugar was greater than 360 mg/dl.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>36193</p> <p>Based on review of records and staff interview, it was determined the facility failed to ensure glucometers were calibrated to maintain accuracy of results for 3 of 3 halls (Oak Hall, Maple Hall, and Transitional Care Unit - TCU) whose glucometers were reviewed. This deficient practice had the potential for a higher risk for inaccurate blood glucose readings of residents who required blood glucose monitoring. Findings include:</p> <p>The EvenCare Blood Glucose Monitoring System under the section Control Solution Testing documented a control solution should be performed when:</p> <ul style="list-style-type: none"> - Using the meter for the first time. - Using a new package of EvenCare G3 Blood test strips. - At least once per week to verify that the meter and test strips are working properly together. <p>The facility's glucometer calibration logbooks were reviewed and revealed the following:</p> <ul style="list-style-type: none"> - Oak Hall glucometer calibration was not consistently done for the month of October to November 7, 2024 - Maple Hall glucometer calibration was not done for the month of October to November 7, 2024. <p>On 11/7/24 at 4:08 PM, RN #1 stated the glucometer was being calibrated by the night shift nurse.</p> <p>On 11/7/24 at 5:33 PM, the CNO stated the facility did not have a policy for calibrating the glucometer. The CNO reviewed the log book for Oak and Maple Hall, and stated the calibration were not consistently done. When asked about the TCU logbook, the CNO stated she was unable to find the logbook for the TCU glucometer calibration.</p>