STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135116	A. Building B. Wing	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Plaza Health and Rehabilitation of Cascadia	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36193 Based on observation and staff interview, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 2 of 12 residents (#16 and #24) observed dining in the facility. This failure had the potential to cause a decrease in residents' sense of self-worth and psycho-social well-being. Findings include: On 6/27/18 at 5:42 PM, Resident #16 and Resident #24 were seated across from each other at a table in the main dining room with another female resident and a male resident. On 6/27/18 at 5:50 PM, the first meal tray was served to the assisted area of the main dining room. On 6/27/18 at 6:00 PM, two meal trays were brought to Resident #16 and Resident #24's table. The trays were for the female and male resident. Resident #16 and Resident #24 did not receive their meal. Resident #16 and Resident #24 were quiet and looking at each other as the female and male resident started eating their meals. On 6/27/18 at 6:15 PM, the male resident was observed looking occasionally at Resident #16 and Resident #24 while he was eating. He asked Resident #16 and Resident #24 when they were going to eat. Resident #16 did not answer. The male resident then offered his half-eaten burger to Resident #16. Resident #16 just smiled at the male resident. On 6/27/18 at 6:18 PM, both the male and the female residents finished their main meals and were now eating their desserts. Resident #16 and Resident #24 still had not received their meal. The male resident waved his hand to get the attention of one of the staff. A CNA came over and Resident #24 stated every one else had gotten their food but he and Resident #16 had not received their meal. On 6/27/18 at 6:23 PM, Resident #16 and Resident #24's meal trays arrived at the table. On 6/27/18 at 6:34 PM. CNA #1 said they usually served meals to all residents at a table at the same time so they could all eat together. CNA #1 said Resident #16 and Resident #24's meal tickets might have been stacked with other meal tickets or misplaced. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/18 at 9:49 AM, LPN #1 said the first tray should be served beginning with residents in the assisted area if there were staff to assist them, followed by residents who needed to be reminded or cued to eat, and then other residents to follow. LPN #1 said she usually checked if the residents sitting together have their food delivered but she did not check yesterday. She said because there were so many staff members in the dining room other staff should have noticed Resident #16 and Resident #24 did not receive their tray. She said residents sitting together at a table should be served at the same time.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39924 Based on resident and staff interview, policy review, and record review, it was determined the facility failed to provide the services needed to prevent harm and injury of a resident. This was true for 1 of 1 resident (#36) reviewed for accidents. Resident #36 sustained an injury when a staff member failed to follow the care plan when attempting to transfer her during toileting. This failure created harm when the resident suffered a broken femur. Findings include: Resident #36 was readmitted to the facility on [DATE], with diagnoses which included right knee replacement and right hip replacement. Resident #36's record included a care plan with identified deficits related to urinary incontinence and ADLs. The care plan stated Resident #36 required extensive assistance when transferring. The interventions in her care plan included having 2 staff members to assist with transfers and using a gait belt. Resident #36's Care Directive Form, dated 5/11/17, documented she required extensive assistance with 2 staff members for toileting. A facility policy Gait Belt, updated September 2008, stated gait belts were to be used when transferring resident from a chair to a commode or toilet. The policy also stated the use of a gait belt was mandatory for transfers. An Occurrence Report, dated 4/22/18, documented Resident #36 fell in her bathroom during a transfer. The report stated after toileting, Resident #36 was attempting to transfer from the toilet to her wheelchair and she was unable to support her weight. In the report Resident #36 stated her knees were feeling weak and she could not hold on anymore. CNA #2 stated in the report Resident #36 was standing after toileting and was holding onto the grab bar and she was standing behind Resident #36 attempting to pull up her adult incontinence brief. CNA #2 stated she observed Resident #36's right leg turning inward and she began to lower. CNA #2 stated she then attempted to help Resident #36 into her wheelchair, by placing her arms underneath Resident #36's arms and slowly lower her into the wheelchair. She stated Resident #36 was partially seated her in wheelchair and screaming her leg hurt. CNA #2 stated she then .kicked her chair out of the way to lay her down. A Nursing Home to Hospital Transfer form, dated 4/22/18, documented Resident #36 was transferred to an acute care hospital with pain to her right lower extremity after a fall. An Emergency Department Note, dated 4/22/18, documented Resident #36 presented for evaluation of her right clavicle, right hip, and right knee due to pain after a fall. The note stated Resident #36 was being transferred from the toilet to her wheelchair when she fell and she landed on her right side. The note documented Resident #36 had swelling to the center or her right clavicle, mild pain in the right hip, and severe pain to her right knee. The note stated x-rays of Resident #36's right knee showed a fracture of the right distal femur (thigh bone). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/26/18 at 11:21 AM, Resident #36 stated she broke her leg during a transfer in the restroom. She stated she twisted her knee and fell . She stated its almost healed. She stated she was not wearing the brace any longer. She denied pain. On 6/26/18 at 4:59 PM, the DON stated CNA #2 transferred the resident without a second staff member and she did not use a gait belt. She stated CNA #2 received additional training and education following the incident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on staff interview and record review, it was determined the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASRR) were complete and accurate for 1 of 1 resident (#13) reviewed for a PASRR. The deficient practice had the potential to cause more than minimal harm if residents required, but did not receive, specialized services for mental health while residing in the facility. Findings include: Resident #13 was admitted to the facility on [DATE], with multiple diagnoses which included bipolar disorder (mental disorder). Resident #13's admission MDS assessment, dated 2/6/17, documented she had no behaviors and there was no level II PASRR. Resident #13's PASRR, dated 1/30/17, documented she was currently taking bupropion 75 mg for depression, clonazepam 0.5 mg for anxiety, and venlafaxine 37.5 mg for anxiety. The MDS also documented the attending physician certified prior to admission Resident #13 would require less than 30 calendar days of services in a nursing facility and her symptoms were stable, therefore she was exempt from a level II PASRR. Resident #13's PASRR, dated 3/23/17, documented she had depressive disorder and was taking bupropion 0.5 mg and venlafaxine 37.5 mg for Major Depressive Disorder, and klonopin 0.5 mg for anxiety. There was no documentation in Resident #13's clinical record a level II PASRR screening was completed or whether or not she required specialized services for her mental issues. On 6/27/18 at 10:00 AM, the Administrator said the Social Worker who was responsible for completing the PASRR form was no longer in the facility. She said Resident #13 should have had a level II PASRR completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on record review, observation, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans related to the use of psychotropic medications and resident preference to use a recliner for sleep for 2 of 12 residents (#13 and #17) whose care plans were reviewed. The residents' care plans did not address the identification of resident specific behaviors to monitor, behavioral goals, or resident-specific interventions to address behaviors exhibited, or the resident's preference to sleep in her recliner. This failure created the potential for harm if residents experienced continued anxiety, depression, or a deterioration in their physical and mental health status. Findings include: 1. Resident care plans did not identify or address monitoring or interventions related to behavioral symptoms and ordered medications. a. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses which included major depression. A Care Plan dated 6/5/17, documented Resident #17 had a diagnosis of chronic depression and received psychotropic medications to control these symptoms. The care plan did not include resident-specific behaviors the staff were to monitor or resident-specific interventions staff were to implement when she exhibited target behavioral symptoms. An annual MDS assessment dated [DATE], documented Resident #17 was cognitively impaired, received antidepressant medications daily, and had no signs of depression. Behavior Monthly Flow Sheets, included the following: - March 2018 - Resident #17 was monitored for agitation, anxiety, and depressed withdrawn. - April 2018 - Resident #17 was monitored for fear and/or panic, agitation, and anxiety. - May 2018 - Resident #17 was monitored for exhibiting poor eye contact, wandering, and depressed withdrawn. A Psychoactive Drug and Behavior Medication Review Form, dated 5/3/18, documented a recent increase in behaviors which included exit-seeking and wandering. The Psychoactive Drug and Behavior Medication Review Form did not reflect documentation for the changes in the Behavior Monthly Flowsheets for the months of March 2018 and April 2018. The most recent mental health visit, dated 5/24/18, documented Resident #17 exhibited difficulty sleeping, exit-seeking behavior, and stayed in her room and rarely left her bed. On 6/27/18 at 4:15 PM, the DON stated she was not able to find documentation of resident-specific target behaviors or interventions to address behavioral symptoms on Resident #17's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36193 2. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses which included bipolar disorder (mental disorder) and dementia. Resident #13's Annual MDS assessment, dated 1/27/18, documented she was cognitively intact, had no behaviors, no signs of depression, and received anti-depressant and anti-anxiety medications daily. Resident #13's Quarterly MDS assessment, dated 4/23/18, documented she was moderately cognitively impaired and had a feeling of being tired or having little energy several days of the week. Resident #13's recapitulated Physician's Order for April 2018, May 2018 and June 2018, documented she was to receive bupropion hcl (hydrochloride) 75 mg for Major Depressive Disorder and klonopin 0.25 mg for Somatization Disorder (mental illness which causes pain). Resident #13's care plan, documented she had anxiety and depression triggered by changes in daily routine and health status. The goal, with a goal date of 7/31/18, was for Resident #13's symptoms of anxiety and depression to be controlled with minimal side effects over the next quarter. Interventions included in the care plan were Engage Resident #13 in group/individual activities that reduce periods of anxiety. Monitor for side effects of medication (drowsiness, loss of coordination, fatigue, mental slowness .). Provide quiet atmosphere with one-on-one support during periods of increased anxiety .Record behavior on Behavior Tracking Form. The care plan did not indicate Resident #13's specific type behaviors or how she manifested her anxiety or depression. Behavior Monthly Flow Sheets for Resident #13 included the following: - January 2018 - Resident #13 was monitored for anxiety and being depressed withdrawn. - February 2018 - Resident #13 was monitored for agitation, anxiety, and continuous crying. - March 2018 - Resident #13 was monitored for anxiety, being depressed, withdrawn and mood changes. - April 2018 - Resident #13 was monitored for being agitated and depressed, withdrawn, and angry. - May 2018 - Resident #13 was monitored for anxiety, being agitated and continuous crying. The Behavior Monthly Flow Sheet, documented Resident #13 had not demonstrated any behaviors. Resident #13's Psychoactive Drug and Behavior Medication Review Form documented on 1/16/18, there was a failed Gradual Dose Reduction (GDR) of klonopin since restart and there were no new behaviors or outbursts. Resident #13's plan of care was to be continued. On 5/2/18, Resident #13's plan of care was to be continued. Resident #13's Nursing Notes, dated 1/31/18 through 6/3/18, documented she had no behaviors. On 6/26/18 at 9:00 AM, Resident #13 was observed with other residents in the Day Room participating in the Restorative Program. At 11:34 AM, Resident #13 was observed sitting in her recliner in her room reading a Reader's Digest book with her room door open. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/18 at 10:47 AM, the DON said Resident #13's care plan did not document her specific target behaviors and she did not know the reason why Resident #13 was monitored for different behaviors monthly.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on record review and staff interview, it was determined the facility failed to ensure physicians wrote, signed, and dated progress notes for each resident. This was true for 1 of 12 residents (#17) whose records were reviewed. This had the potential for lack of care and services needed by residents in the facility and created the potential for harm to residents who may not have received ordered care and services. Findings include: Resident #17 was admitted to the facility on [DATE], with multiple diagnoses which included major depression. Resident #17 was transported to the physician's office by the facility staff for appointments. Resident #17's medical record did not reflect physician visits. On 6/27/18 at 3:45 PM, the DON provided 2 faxed forms that documented the facility requested the physician's office to provide a signed copy of the office note for the visits Resident #17 had on 1/10/18 and on 3/29/18. Communication Result Reports, dated 2/2/18 and 4/19/18, requested the progress notes for the physician visits which occurred on the above listed dates. The DON stated the physician's office did not provide the documentation requested.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37888 Based on record review and staff interview, it was determined the facility failed to ensure residents receiving a psychoactive medication had resident-specific target behaviors identified and monitored, and had an appropriate indication for use for these medications. This was true for 2 of 5 (#13 and #17) sampled residents who received psychoactive medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include: 1. Resident #17 was admitted to the facility on [DATE], with multiple diagnoses which included major depression. A Care Plan dated 6/5/17, documented Resident #17 had a diagnosis of chronic depression and received psychotropic medications to control these symptoms. The care plan did not include resident-specific behaviors the staff were to monitor or interventions staff were to implement when she exhibited target behavioral symptoms. An annual MDS assessment dated [DATE], documented Resident #17 was cognitively impaired, received antidepressant medications daily, and had no signs of depression. A facility Psychoactive Drug and Behavior Medication Review Form, dated 5/3/18, documented Resident #17 had a recent increase in behaviors which included exit-seeking and wandering. The most recent mental health visit, dated 5/24/18, documented staff reported Resident #17 exhibited periods of difficulty sleeping, exit-seeking behavior, and stays in her room and rarely leaves her bed. The visit note documented Resident #17 had good eye contact and stated she prefers to usually stay alone in her room. Resident #17's physician orders for June 2018, included bupropion ER (antidepressant) 150 mg, 2 tablets by mouth for major depressive disorder, mirtazapine (antidepressant) 15 mg by mouth at bedtime for major depressive disorder, and Depakote (mood stabilizer) 125 mg, 2 capsules two times daily. The facility Behavior Monthly Flowsheets provided staff 38 standardized choices of exhibited behaviors and 12 standardized choices for interventions to select. The flowsheet did not document resident-specific behavior related to anxiety and depression. Each of the target behaviors were monitored each shift during the day, evening, and night. The form directed staff to enter the number of times the behavior occurred, the intervention/drug used, and the outcome. A Behavior Monthly Flowsheet, dated March 2018, directed the staff to monitor for and document the number of episodes of Resident #17 being agitated, exhibiting anxiety, being depressed and withdrawn. The Behavior Monthly Flowsheet documented 13 days that reflected Resident #17 of being depressed and withdrawn on day and evening shift in the month of April 2018. A Behavior Monthly Flowsheet, dated April 2018, directed the staff to monitor for and document the number of episodes of Resident #17 being afraid, panicked, agitated, or anxious. The Behavior Monthly Flowsheet reflected 6 episodes of agitation on evening shift in the month of April 2018. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Monthly Flowsheet, dated May 2018, directed the staff to monitor for and document the number of episodes of Resident #17 being depressed or withdrawn, having poor eye contact, and wandering. The Behavior Monthly Flowsheet documented 2 episodes of wandering on night shift in the month of May 2018. On 6/27/18, the DON stated she was not able to determine why the behaviors monitored changed monthly. The facility failed to ensure resident-specific target behaviors and interventions were in place for the staff to monitor to have a positive outcome for Resident #17. 36193 2. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses which included bipolar disorder (mental disorder) and dementia. Resident #13's Annual MDS assessment, dated 1/27/18, documented she was cognitively intact, had no behaviors, no signs of depression, and received anti-depressant and anti-anxiety medications daily. Resident #13's Quarterly MDS assessment, dated 4/23/18, documented she was moderately cognitively impaired and had a feeling of being tired or having little energy several days of the week. Resident #13's recapitulated Physician's Order for April 2018, May 2018 and June 2018, documented she was to receive bupropion hcl (hydrochloride) 75 mg for Major Depressive Disorder and klonopin 0.25 mg for Somatization Disorder (mental illness which causes pain). Resident #13's care plan, documented she had anxiety and depression triggered by changes in daily routine and health status. The goal, with a goal date of 7/31/18, were for Resident #13's symptoms of anxiety and depression to be controlled with minimal side effects over the next quarter. Interventions included in the care plan were Engage Resident #13 in group/individual activities that reduce periods of anxiety. Monitor for side effects of medication (drowsiness, loss of coordination, fatigue, mental slowness .). Provide quiet atmosphere with one-on-one support during periods of increased anxiety .Record behavior on Behavior Tracking Form. The care plan did not indicate Resident #13's specific type behaviors or how she manifested her anxiety or depression. Behavior Monthly Flow Sheets for Resident #13 included the following: - January 2018 - Resident #13 was monitored for anxiety and being depressed, withdrawn. - February 2018 - Resident #13 was monitored for agitation, anxiety, and continuous crying. - March 2018 - Resident #13 was monitored for anxiety, being depressed, withdrawn, and mood changes. - April 2018 - Resident #13 was monitored for being agitated and depressed, withdrawn, and angry. - May 2018 - Resident #13 was monitored for anxiety, being agitated, and continuous crying. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Behavior Monthly Flow Sheet, documented Resident #13 had not demonstrated any behaviors. Resident #13's Psychoactive Drug and Behavior Medication Review Form documented on 1/16/18, there was a failed Gradual Dose Reduction (GDR) of klonopin since restart and there were no new behaviors or outbursts. Resident #13's plan of care was to be continued. On 5/2/18, the form stated there were 2 failed attempts of bupropion and klonopin and Resident #13 did not exhibit new behaviors. Resident #13's plan of care was to be continued. Resident #13's Nursing Notes, dated 1/31/18 through 6/3/18, documented she had no behaviors. On 6/26/18 at 9:00 AM, Resident #13 was observed with other residents in the Day Room participating in Restorative Program. At 11:34 AM, Resident #13 was observed sitting in her recliner in her room reading a Reader's Digest book with her room door open. On 6/27/18 at 10:47 AM, the DON said Resident #13's care plan did not document her specific target behaviors and she did not know the reason why Resident #13 was monitored for different behaviors monthly. The facility failed to ensure resident specific behaviors were documented and monitored adequately to determine the ongoing necessity of psychotropic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37888 Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This affected 12 of 12 (#1, #8, #13, #15, #16, #17, #22, #24, #36, #37, #40, and #91) sample residents who resided in the facility and the 32 other residents who dined in the facility. This failure created the potential for harm if residents contracted foodborne illnesses. Findings include: On 6/27/18 at 4:50 PM, DS #1 was observed wearing an apron during the dish washing process. DS #1 removed clean dishes from the dishwasher and stacked them on a 3-tier cart. DS #1 placed a dirty dish tub in the dishwasher and removed it when the cleaning process was completed. DS #1 then placed multiple dirty baking sheets, one at a time, in the dishwasher and removed them when the cleaning process was completed. DS #1 did not change his apron after handling dirty dishes and kitchen supplies prior to handling clean dishes and kitchen supplies, or when moving between the dirty and clean areas of the kitchen. DS #1 stated he did not know about changing his apron between the clean and dirty sections. He stated he would change his apron after the work was done or if the apron he was wearing became messy. On 6/28/18 at 4:30 PM, the CDM stated DS #1 was trained to change his apron between the dirty to clean areas in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135116	A. Building B. Wing	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Plaza Health and Rehabilitation of Cascadia	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39924 Based on staff interview, policy review, and record review, it was determined the facility failed to initiate, update, and implement a tracking process to minimize the risk of residents acquiring, transmitting, or experiencing complications from the pneumococcal (bacterial) pneumonia. this was true for 5 of 5 residents (#1, #15, #36, #37, #91) reviewed for pneumococcal vaccines and the other 41 residents who resided in the facility. These failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage. Findings include: On 6/27/18 at 1:08 PM, the DON stated the facility's immunizations were not being tracked until after the facility standards state call regarding immunizations. She was observed calling a pharmacy and requesting a list of the immunizations which were sent to the facility. The DON was unable to provide a tracking system that showed who received the vaccines, which vaccine was received, when the next vaccination was due, and who refused and the reason why it was refused. A Pneumococcal Vaccination policy, updated October 2015, stated a log was maintained documenting the number of residents who received each version of the vaccine (PCV 13, PPSV 23) and those residents who refused or did not receive the vaccine. Residents who received a vaccine were to have it documented in their immunization record. The policy further stated pneumococcal vaccination occurred at the facility per the CDC guidelines. The Centers for Disease Control and Prevention (CDC) website, accessed 7/11/18, included recommendations for Pneumococcal vaccination (PCV 13 and PPSV 23) for all adults [AGE] years or older. The recommendations stated adults who were [AGE] years or older, who had not previously received PCV 13, should receive a dose of PCV 13 first. A dose of PPSV 23 should occur 1 year later. The recommendations stated if a resident already received 1 or more doses of PPSV 23, the dose of PCV 13 should be given at least 1 year after they received the most recent dose of PPSV 23. The facility policy was not followed. Examples include: a. Resident #1 was admitted to the facility on [DATE], with diagnoses which included hypothyroidism, vitamin D deficiency, deficiency of other nutrient elements, and muscle weakness. A Pneumococcal Vaccine consent, dated 6/14/18, documented verbal consent from a family member of Resident #1 for a pneumococcal vaccine to be given. There was no documentation which vaccine (PCV13 or PPSV23) was consented to. Resident #1's Immunization record did not include documentation of a pneumococcal vaccination. b. Resident #15 was admitted to the facility on [DATE], with diagnoses which included muscle weakness, legally blind, and polyosteoarthritis. A Pneumococcal Vaccine consent, dated 6/14/18, was signed by the resident. There was no documentation which vaccine (PCV13 or PPSV23) was consented to. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135116	A. Building B. Wing	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Plaza Health and Rehabilitation of Cascadia	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)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #15's Immunization record did not include documentation of a pneumococcal vaccination. c. Resident #36 was admitted to the facility on [DATE], with diagnoses which included COPD, nutritional deficiency, vitamin deficiency, muscle weakness, cerebral infarct (stroke), and shortness of breath. A Pneumococcal Vaccine consent, dated 6/14/18, was signed by the resident. There was no documentation which vaccine (PCV13 or PPSV23) was consented to. Resident #36's Immunization record did not include documentation of a pneumococcal vaccination. d. Resident #37 was admitted to the facility on [DATE], with diagnoses which included displaced fracture of the left femur, weakness, and diabetes type II. A Pneumococcal Vaccine consent, dated 6/21/18, documented Resident #37 refused the pneumococcal vaccine because she already had it. There was no documentation which vaccine she received or the date it was given. There was no documentation which vaccine (PCV13 or PPSV23) was refused. e. Resident #91 was readmitted to the facility on [DATE], with diagnoses which included vitamin deficiency, nutritional deficiency, heart failure, COPD, muscle weakness, and pulmonary embolism. A Pneumococcal Vaccine consent, dated 6/25/18, documented Resident #91 consented to receive a pneumococcal vaccine. There was no documentation which vaccine (PCV13 or PPSV23) was consented to.