



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- 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 9, 2015

Candice Hale, Administrator  
Clearwater Health & Rehabilitation  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

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

Dear Ms. Hale:

On **December 3, 2015**, a Facility Fire Safety and Construction survey was conducted at **Clearwater 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

Candice Hale, Administrator  
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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 22, 2015**. Failure to submit an acceptable PoC by **December 22, 2015**, may result in the imposition of civil monetary penalties by **January 11, 2016**.

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 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 7, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 7, 2016**. A change in the seriousness of the deficiencies on **January 7, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 7, 2016**, includes the following:

Denial of payment for new admissions effective **March 3, 2016**.  
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 3, 2016**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 3, 2015**, 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:

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

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

BFS Letters (06/30/11)

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

This request must be received by **December 22, 2015**. If your request for informal dispute resolution is received after **December 22, 2015**, 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,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/j  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER <b>CLEARWATER HEALTH &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(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	INITIAL COMMENTS  The facility is a single story type V (111) building with a small basement which includes a maintenance shop and boiler room. The facility is protected by a complete sprinkler system and was built in 1969. The fire alarm system was replaced in 2001. Currently the facility is licensed for 60 beds.  The following deficiencies were cited during the annual life safety code survey conducted on December 3, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<i>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth in this statement of deficiencies; This plan of correction is prepared solely for the purpose for meeting federal and state regulations</i>  <b>K-20 (D)</b> <i>No residents, staff or vendors were found to have been affected by the stairwell door that did not self-close; the door has been repaired by replacing the striker plate and felt door seal that was originally preventing door from latching properly</i>	
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that stairwell doors communicating between floors would self-close and latch. Failure to provide doors communicating between floors which self-close and latch could allow fires and their by-products of combustion to pass between floors, exposing	K 020	<i>The facility completed a global check of all vertical openings requiring self-close and latch; no further issues were noted</i>  <i>Checking the stairwell door for self-closing to ensure it latches properly has been added to Maintenance weekly preventative maintenance log; Executive Director has provided 1:1 education to the Maintenance Director regarding his role in ensuring that stairwell doors communicating between floors will self-close and latch properly</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Candice Hale, Executive Director*  
TITLE

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

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NAME OF PROVIDER OR SUPPLIER <b>CLEARWATER HEALTH &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</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 020	<p>Continued From page 1</p> <p>residents to those risks associated with fire events. This deficient practice affected staff and vendors of the Kitchen and basement service area on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 46 on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 3, 2015 from 1:30 PM to 4:30 PM, observation and operational testing of the lower stairwell door leading from the upper level of the facility into the basement revealed the door would not self-close and latch. Interview of the Operations Manager indicated he was aware this door was required to self-close and latch.</p> <p>Actual NFPA standard:</p> <p>19.3 PROTECTION 19.3.1 Protection of Vertical Openings. 19.3.1.1 Any vertical opening shall be enclosed or protected in accordance with 8.2.5. Where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. Exception No. 1: Unprotected vertical openings in accordance with 8.2.5.8 shall be permitted. Exception No. 2: Exception No. 1 to 8.2.5.6(1) shall not apply to patient sleeping and treatment rooms. Exception No. 3: Multilevel patient sleeping areas in psychiatric facilities shall be permitted without enclosure protection between levels, provided that all the following conditions are met: (a) The entire normally occupied area, including all communicating floor levels, is sufficiently open and unobstructed so that a fire or other dangerous condition in any part is obvious to the</p>	K 020	<p><i>Executive Director or designee will monitor the stairwell door 3 x's per week x's 3 weeks, then monthly x 3 months to ensure proper self-closing and latching with results to the facility's monthly QAPI Committee to ensure substantial compliance</i></p> <p><i>December 18, 2015</i></p>	12/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2015</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 020	Continued From page 2 occupants or supervisory personnel in the area. (b) Egress capacity is sufficient to provide simultaneously for all the occupants of all communicating levels and areas, with all communicating levels in the same fire area being considered as a single floor area for purposes of determination of required egress capacity. (c) The height between the highest and lowest finished floor levels shall not exceed 13 ft (4 m); the number of levels shall not be restricted. Exception No. 4: Unprotected openings in accordance with 8.2.5.5 shall not be permitted. Exception No. 5: Where a full enclosure of a stairway that is not a required exit is impracticable, the required enclosure shall be permitted to be limited to that necessary to prevent a fire originating in any story from spreading to any other story. 19.3.1.2 A door in a stair enclosure shall be self-closing and shall normally be kept in the closed position. Exception: Doors in stair enclosures held open under the conditions specified by 19.2.2.2.6 and 19.2.2.2.7.	K 020	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	<p><b>K-52 (F)</b> <i>Facility conducted sensitivity testing on the fire alarm system on 12/16/15</i></p> <p><i>Sensitivity testing on the fire alarm system has been scheduled with Fisher Systems, Inc. to meet the two-year requirement (alternating year)</i></p> <p><i>The Executive Director has provided 1:1 education to the Maintenance Director regarding his role in ensuring sensitivity testing on the fire alarm system</i></p> <p><i>Maintenance Director will report to the facility's monthly Safety Committee results of the sensitivity testing to ensure substantial compliance; Safety Committee minutes will be reviewed by the facility's monthly QAPI Committee to ensure substantial compliance</i></p> <p><i>December 18, 2015</i></p>
			<b>12/18/15</b>

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

Printed: 12/08/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2015</b>	
NAME OF PROVIDER OR SUPPLIER <b>CLEARWATER HEALTH &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
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K 052	<p>Continued From page 3</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that sensitivity testing for the fire alarm system was performed. Failure to conduct sensitivity testing on the fire alarm system could hinder system response during a fire event. This deficient practice affected 46 residents, staff and visitors on the date of the survey. The facility is licensed for 60 SNF/NF residents and had a census of 46 on the day of the survey.</p> <p>Findings include:</p> <p>During record review conducted on December 3, 2015 from 1:30 PM to 2:30 PM, review of the facility fire alarm records provided revealed the last sensitivity testing performed was conducted on October 16, 2009. When asked about the testing, the Operations Manager stated he thought he wasn't due for the sensitivity test until 2016.</p> <p>Actual NFPA standard:</p> <p>NFPA 72</p> <p>7-3.2.1*</p> <p>Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be</p>	K 052		

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

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NAME OF PROVIDER OR SUPPLIER <b>CLEARWATER HEALTH &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
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K 052	<p>Continued From page 4</p> <p>maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer ' s calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p> <p>Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p>	K 052		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  
**CLEARWATER HEALTH & REHABILITATION**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**1204 SHRIVER ROAD  
OROFINO, ID 83644**

(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) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The facility is a single story type V (111) building with a small basement which includes a maintenance shop and boiler room. The facility is protected by a complete sprinkler system and was built in 1989. The fire alarm system was replaced in 2001. Currently the facility is licensed for 60 beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on December 3, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><i>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth in this statement of deficiencies; This plan of correction is prepared solely for the purpose for meeting federal and state regulations</i></p> <p><b>C-226</b> <i>Corrective actions accomplished for those residents found to have been affected by the deficient practice. No residents were found to have been affected by the deficient practice; for staff and vendors affected by the deficient practice the door has been repaired by replacing the striker plate and felt door seal that was originally preventing door from latching properly.</i></p>	
C 226	<p>02.106 Meet Fire and Life Safety Standards</p> <p><b>106. FIRE AND LIFE SAFETY.</b> Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Please refer to federal "K" tags: K-020 Stairway doors K-052 Fire alarm system maintenance</p>	C 226	<p><i>Corrective action for other residents having the potential to be affected by the deficient practice</i> <i>All residents have the potential to be affected by the deficient practice; the facility completed a global check of all vertical openings requiring self-close and latch; no further issues were noted.</i></p>	

Bureau of Facility Standards

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

*Caroline L. Hall*

TITLE

*Administrator*

(X6) DATE

12/16/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
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C 446 C 445	Continued From page 1 02.120,13,c Hot Water Temps 105-120 Degrees F  c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. This Rule is not met as evidenced by: Based on observation, operational testing and interview, the facility did not maintain water temperatures in resident toilet areas at a minimum of 105 degrees. Failure to provide water temperatures of at least minimum required temperatures would not provide a comfortable bathing experience for residents. This deficient practice affected 28 residents on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 46 on the day of the survey.  Findings include:  During the facility tour conducted on December 3, 2015 from 1:30 PM to 3:30 PM, observation and operational testing of water temperatures in Room 22 of the "C" hall and Room 8 of the "A" hall revealed the maximum water temperature was eighty-two (82) degrees. When asked, the Operations Manager indicated there could be a problem with the boiler system on these two halls.  Actual IDAPA regulation:  IDAPA 16.03.02.13 c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.	C 445 C 445	<i>Measures and/or systemic changes that will be put in place to ensure the deficient practice does not recur</i> <i>Maintenance will monitor the stairwell door 3 x's per week x's 3 weeks, then monthly x 3 months to ensure proper self-closing and latching</i>  <i>How the corrective actions will be monitored to ensure the deficient practice will not recur</i> <i>Maintenance will monitor the stairwell door 3 x's per week x's 3 weeks, then monthly x 3 months to ensure proper self-closing and latching with results of monitoring to the facility's QAPI Committee for review and development of further plan of correction if needed</i>  <i>Date when corrective action will be completed</i> <i>December 18, 2015</i>  <i>Who is responsible to ensure the corrective action is completed</i> <i>The Executive Director is responsible to ensure correction of the deficient practice and has provided 1:1 education to the Maintenance Director regarding his role in ensuring that stairwell doors communicating between floors will self-close and latch properly</i>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2015	
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			<p><b>C-445</b>  <i>Corrective actions accomplished for those residents found to have been affected by the deficient practice</i>  <i>The hot water heaters that were accidentally shut off at the breaker were turned on immediately; water temperatures were brought up to 105f or &gt; within a few hours and temps were monitored / logged for the next 72 hours to ensure appropriate water temperature for the residents; residents on Hall A and C had the potential to be affected</i></p> <p><i>Corrective action for other residents having the potential to be affected by the deficient practice</i>  <i>Hot water heaters have been re-labeled at the breakers to ensure they do not accidentally get turned off</i></p> <p><i>Measures and/or systemic changes that will be put in place to ensure the deficient practice does not recur</i>  <i>Facility will monitor breakers and water temps daily during the week x 3 months to ensure appropriate water temperatures</i></p> <p><i>How the corrective actions will be monitored to ensure the deficient practice will not recur</i>  <i>The facility's QAPI Committee will review this POC Monthly x3 months and develop further plans of correction if needed</i></p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83644		
(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) COMPLETE DATE
			<p><i>Date when corrective action will be completed</i> <u>December 18, 2015</u></p> <p><i>Who is responsible to ensure the corrective action is completed</i> <i>The Executive Director is responsible to ensure correction of the deficient practice and has provided 1:1 education to the Maintenance Director regarding his role in ensuring adequate water temperatures</i></p>	