



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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
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CERTIFIED MAIL: 7012 3050 0001 2125 6614

December 2, 2014

Bernardo Carotenuto, Administrator
Clearwater Health & Rehabilitation
1204 Shriver Road
Orofino, ID 83544-9033

Provider #: 135048

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

Dear Mr. Carotenuto:

On **November 18, 2014**, 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 and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on

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page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 15, 2014**. Failure to submit an acceptable PoC by **December 15, 2014**, may result in the imposition of civil monetary penalties by **January 4, 2015**.

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 **December 23, 2014**, (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 **December 23, 2014**. A change in the seriousness of the deficiencies on **December 23, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 23, 2014**, includes the following:

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Denial of payment for new admissions effective **February 18, 2015**.
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 **May 18, 2015**, 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 **November 18, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

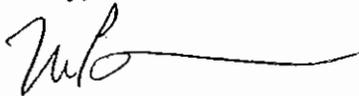
BFS Letters (06/30/11)

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

This request must be received by **December 15, 2014**. If your request for informal dispute resolution is received after **December 15, 2014**, 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.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 11/26/2014
FORM APPROVED
OMB NO. 0938-0391

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 11/18/2014
NAME OF PROVIDER OR SUPPLIER CLEARWATER HEALTH & REHABILITATION		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 November 18, 2014. 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	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 sets forth in this statement of deficiencies. This plan of correction is prepared solely for the purpose of meeting Federal and State regulations.	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed at the proper height per NFPA 10. Failure to install fire extinguishers correctly could hinder their immediate use during a fire event. This deficient practice affected all staff, residents and visitors on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census	K 064	K 064 1. One of the three 5 pound ABC Fire Extinguishers has been removed from the facility kitchen. The 5 pound ABC Fire Extinguisher in the Administrators office has been lowered to the 60 inch requirement. The 5 pound ABC Extinguisher at the nurse's station has been lowered to the 60 inch requirement. The 5 pound ABC Extinguishers at the end of all three resident corridors have been lowered to the 60 inch requirement. All other facility 5 pound ABC extinguishers were audited by facility Maintenance Director to ensure proper height. One 5 pound ABC extinguisher was identified during this audit in the facility laundry room to be installed to high. The 5 pound ABC Fire Extinguisher was also lowered to the 60 inch requirement in the facility laundry room. Continued on Page 2	12/23/14

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

12/12/14

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

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K 064	Continued From page 1 of 36 on the day of the survey. Findings include: During the facility tour conducted on November 18, 2014 from 9:30 AM to 12:30 PM, observation of the 5 lb ABC type fire extinguisher located at the main kitchen indicated it was installed more than 60 inches from the floor. Further investigation of four additional extinguishers located in each resident room corridor at the main facility intersection and the extinguisher located in the Administrator's office, found they measured between 64 to 66 inches from the floor. During interview, the Maintenance Supervisors stated all extinguishers in the facility were mounted at these heights and he was not aware of any height requirement of the installation of extinguishers prior to the survey. Actual NFPA standard: NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	Continued from Page 1 2. No other resident's identified to be affected by the deficient practice. No negative outcomes. 3. Any new 5 pound ABC Extinguishers that are needed in the facility will be installed by facility Maintenance Director to ensure proper placement for height requirements of 60 inches or less from the floor. 4. When any new 5 pound ABC Fire Extinguishers are installed in the facility, the facility QAPI committee will be informed through monthly meeting to ensure proper compliance with height requirements.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	1. Boxes identified on the Medical Records Office were immediately removed by facility Maintenance Director and returned to record storage.	12/23/14

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K 130	Continued From page 2 This Standard is not met as evidenced by: Based on observation, physical examination and interview, the facility failed to ensure that spacing of heat sources to combustible materials was provided. Failure to provide spacing between heat sources to combustible materials could potentially expose occupants to risk of fire or unnecessary evacuation. This deficient practice affected staff and visitors in 1 of 4 smoke compartments on the date of the survey. The facility is licensed for 60 SNF/NF beds and had a census of 36 on the day of the survey. Findings include: During record review and facility tour conducted on November 18, 2014 from 8:30 AM to 12:30 PM, observation Medical Records office found the wall heating element of the heating system to be blocked by stacks of medical records in boxes stored directly against it. When examined, these boxes felt hot to the touch. Interview of the Maintenance Supervisor found he was not aware of why these boxes were stored directly against the heating . Actual NFPA standard: NFPA 1 3-1 Fundamental Requirements. 3-1.1 Every new and existing building or structure shall be constructed, arranged, equipped, maintained, and operated in accordance with this Code so as to provide a reasonable level of life safety, property protection, and public welfare from the actual and potential hazards created by fire,	K 130	Continued on Page 2 2. Maintenance Director and facility Administrator conducted a full tour of the facility on 11/19/14 to include all offices, resident rooms, and all corridors to ensure that no other items were stored directly in front of a heat source. 3. All facility staff have been in serviced by facility Maintenance Director on proper placement of items around heat sources. 4. Facility Maintenance Director will conduct environmental rounds to ensure nothing is stored or placed directly in front of an active heat source five times a week for four weeks, then one time a week for four weeks, and monthly times three thereafter. Results from the audits will be reported to the QAPI committee to ensure proper compliance.	

Bureau of Facility Standards

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C 226	Continued From Page 1 K 130 Miscellaneous - Protection of occupants	C 226	Continued from Page 1 Please refer to K 130	