



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 9, 2016

Kenneth Shull, Administrator  
Clearwater Health & Rehabilitation  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Shull:

On **August 26, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **July 25, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

**0309-Provide Care/services For Highest Well Being-483.25**

**0329-Drug Regimen Is Free From Unnecessary Drugs-483.25(l)**

**0280-Right To Participate Planning Care-Revise Cp-483.20(d)(3), 483.10(k)(2)**

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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Kenneth Shull, Administrator  
September 9, 2016  
Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 22, 2016**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

As noted in the Bureau of Facility Standards' letter of **July 1, 2016**, following the survey of **June 10, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions effective **September 10, 2016** and termination of the provider agreement on **December 10, 2016**, if substantial compliance is not achieved by that time.

Kenneth Shull, Administrator  
September 9, 2016  
Page 3 of 4

The findings of non-compliance on **August 26, 2016**, has resulted in our recommendation of continuance of the remedy(ies) previously mentioned to you in our letter of **July 1, 2016**.

- DPNA effective September 10, 2016

**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 the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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>

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 **September 22, 2016**. If your request for informal dispute resolution is received after **September 22, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Kenneth Shull, Administrator  
September 9, 2016  
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Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive, flowing style.

DAVID SCOTT, Supervisor  
Long Term Care

DS/pt  
Enclosures



September 19, 2016

Idaho Department of Health & Welfare  
Bureau of Facility Standards  
3232 Elder Street  
Boise, ID 83720

*RECEIVED*  
*SEP 20 2016*  
*FACILITY STANDARDS*

Attn: David Scott

Dear Sir:

Enclosed you will find the Plan of Correction for Clearwater Health & Rehabilitation. If there's anything additional you need, please don't hesitate to call.

Sincerely,

*K. Shull*  
Kenneth Shull  
Administrator

crb

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

PRINTED: 09/09/2016  
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 _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 08/26/2016
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
{F 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a revisit survey of your facility conducted 8/24/16 through 8/26/16.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN - Team Coordinator Rachel Moorhead-Lopez, LSW Teresa Kobza, RDN, LD</p> <p>Acronyms used in this report include:</p> <p>BG = Blood Glucose CKD = Chronic Kidney Disease CNA = Certified nursing assistant DCS = Director of Clinical Services DM = Diabetes Mellitus Hx = History I&amp;A = Incident and Accident LPN = Licensed Practical Nurse MAR = Medication Administration Record MD = Physician MDS = Minimum data set mg = Milligram mg / dL = Milligram per deciliter mL = Milliliter PT = Physical Therapist PVD = Peripheral Vascular Disease RNP = Restorative Nursing Program RN = Registered Nurse ROM = Range of Motion SBAR = Situation, Background, Assessment, Recommendation SSD = Social Services Director VP = Vice President WNL = Within Normal Limits</p> <p>F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO</p>	{F 000}		

RECEIVED  
SEP 20 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*[Signature]*  
TITLE Administrator  
(X8) DATE 9/19/16

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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F 280 SS=D	<p>Continued From page 1 PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to update care plan interventions for 1 of 6 sampled residents (#5). This resulted in a care plan that did not accurately reflect a resident's needs and created the potential for harm due to receiving psychotropic medication without adequate monitoring. Findings include:</p> <p>Resident #5 was admitted to the facility on 3/20/15, with a diagnosis of dementia.</p> <p>A 7/28/16, Physician Note documented staff was</p>	F 280	<ol style="list-style-type: none"> <li>1. Resident #5 was assessed by the Primary Care Physician (PCP) on 8/31/16. Behavior Management care plans for Resident #5 were reviewed and revised, if indicated, by the Interdisciplinary Team (IDT) on 8/31/16 and 9/16/16.</li> <li>2. Those who reside in the facility have the potential to be affected by not updating the care plan. The care plans for residents receiving antipsychotic medications were reviewed and revised, if indicated, to ensure adequate monitoring.</li> <li>3. The Regional Director of Clinical Services (RDCS)/ Divisional Executive Director (DED) re-educated the Interdisciplinary Team (IDT) on the regulation F-280 and ensure Care Plan development/revisions includes adequate monitoring. The Director of Clinical Services (DCS) /Nurse Manager re-educated the Licensed Nurses on care plan development and revisions.</li> </ol>	09/18/2016	

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F 280	<p>Continued From page 2</p> <p>instructed to observe Resident #5 for worsening paranoia, delusions with agitation, and being over-somnolent.</p> <p>Resident #5's Behavior Management Care Plan, dated 9/11/15, documented she had the potential for inappropriate behaviors related to dementia. The care plan documented Resident #5's behaviors were aggression, hitting, grabbing, biting, and repetitive verbalization. The care plan was not updated to include monitoring Resident #5 for paranoia, delusions with agitation, and being over-somnolent.</p> <p>A Behavior Symptom Monitoring Flow Record, dated August 2016, documented behaviors to include:</p> <ul style="list-style-type: none"> <li>* "A. Hx of physical aggression"</li> <li>* "B. Biting"</li> <li>* "C. Repetitive singing"</li> </ul> <p>The August 2016 Behavior Monitoring Flow Record did not include paranoia, delusion with agitation, or over-somnolent, as directed by the physician on 7/28/16.</p> <p>On 8/26/16 at 9:54 am, the SSD agreed that Resident #5's Care Plan did not include monitoring her for the specific behaviors as outlined in the 7/28/16 physician note.</p> <p>{F 309} 483.25 PROVIDE CARE/SERVICES FOR SS=D HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in</p>	F 280	<p>4. The Minimum Data Set (MDS) RN/ designee will perform Quality Improvement (QI) monitoring of regulation F-280 to ensure care plans include adequate monitoring. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained using a sample size of five random residents. The MDS RN will report the findings to two quarterly Quality Assurance/Performance Improvement (QAPI) committee meetings. The QAPI committee (consisting of the Medical Director, DCS, Executive Director (ED) and at least 3 Department Managers) will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>		

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{F 309}	Continued From page 3 accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident, family member, and staff interview, it was determined the facility failed to ensure staff clarified physicians' insulin order and to ensure the order was written to improve the safety/reduce the risk of the wrong dose of medication being administered. This was true for 1 of 1 resident (#18) sampled who received insulin. This resulted in the potential for harm when the resident received an excessive dose of insulin. Findings include:  Resident #18 was admitted to the facility on 6/24/16 with diagnoses which included DM and CKD stage 3.  Resident #18's Nutrition Care Plan documented she was at risk for altered nutrition related to diabetes and interventions included monitoring her blood glucose level, as needed.  Resident #18's August 2016 Physicians Recap Orders documented:  * Lantus insulin 100 units/mL vial: inject 14 units subcutaneously two times a day for diabetes, beginning 6/24/16.  The physician order for Lantus did not give a specific times for administration for one of the two orders for insulin. The MAR failed to document the time the Lantus insulin was administered.	{F 309}	1. On 8/21/2016, Resident # 18 was assessed by a Licensed Nurse; the physician and family were notified; and the resident was sent to the hospital per physician's orders.  2. Residents receiving insulin have the potential to be affected by not clarifying physician's insulin orders and not writing the order in a manner which reduces risk for error.  Residents with orders for insulin were assessed for any changes in condition and any noted changes were immediately called to the Physician for further orders/interventions on 8/23/16.  Residents receiving insulin have had their physician's orders and Medication Administration Records (MAR) reviewed to ensure the orders are written in a manner which reduces risk for error.	09/18/2016	

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{F 309}	Continued From page 4  * Novolog insulin 100 unit/mL vial: inject subcutaneously before meals and at bed time per sliding scale for diabetes, beginning 6/24/16.  Resident #18's Novolog insulin sliding scale was:  * 145 - 170 = 2 units * 171 - 245 = 4 units * 246 - 350 = 6 units * 351 - 400 = 8 units  The order as written in the MAR, identified the units of insulin per mL in the bottle (100u/mL) instead of the units of insulin to be administered.  The August MAR for August 21, 2016, documented an untimed entry that the Resident #18 received Lantus insulin. In addition, an entry for August 21, am, untimed documented blood glucose level of 219 mg/dL and per the sliding scale received Novolog insulin.  On 8/21/16 at 7:45 am, a Medication Incident report documented Resident #18 was administered 100 units of Lantus instead of 14 units, and 100 units of Novolog instead of 4 units. The statement from the nurse documented, the nurse misread the dosage of insulin. The resident received 100 units of lantus and 100 units of Novolog. In addition, the nurse thought the dose seemed high, reread the order and realized the error.  On 8/21/16 at 2:00 pm, Resident #18's Nurses' Note documented she was transferred to the hospital at 8:00 am following a medication error. Resident #18 had been given 100 units of Lantus insulin and 100 units of Novolog insulin.	{F 309}	3. Licensed Nurses were re-educated on Medication Administration, the facility's insulin administration policy and following physician's orders. Physician's orders will be reviewed during the morning clinical meeting to ensure orders are written in a manner which reduces risk of for error. 4. The Director of Clinical Services (DCS)/ designee will perform QI monitoring of the regulation F-309 to ensure medication orders are written in a manner which reduces risk for error via medical record review and medication administration observations. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained using a sample size of five random residents. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.		

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{F 309}	Continued From page 5  The SBAR Communication Form completed on 8/21/16 at 8:00 am after the insulin administration, documented an untimed blood glucose check of 224 mg/dL.  Resident #18 was transferred to the hospital for treatment of an inadvertent overdose of insulin.  On 8/24/16 at 1:30 pm, Resident #18 and a family member stated she recently had to go to the hospital because of receiving too much insulin. The family member stated he had been at the facility when it happened and he told the nurse "isn't that too much [insulin]?" The nurse continued to give Resident #18 the insulin.  On 8/25/16 at 10:20 am, the DCS stated the staff member had called her as soon as the medication error happened and the nurse stated the family member told the nurse "isn't that too much?" The DCS stated the nurse told her that she had misread the order and did not verify or check the order before administering the insulin. The DCS stated the nurse told her she thought it was too much but still administered it. The DCS stated the nurse read the form the way it was written and did not continue to read the whole order to where the dosage was located. The DCS agreed the order could have been misread.  On 8/25/16 at 10:30 am, Regional Nurse #1, Regional Nurse #2, Regional Nurse #3, Administrator, and Divisional VP, stated they have changed the facility's policy to now have two nurses check the insulin level both nurses had to sign off on the MAR.	{F 309}			
{F 329}	483.25(l) DRUG REGIMEN IS FREE FROM	{F 329}			

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{F 329} SS=D	Continued From page 6 <b>UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interviews, it was determined the facility failed to ensure residents did not receive medication without adequate monitoring. This was true for 1 of 1 residents (#5) sampled for duplicate therapy medication use. The deficient practice created the potential for harm when a resident received medications without monitoring the effectiveness and potential adverse reactions of the	{F 329}	1. Resident #5 was assessed by the Primary Care Physician (PCP) on 8/31/16.  Behavior Management care plans for Resident #5 were reviewed and revised, if indicated, by the Interdisciplinary Team (IDT) on 8/31/16 and 9/16/16.  2. Residents receiving medications have the potential to be affected by not adequately monitoring.  The Care Plans and Behavior Monitoring Flow Records for residents receiving antipsychotic medications were reviewed and revised, if indicated, to ensure adequate monitoring.  3. The RDCS/ DED re-educated the Interdisciplinary Team (IDT) on the regulation F-329 to ensure adequate monitoring.  Behavior Monitoring Flow Records will be reviewed by the IDT for adequate monitoring during the weekly behavior management meeting.	09/18/2016	

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{F 329}	Continued From page 7 medications. Findings include:  Resident #5 was admitted to the facility on 3/20/15, with a diagnosis of dementia.  Resident #5's August 2016 Physician Orders documented she received:  * Seroquel 25 mg in the morning for depression, beginning 5/27/16.  * Seroquel 50 mg at bedtime for depression, beginning 5/27/16.  * Zolof 50 mg in the morning for depression, beginning 5/27/16.  Resident #5's 6/6/16 Quarterly MDS assessment, documented she had minimal physical behaviors and other behavioral symptoms not directed at others. In addition, the MDS documented and had a significant cognitive impairment with signs of mild depression.  Resident #5's Behavior Management Care Plan, dated 9/11/15, documented she had the potential for inappropriate behaviors related to dementia. The care plan documented Resident #5 behaviors were aggression, hitting, grabbing, biting, and repetitive verbalization. Interventions documented Resident #5 was to receive her medication as ordered by the physician.  A 7/28/16, Physician Note documented staff was instructed to observe Resident #5 for worsening paranoia, delusions with agitation, and being over-somnolent.  On 8/26/16 at 9:30 am, the facility provided an	{F 329}	4. The Social Services Director (SSD)/ designee will perform QI monitoring of the regulation F-329 via medical record review for residents on antipsychotic medications. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained. The SSD will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 08/26/2016
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	
{F 329}	<p>Continued From page 8</p> <p>unsigned document on behalf of Resident #5's physician which documented she had increased paranoia. In addition, it documented Resident #5's verbalization varied from pleasant and happy to agitated and dysphoric (unhappy).</p> <p>The July 2016 Behavior Monitoring Flow Record did not reflect the changes in the 7/28/16 physician order for staff to monitor the additional behaviors of paranoia, delusion with agitation, or the symptom of being over-somnolent.</p> <p>A Behavior Symptom Monitoring Flow Record, dated August 2016, documented behaviors to include:</p> <ul style="list-style-type: none"> <li>* "A. Hx of physical aggression"</li> <li>* "B. Biting"</li> <li>* "C. Repetitive singing"</li> </ul> <p>The August 2016 Behavior Monitoring Flow Record through 8/25/16 documented no behaviors.</p> <p>The August 2016 Behavior Monitoring Flow Record did not include the additional behaviors/symptoms of paranoia, delusion with agitation, or the over-somnolent as directed by the physician on 7/28/16. Resident #5's records did not contain documentation of staff monitoring her for paranoia, delusions with agitation, and over-somnolent.</p> <p>On 8/26/16 at 9:54 am, the SSD and Regional VP stated the MD reported Resident #5's need for the medication was due to paranoia, per the note he wrote on 8/26/16.</p> <p>On 8/26/16 at 10:28 am, Resident #5's Physician</p>	{F 329}			

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

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{F 329}	Continued From page 9 stated Resident #5's paranoia presented as fearfulness and suspicion. He stated the fear was shown on her face and no matter how he approached her, Resident #5 was afraid. The Physician stated he would expect the staff to monitor for the verbalization of what Resident #5 said to include happy noise, sad noise, fear, and fighting back. In addition, the Physician stated he wanted to know what type of delusions Resident #5 was experiencing. He defined this as including dysphoric delusion or happy delusions. If Resident #5 was experiencing delusion of the dysphoric nature then he would better be able to determine the medication had an adequate indication for use.	{F 329}			