



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSSELL S. BARRON – 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 18, 2017

David Welker, Administrator  
Clearwater Of Cascadia  
1204 Shriver Road,  
Orofino, ID 83544-9033

Provider #: 135048

Dear Mr. Welker:

On **August 28, 2017**, a survey was conducted at Clearwater Of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) in writing on **August 25, 2017**.

On **August 31, 2017**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, and an onsite revisit **September 5, 2017** it was determined that the immediate jeopardy to the residents had been removed effective **11:59 pm September 1, 2017**. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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.

David Welker, Administrator  
September 18, 2017  
Page 2

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 28, 2017**. Failure to submit an acceptable PoC by **September 28, 2017**, may result in the imposition of additional civil monetary penalties by **October 23, 2017**.

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*.

Based on the immediate jeopardy cited during this survey:

**F0520 -- S/S: L -- 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) -- Qaa Committee-Members/meet Quarterly/plans**

**F0225 -- S/S: L -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals**

**F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implment Abuse/neglect, Etc Policies**

David Welker, Administrator  
September 18, 2017  
Page 3

**F0490 -- S/S: L -- 483.70 -- Effective Administration/resident Well-Being**

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Civil money penalty,  
Denial of Payment for new admissions effective 11/28/2017

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 25, 2018**, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

**F0225 -- S/S: L -- 483.12(a)(3)(4)(c)(1)-(4) -- Investigate/report Allegations/individuals; F0226 -- S/S: L -- 483.12(b)(1)-(3), 483.95(c)(1)-(3) -- Develop/implement Abuse/neglect, Etc Policies**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # 7, 8, 9, 11, 12, 13, 14, 15, 16, as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

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, 83720-0009; 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.

David Welker, Administrator  
September 18, 2017  
Page 4

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 28, 2017**. If your request for informal dispute resolution is received after **September 28, 2017**, 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, 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,



David Scott, RN, Supervisor  
Long Term Care

ds/dr  
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted at the facility from August 21, 2017 to August 28, 2017. Immediate Jeopardy was identified on August 25, 2017 at 42 CFR 483.12 [F225 and F226], 483.70 [F490], and 483.75(g) [F520].</p> <p>Immediate Jeopardy at F225, F226, F490, and F520 was removed September 1, 2017 at 11:59 pm.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Sharon Whitehead, BSN, RN</p> <p>Definitions Include:</p> <p>ADL - Activities of Daily Living ADON - Acting Director of Nursing am - morning BG - Blood Glucose [sugar] BIMS - Brief Interview for Mental Status bpm - beats per minute BP - blood pressure CDC - Centers for Disease Control and Prevention cm - Centimeter CNA - Certified Nursing Assistant C/O - Complains of CPR - cardiopulmonary resuscitation CVA - Cerebrovascular accident D/C - discontinue DM - Diabetes Mellitus DNR -Do Not Resuscitate DON - Director of Nursing FSD - Food Service Director g - Gram</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/28/2017

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.

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 000	Continued From page 1 HTN - Hypertension I&A - Incidents and Accidents IM - intramuscularly LPN - Licensed Practical Nurse LTC - Long Term Care MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set mg - Milligram mg/dl - Milligram/deciliter mL - Milliliter mmHg - millimeters pressure of mercury OCD - obsessive compulsive disorder P & P - Policy and Procedure PRN - as needed PROM - passive ROM PT - Physical Therapist Q - every QAA - Quality Assessment and Assurance Program RSC - Resident Services Coordinator RN - Nurse ROM - Range of Motion r/t - Related to TAR - Treatment Administration Record UTI - Urinary Tract Infection w/c - Wheelchair	F 000			
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 155		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 155	<p>Continued From page 2</p> <p>the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p>	F 155			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 155	<p>Continued From page 3 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to update clinical records to accurately reflect residents' emergency status directives. This was true for 1 of 10 residents (#3) reviewed for Advanced Directives and created the potential for harm should the facility not honor residents emergency and end-of-life choices. Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/22/17, documented Resident #3 was cognitively intact, and exhibited no signs or symptoms of delirium, depression, or psychosis.</p> <p>Resident #3's clinical record contained the following:</p> <p>* A full-page undated form in the front of the clinical record with the letters "DNR" (Do Not Resuscitate) listed in bold black lettering in the center of the form.</p> <p>* An Admission Record, dated 5/11/17, documented Resident #3's Code Status (used to determine whether staff should initiate cardiopulmonary resuscitation - CPR - in emergency situations) as "Full Code" rather than "Do Not Resuscitate," or DNR, signifying</p>	F 155	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F155 Resident Specific The IDT reviewed resident #3's medical record, it is updated to consistently reflect the wishes of the resident.</p> <p>Other Residents The IDT reviewed other resident records to validate advance directive election, if made, is accurately reflected throughout the record. Adjustments were made as indicated.</p> <p>Facility Systems</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 155	<p>Continued From page 4</p> <p>Resident #3 did not wish to have CPR performed should a life-ending incident or emergency arise.</p> <p>The August 2017 Physician's Orders documented Resident #3's Code Status as "Full Code."</p> <p>A Resident Care Conference Report, dated 8/9/17, signed by the Social Services Director, Activity Director, Registered Nurse (RN) #2, and Director of Nursing (DON) documented, "Discussed care plans w/ [with Resident #3]. He did mention again that he would like to change his code status to No Code [DNR]. This was discussed w/ [Resident #3] in Feb[ruary] and he wanted to change, but then changed his mind. Call [Resident #3's family member] on Code Change- Called [Resident #3's family member] and she will be in to sign new POST [Physician Orders for Scope of Treatment]."</p> <p>Resident #3's clinical record contained physician Telephone Orders that did not include any orders referencing the resident's code status.</p> <p>Resident #3's August 2017 Medication Administration Record (MAR) documented, "Code Status: Full Code." There were no additional entries regarding Resident #3's code status.</p> <p>Resident #3's care plan, dated 8/21/17, documented, "[Resident #3] has changed his code status to a DNR CODE status."</p> <p>On 8/23/17 at 9:00 am, Resident #3 was observed sitting in a chair in his room. The resident was awake and alert and correctly</p>	F 155	<p>Nursing staff, social service designee, and medical records are educated by the DON and/or designee to the updated Advanced Directives policy to include but not limited to, where the code status/advanced directives are located, process for residents who revise their code status/advanced directives, how the care plan and face sheet is updated. The system is amended to include a new policy which includes the process for managing when residents make changes. These order changes or reviewed in clinical meeting.</p> <p>Monitor The medical records clerk and/or designee will audit code status/advance directive consistency throughout the medical record during end-of-month physician order recapitulation review for 3 months. Starting the month of October, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 155	<p>Continued From page 5</p> <p>stated his name, date, and the name of the nursing facility. When asked how he would like to staff to respond should his heart and/or breathing stop, Resident #3 stated he did not want the staff to perform CPR.</p> <p>On 8/24/17 at 10:50 am, the Director of Nursing (DON) stated when residents decided to change their code status to DNR, the Social Services Director reviews the DNR paperwork with the resident, and the resident signs the DNR form. The facility then sends the original form to the resident's attending physician for their signature. When the facility receives the signed form back from the physician, staff then places a DNR form in the resident's clinical record, and updates other pertinent resident documentation to reflect the resident's "DNR" code status. The DON stated a physician's order was required to change a resident's code status and said staff were required to check the resident's chart for the code status in the case of a cardiopulmonary event. The DON stated the Social Services Director was responsible for updating residents' care plans with the changed code status and the nurse who noted the code change order was responsible for making changes to the residents' MARs. The DON said he was not certain which staff was responsible for updating individual resident's "Admission Record."</p> <p>On 8/25/17 at 8:05 am, the DON provided a physician's Telephone Order for Resident #3, dated 8/24/17, that read, "Change code status to DNR, comfort, limited additional interventions, ... TF [tube feeding], IV [intravenous] fluids, Abx [antibiotics] and blood products. Effective 8/17/17."</p>	F 155			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 155	Continued From page 6	F 155			
F 225 SS=L	<p>The facility's Advance Directives- Admissions/Social Service policy, effective 11/30/14, did not provide procedures for staff to follow when documenting and/or updating residents' code status and other life-sustaining treatments in the residents' clinical record or other healthcare-related documents.</p> <p>483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>483.12(a) The facility must-</p> <p>(3) Not employ or otherwise engage individuals who-</p> <p>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;</p> <p>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or</p> <p>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect,</p>	F 225		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 7</p> <p>exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of clinical records and Incident and Accident Reports, it was determined the facility</p>	F 225	<p>F225 For resident #s 7 - 9, and resident #s 11 - 16 and other residents in the facility, the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 8 failed to ensure:</p> <ul style="list-style-type: none"> <li>* Injuries of unknown origin and residents' allegations of staff mistreatment were recognized as potential indicators of abuse or neglect.</li> <li>* Allegations of potential abuse and neglect, as well as injuries of unknown origin, were thoroughly investigated.</li> <li>* Staff received abuse and neglect training.</li> <li>* Allegations of potential abuse or neglect, and injuries of unknown origin, were reported to the State Agency and the facility's Abuse Coordinator.</li> </ul> <p>This was true for 9 of 17 residents (#'s 7 - 9 and #'s 11 - 16) reviewed for accidents and supervision and for 1 of 3 Certified Nursing Assistants (CNA) #4, who did not receive abuse/neglect training prior to working in the facility. Specifically:</p> <p>a) Resident #7 sustained a 7 centimeter (cm) by 7 cm purple bruise to her right breast that the facility failed to investigate as an injury of unknown origin or report to the State Agency.</p> <p>b) Resident #9 was assessed on 7/4/17 with bruises to her left inner wrist and right forearm that were depicted by the facility as possibly caused by "finger tips." There was no evidence the facility investigated this statement as potential abuse or to determine the cause of the injury. The facility failed to report the injury of unknown origin to the State Agency.</p> <p>c) Resident #12 voiced a concern of an unsafe transfer on 6/11/17, which resulted in a fall and skin injuries to her back. The facility did not</p>	F 225	<p>facility shall;</p> <ul style="list-style-type: none"> <li>a. Ensure the Abuse Prevention and Prohibition Program is made operational. Staff will be educated prior to their next shift. The Director of Compliance or designee will perform the education. <ul style="list-style-type: none"> <li>i. The Abuse Prevention and Prohibition Program shall specifically outline the definition of Injury of unknown source.</li> <li>ii. The Abuse Prevention and Prohibition Program shall specifically outline the procedures for investigating an injury of unknown origin.</li> </ul> </li> <li>b. The facility shall thoroughly investigate or reinvestigate allegations related to the residents stated above.</li> <li>c. Investigations related to the above referenced residents shall be re-investigated and reported, as necessary, through the State on-line portal. In the absence of the Executive Director, the Director of Nursing or the Social Services Director shall report allegations of abuse, neglect, and injury of unknown source to the State portal, and shall start an investigation.</li> <li>d. The Executive Director shall ensure that injuries of unknown origin, potential unknown origin, or potential neglect are thoroughly investigated and reported through the State on-line portal.</li> <li>e. Future investigations related to abuse/neglect, injuries of unknown origin, misappropriation of property, and exploitation shall be reported through the State on-line portal and thoroughly investigated as outlined in the Abuse Prevention and Prohibition Program. The</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 9</p> <p>conduct an investigation into the resident's concerns and failed to report the incident to the State Agency. Resident #12 sustained other injuries of unknown origin on 7/25/17, which the facility failed to investigate or report to the State Agency.</p> <p>d) Residents #'s 8, 11, 13, 14, 15 and 16 sustained various injuries of unknown origin in which the facility failed to thoroughly investigate or report to the State Agency.</p> <p>e) CNA #4 was unable to identify various forms of abuse and neglect.</p> <p>This deficient practice placed Residents #'s 7 - 9 and #'s 11 - 16, as well as 19 other residents in the facility, in immediate jeopardy of serious harm, injury, or death from the facility's failure to recognize, prevent, protect, and report potential incidents of abuse and/or neglect.</p> <p>Findings include:</p> <p>1. Resident #7's quarterly Minimum Data Set (MDS) assessment, dated 6/26/17, documented moderate cognitive impairment with no signs or symptoms of delirium or psychosis; did not exhibit "behaviors;" required the total assistance of at least two staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing; was non-ambulatory; and required the total assistance of one staff for wheelchair mobility.</p> <p>a. A 6/20/17 Interdisciplinary Progress Note documented staff observed a purple bruise to Resident #7's right breast that measured 7</p>	F 225	<p>Executive Director shall ensure this occurs and log all such investigations. The facility Executive Director is the Abuse Prevention Coordinator and staff will be educated that allegations of abuse, neglect, exploitation, and injury of unknown source, are immediately reported to the Executive Director. The Director of Compliance or designee will perform the education with completion prior to the staff's next shift. The facility Executive Director will ensure that new employees will be trained on the Abuse Prohibition policy. Those employees that have been hired in the last six months will be required to attend the training. The Director of Compliance or designee will perform the education with completion prior to the staff's next shift. The facility Executive Director in collaboration with the Director of Compliance will provide the Director of Nursing with training and ongoing oversight in providing training to the staff providing resident care. The records of this training and the Abuse Prohibition policy will be presented to the Quality Assurance Committee on Thursday 8/31/2017 for evaluation and further comment. The Quality Assurance Committee will recommend specific Performance Improvement Plans as indicated. On a weekly basis, the Executive Director, DNS, and/or Social Service department shall conduct random interviews of staff to ensure they fully</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 10</p> <p>centimeters (cm) by 7 cm. The Note documented the resident did not know the cause of the bruise and noted, "[Resident #7] does use [the] sit to stand [mechanical lift and transfer device] with sling, this may be the cause of the bruise. Family notified."</p> <p>A 6/20/17 Incident and Accident (I&amp;A) Report documented staff discovered a 7 cm x 7 cm "purple" bruise on Resident #7's right breast; the resident was "sleeping" immediately prior to staff discovering the bruise; and Resident #7, whose skin was described as "dry, fragile, transparent/thin, decreased sensation, impaired circulation," experienced both short- and long-term memory impairment. The I/A documented Resident #7 had a history of falls and did not have a history of falls; there had been no change in the resident's usual caregiver.</p> <p>The I/A, which had been signed by a direct care nurse and the facility's Director of Nursing (DON), documented the bruise to Resident #7's right breast was "probably d/t [due to] sit to stand sling - res [Resident #7] has lg [large] breast (sic) - sling won't cover [her] breasts so staff will put [the sling] under her breast (sic)." On the reverse side of the I/A, the DON wrote, "Staff inserviced for placement of sling straps." The I&amp;A included no other documentation.</p> <p>On 8/24/17 at 2:40 pm, Resident #7 stated she did not remember anything about the June bruising to her right breast.</p> <p>b. Resident #7's August 2017 Physician's Orders included a 7/1/17 order that documented, "[Right] forearm bruise: Monitor every shift until</p>	F 225	<p>understand the Abuse Prohibition Program. These interviews will consist of standardized questions. Inaccurate responses to the standardized questions shall be immediately remediated. The results of these weekly interviews shall be reported to the QA Committee for 4 weeks. The QA Committee shall determine if and when the interviews may be altered or terminated. The Facility shall ensure that new hires are trained on the Abuse Prohibition Program prior to working their first shift. Additionally, retraining shall occur for employee on at least an annual basis. If the Abuse Prohibition Program is amended staff shall be retrained related to the amendments in a timely fashion. Retraining shall be documented and reported to the QA Committee. Responsible: Executive Director, DON, Social Services, all facility employees</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 11 resolved."</p> <p>Resident #7's Interdisciplinary Progress Notes from 7/1/17 through 8/24/17 did not include any documentation or investigation related to a bruise on the resident's right forearm.</p> <p>2. Resident #8's annual MDS assessment, dated 8/9/17, documented severe cognitive impairment; no signs or symptoms of delirium or psychosis, no behaviors; total assistance of at least two staff required for bed mobility, transfers, toileting, and bathing; unable to ambulate; extensive assistance of one staff required for wheelchair mobility and personal hygiene; and anticoagulant therapy.</p> <p>a. A 7/26/17 I&amp;A Report documented, "Upon arriving at [6:00 pm] ...CNA notified this nurse of bruise on [Resident #8's] left hip." The I&amp;A Report documented the bruise was purple; the resident experienced short- and long-term memory impairment; required extensive assistance with transfers; and was dependent on staff for bed mobility. The I&amp;A Report's Summary documented, "CNA reported finding bruise at start of shift [6:00 pm] and unknown (sic) how it happened." The report was not signed by the DON to indicate it had been reviewed, and did not contain any other documentation.</p> <p>A 7/28/17 Interdisciplinary Progress Note documented a "late-entry" note for 7/26/17 of a bruise "of unknown origin" to Resident #8's left hip. The Note documented staff attempted to to notify the resident's family, and the resident's physician was notified of the bruise.</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 12</p> <p>b. A 7/29/17 Interdisciplinary Progress Note documented a nurse contacted the facility's Medical Director regarding an abrasion to Resident #8's right knee and bruise to her right leg.</p> <p>A 7/29/17 I&amp;A Report documented, "CNA notified this nurse of [an] abrasion on [Resident #8's right] knee and fading bruise on left sided (sic) shin." The wounds were described as "red," no cause had been identified for the bruise or abrasion, the resident was "independent" with bed mobility, but required "extensive" staff assistance with transfers, and had an elevated PT/INR (blood clotting) lab value which made her prone to bleeding and bruising. The Report's Summary documented, "Educate CNAs about safety with transfers when using Hoyer [mechanical lift]." The report was not signed by the DON and included no other documentation.</p> <p>3. Resident #11's quarterly MDS assessment, dated 6/26/17, documented severe cognitive impairment; no signs or symptoms of delirium or psychosis; no behaviors; total assistance of at least two staff required for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing; total assistance of one staff required for wheelchair mobility; and the resident was not receiving anticoagulant therapy.</p> <p>a. A 3/26/17 I&amp;A Report documented Resident #11 was assessed with a bruised bottom lip that was "green and brown," the resident experienced short- and long-term memory impairment, and no cause was identified for the bruised lip.</p> <p>The I/A documented Resident #11 had been</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 13</p> <p>"sleeping" prior to the identification of the bruised lower lip and noted that her "identified behaviors" included, "Lays head on surfaces when tired." The I/A documented Resident #11 had 1 bruise in the previous 30 days, had "fragile" skin, and there had been no changes in Resident #11's usual caregiver. The I/A Summary documented, "Resident lays head on surfaces when tired and this might be how she got her bruise. When resident shows signs of being tired will be layed (sic) down in bed." The DON signed the report on 3/30/17 and added, "C/P [Care plan] when sleepy/leaning forward, [Aassist] to bed..." The I/A included no other documentation.</p> <p>b. A 7/24/17 I&amp;A Report documented a bruise on Resident #11's right forearm was red and that the resident was dependent on staff for transfers and that she experienced both short- and long-term memory impairment. The Report's Summary documented, "[Resident #11] has bruise on [right] forearm, notified MD [physician on] 7/25/17, will continue to monitor area." The Report documented the resident would be equipped with "arm protectors," and had been signed as reviewed. No other documentation was included in the Report.</p> <p>A 7/25/17 Interdisciplinary Progress Note documented a physician's Telephone Order directed staff to monitor Resident #11's right forearm bruise daily until resolved.</p> <p>The facility failed to thoroughly assess the potential cause of injuries sustained by Resident #s 7, 8, and 11 to rule out abuse and protect each resident from further injury.</p>	F 225			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 14</p> <p>4. Resident #9 was admitted to the facility on 8/8/14 with diagnoses which included hemiplegia and hemiparesis of the right side, cerebrovascular disease, cerebrovascular accident (CVA - stroke), pain, and a mental disorder.</p> <p>Resident #9's Annual MDS assessment, dated 7/28/17, documented severe cognitive impairment and extensive assistance or dependence on 1 staff member for activities of daily living (ADL).</p> <p>An Impaired Cognition Care plan, dated 3/16/17, documented Resident #9 was cognitively impaired related to dementia and CVA.</p> <p>An I&amp;A Report, dated 7/4/17, documented Resident #9 sustained multiple bruises of unknown origin that were nickel sized and brownish on her left inner wrist and right forearm. No further measurements were included and the report did not include a body diagram to illustrate the bruises arrangement at either location.</p> <p>A 7/5/17 follow-up to the I&amp;A documented Resident #9's bruises were small and circular, appeared to be caused by "finger tips," and were 3-5 days old. The I/A concluded the bruising was likely due to staff assisting Resident #9 with transfers, but no "specific occurrence" was determined. The I/A did not include witness statements, staff interviews, or resident interviews to determine the origin of the bruises, or a complete investigation to rule out potential abuse or neglect. The injuries of unknown origin were not reported to the State Agency.</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 15</p> <p>Resident #9's clinical record did not contain progress notes identifying the discovery of the wounds, their progression, or investigations of their cause.</p> <p>5. Resident #12 was readmitted to the facility on 3/16/17 with diagnoses which included osteoporosis, cerebrovascular disease, hemiplegia, epilepsy, and muscle weakness.</p> <p>A Skin Risk Care Plan, dated 6/23/16, documented Resident #12 was at risk of skin breakdown related to incontinence and immobility.</p> <p>Resident #12's Quarterly MDS assessment, dated 7/25/17, documented moderate cognitive impairment and dependence on 2 staff for transfers, bed mobility, toileting, and showers.</p> <p>A Fall Care Plan, dated 7/28/17, documented Resident #12 was at risk for falls and directed transfers were to be performed by 2 staff using a Hoyer mechanical lift.</p> <p>a. An I&amp;A Report, dated 6/11/17, documented Resident #12 sustained 2 abrasions on her back. The report did not document the size or appearance of the abrasions. The report, which noted Resident #12 required the assistance of 2 staff for transfers, documented the abrasions were caused by a fall on 6/10/17.</p> <p>A 6/11/17 Witness Statement documented CNA #5 first observed the back abrasions while showering Resident #12. CNA #5 stated Resident #12 became upset when asked about</p>	F 225			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 16</p> <p>the abrasions and stated she had been dropped on the floor by a staff member. CNA #5 stated Resident #12 said 1 staff member was assisting with the transfer, but the resident could not remember the name of the CNA.</p> <p>A 6/11/17 Witness Statement documented CNA #6 was showering Resident #12 and noticed red marks on her back. CNA #6 asked Resident #12 what happened and Resident #12 said she "fell" the day before when a staff member, whose name she could not remember, dropped her to the floor while assisting the resident transfer.</p> <p>A 6/16/17 Follow up to the I&amp;A documented the abrasions were "probably" related to a gait belt used during transfers. No other witness statements were included in the report and the injuries of unknown origin and the 6/10/17 fall were not reported to the State Agency.</p> <p>b. An I&amp;A Report, dated 7/25/17, documented staff discovered an open area on Resident #12's right buttock and a scratch on her right hip. The report did not document the size or appearance of the wounds. The report documented Resident #12 required 2 staff and a Hoyer mechanical lift for transfers.</p> <p>A follow-up to the I&amp;A, which did not identify the cause of the 2 wounds, was signed as reviewed on 7/27/17. The conclusion did not include witness statements, staff interviews, or resident interviews to determine the cause of the wounds or to determine whether the injuries were the result of potential abuse or neglect. Resident #12's injuries of unknown origin were not reported to the State Agency.</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 17</p> <p>6. Similar findings were found for Residents #'s 13-16.</p> <p>On 8/24/17 at 9:15 am, the DON stated the I&amp;A reports were completed to his knowledge and any witness statements would be attached to the applicable I&amp;A report. The DON stated he did not always document witness statements, especially if the witness did not see anything. The DON stated he submitted investigations to the facility's Executive Director when there were signs of potential abuse or neglect.</p> <p>On 8/24/17 at 3:37 pm, the Executive Director stated an injury of unknown origin was an injury which could not be explained, that was unwitnessed, and the resident could not identify how it occurred. The Executive Director stated the facility was to obtain witness statements, interview staff and residents to try and determine the cause of an injury, and investigate the incident as a case of potential abuse or neglect. The Executive Director said providing State Agency notification of potential abuse and neglect was dependent of the circumstances of the investigation. He stated if the circumstances indicated abuse and/or neglect occurred, then the facility would intervene and report. The Executive Director stated all injuries of unknown origin should be reported to the State Agency. The Executive Director stated he did not complete the investigations for injuries of unknown origin involving Resident #'s 7-9 and #'s 11-16 as these were a "clinical thing." The Executive Director stated investigation reports were to come to him for review. The Executive Director stated the DON completed the</p>	F 225			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 18</p> <p>investigations and that there was not a system in place for supervising the investigations related to injuries of unknown origin. The Executive Director stated he had not reviewed some of the investigations outlined above and that he was not aware of those investigations' deficiencies until 8/24/17. The Executive Director stated if a resident fell while being transferred by 1 staff when he/she was care planned for transfers by 2 staff then the incident should be investigated for potential neglect or abuse.</p> <p>On 8/24/17 at 3:55 pm, the DON stated an injury of unknown origin was an injury that was unexplainable, unwitnessed, and the resident was unable to tell how it occurred. He stated he was not sure when injuries should be reported to the State Agency.</p> <p>7. On 8/25/17 at 10:40 am, CNA #4 said she had been working in the facility since April 2017 and had not received training on abuse and neglect from the facility upon her hiring. CNA #4 stated she had not received a refresher training on abuse and neglect since she had been employed, and was able to identify only three types of abuse, "physical verbal, and mental." CNA #4 could not identify sexual abuse, corporal punishment, involuntary seclusion, or misappropriation of residents' property as signs of possible abuse or neglect. CNA #4 stated she did not know what to do if she suspected the facility's Executive Director of resident abuse.</p> <p>CNA #4's employee file was did not include a training record for any topic related to abuse and neglect.</p>	F 225			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	<p>Continued From page 19</p> <p>An All Staff Education Attendance Sheet on Abuse and Neglect, dated 1/12/17 from 4:10 pm - 4:25 pm, identified 60 individuals who were required to attend. The attendance sheet contained 25 signatures from staff members.</p> <p>An All Staff Education Attendance Sheet on Resident Abuse, dated 1/12/17 from 4:25 pm - 4:35 pm, identified 60 individuals who were required to attend. The attendance sheet contained the same 25 signatures from the 4:10 pm to 4:25 pm meeting.</p> <p>An All Staff Education Attendance Sheet on Resident Abuse, dated 7/18/17 and scheduled for 15 minutes, identified 47 individuals who were required to attend. The attendance sheet contained 13 signatures from staff members. CNA #4's name was not identified on the list as an individual required to attend the training.</p> <p>On 8/25/17 at 11:15 am, the DON stated he could not provide evidence that CNA #4 received training on abuse and neglect prior to working in the facility. He stated there were other staff working in the facility, as well, who had not yet received abuse/neglect training. The DON stated the All Staff Education Training Records provided for review were "all" the abuse/neglect training records the facility had on file.</p> <p>The facility was notified in writing of the immediate jeopardy and the need to formulate and implement a plan of removal on 8/25/17 at 8:23 am.</p> <p>On 9/1/17 at 11:59 pm, the facility provided evidence that an acceptable plan to remove the</p>	F 225			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 225	Continued From page 20 immediacy had been developed and implemented. The plan included:  * Updating the facility's Abuse Policy and Procedure to meet regulatory guidelines and include injuries of unknown origin. * Investigation of the injuries of unknown origin outlined above and implementation of the facility's abuse policy. * Educating staff on the new abuse policy and procedure to ensure injuries of unknown origin were reported and investigated to determine potential neglect and/or abuse.	F 225			
F 226 SS=L	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  483.12 (b) The facility must develop and implement written policies and procedures that:  (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  (2) Establish policies and procedures to investigate any such allegations, and  (3) Include training as required at paragraph §483.95,  483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-	F 226		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 226	<p>Continued From page 21</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure:</p> <ul style="list-style-type: none"> <li>* Investigations into injuries of unknown origin and/or potential abuse and neglect allegations were completed.</li> <li>* Allegations of potential abuse were reported to the facility's Executive Director and State Agency responsible for regulatory oversight.</li> <li>* Neglect/Abuse policies and procedures were current and implemented with existing regulatory requirements.</li> </ul> <p>This deficient practice placed Residents #'s 7 - 9 and #'s 11 - 16, and all 19 other residents in the facility, in immediate jeopardy of serious harm, injury, or death from potentially unrecognized abuse or neglect. Findings include:</p> <p>The facility's Resident Abuse Policy and Procedure, revised 9/1/16, defined physical abuse, verbal abuse, sexual abuse, psychological/ emotional abuse, neglect, and misappropriation of residents' property, but did not define corporal punishment, involuntary seclusion and or injuries of unknown origin.</p>	F 226	<p>F226</p> <p>For resident #s 7 - 9, and resident #s 11 - 16 and other residents in the facility, the facility shall;</p> <ul style="list-style-type: none"> <li>a. Ensure the Abuse Prevention and Prohibition Program is made operational. Staff will be educated prior to their next shift. The Director of Compliance or designee will perform the education. <ul style="list-style-type: none"> <li>i. The Abuse Prevention and Prohibition Program shall specifically outline the definition of Injury of unknown source.</li> <li>ii. The Abuse Prevention and Prohibition Program shall specifically outline the procedures for investigating an injury of unknown origin.</li> </ul> </li> <li>b. The facility shall thoroughly investigate or reinvestigate allegations related to the residents stated above.</li> <li>c. Investigations related to the above referenced residents shall be re-investigated and reported, as necessary, through the State on-line portal. In the absence of the Executive Director, the Director of Nursing or the Social Services Director shall report</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 226	<p>Continued From page 22</p> <p>Additionally, the Policy and Procedure documented:</p> <ul style="list-style-type: none"> <li>* Training - Staff would receive education and training during orientation and annually thereafter on resident rights, and resident abuse and neglect reporting. An addendum documented staff would receive training and competency testing "upon hire, quarterly and following allegations of abuse, neglect or misappropriation of property." It was unclear whether training and education would be provided quarterly and/or annually.</li> <li>* Employee Obligation - The policy documented staff making a false or misleading report of abuse would be in violation of the facility's policy and did not provide protection from reprisal for staff who made allegations of potential abuse and/or neglect in good faith.</li> <li>* Prevention - The policy documented the facility was committed to preventing abuse, neglect, and misappropriation of property, but did not address corporal punishment and involuntary seclusion.</li> <li>* Identification - All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) were to be investigated by the Director of Clinical Services. Patterns or trends would be identified that might constitute abuse. This information was to be forwarded to the Executive Director, who serves as the facility's Abuse Coordinator, and an abuse investigation was to be conducted. The policy did not, however, include injuries of unknown origin requiring investigation for potential abuse or neglect.</li> </ul>	F 226	<p>allegations of abuse, neglect, and injury of unknown source to the State portal, and shall start an investigation.</p> <p>d. The Executive Director shall ensure that injuries of unknown origin, potential unknown origin, or potential neglect are thoroughly investigated and reported through the State on-line portal.</p> <p>e. Future investigations related to abuse/neglect, injuries of unknown origin, misappropriation of property, and exploitation shall be reported through the State on-line portal and thoroughly investigated as outlined in the Abuse Prevention and Prohibition Program. The Executive Director shall ensure this occurs and log all such investigations. The facility Executive Director is the Abuse Prevention Coordinator and staff will be educated that allegations of abuse, neglect, exploitation, and injury of unknown source, are immediately reported to the Executive Director. The Director of Compliance or designee will perform the education with completion prior to the staff's next shift.</p> <p>The facility Executive Director will ensure that new employees will be trained on the Abuse Prohibition policy. Those employees that have been hired in the last six months will be required to attend the training. The Director of Compliance or designee will perform the education with completion prior to the staff's next shift.</p> <p>The facility Executive Director in collaboration with the Director of Compliance will provide the Director of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 226	<p>Continued From page 23</p> <p>* Investigation - The policy documented the Abuse Coordinator or a designee would investigate "all" reports or allegations of abuse. The policy documented those suspected of potential abuse would be segregated from residents pending the investigation. The policy documented a nurse would perform and document a thorough nursing assessment of the resident and file an incident report with the Abuse Coordinator. The policy documented the Abuse Coordinator or the Director of Clinical Services would obtain statements from the "victim, the suspect, and all possible witnesses including all other employees in the vicinity of the alleged abuse," and complete a report. The policy did not include an investigative procedure to follow for injuries of unknown origin.</p> <p>* Procedures for Reporting Abuse - The policy documented staff members suspecting abuse "must immediately" notify nursing supervision, who "must immediately" report to the Executive Director. The policy specified the Executive Director was responsible for reporting allegations to officials per federal guidelines. An addendum documented the facility must complete and submit an "initial" report to the State Agency within 24 hours and a completed "full" investigation within 5 days. The policy did not distinguish between allegations of serious bodily harm and harm for reporting purposes; specify that allegations involving serious bodily harm must be reported to the State Agency no later than 2 hours after an allegation was made; and did not inform staff when to report injuries of unknown origin as defined by regulatory requirement.</p>	F 226	<p>Nursing with training and ongoing oversight in providing training to the staff providing resident care. The records of this training and the Abuse Prohibition policy will be presented to the Quality Assurance Committee on Thursday 8/31/2017 for evaluation and further comment. The Quality Assurance Committee will recommend specific Performance Improvement Plans as indicated.</p> <p>On a weekly basis, the Executive Director, DNS, and/or Social Service department shall conduct random interviews of staff to ensure they fully understand the Abuse Prohibition Program. These interviews will consist of standardized questions. Inaccurate responses to the standardized questions shall be immediately remediated. The results of these weekly interviews shall be reported to the QA Committee for 4 weeks. The QA Committee shall determine if and when the interviews may be altered or terminated.</p> <p>The Facility shall ensure that new hires are trained on the Abuse Prohibition Program prior to working their first shift. Additionally, retraining shall occur for employee on at least an annual basis. If the Abuse Prohibition Program is amended staff shall be retrained related to the amendments in a timely fashion. Retraining shall be documented and reported to the QA Committee. Responsible: Executive Director, DON, Social Services, all facility employees</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 226	<p>Continued From page 24</p> <p>On 8/24/17 at 9:15 am, the Director of Nursing (DON) stated the facility's Incident &amp; Accident Report (I&amp;A) file was complete. The DON stated witness statements would be attached to the applicable I&amp;A Report. The DON stated he did not always document witness statements when the person did not personally witness a reported event. The DON stated he would submit investigations for review to the Executive Director if through the investigation process there were signs of potential abuse or neglect.</p> <p>On 8/24/17 at 3:37 pm, the Executive Director stated an injury of unknown origin was an unwitnessed injury which could not be explained and the resident could not identify how it occurred. He stated the policy did not define injuries of unknown origin because it was not necessary and that staff would investigate these type of injuries. When shown several of the facility's I&amp;A reports, the Executive Director stated he was seeing some of the investigations outlined above for the first time and that he was not aware until 8/24/17 that full and thorough investigations were not completed as required. The Executive Director said the DON completed the investigations and stated that there was no system in place for supervising the investigations related to injuries of unknown origin.</p> <p>Refer to F225 as related to the facility's failure to identify injuries of unknown origin and potential abuse or neglect, report such injuries to the Executive Director and State Agency, and provide abuse/neglect training to staff prior to the provision of resident care.</p> <p>Refer to F494 as related to the facility's failure to</p>	F 226			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 226	Continued From page 25 provide abuse/neglect training to staff.  Refer to F498 as related to the facility's failure to ensure CNA competencies were completed.  The facility was notified in writing on 8/25/17 at 8:23 am of the immediate jeopardy and the need to formulate and implement a plan of removal.  On 9/1/17 at 11:59 pm, the facility provided evidence that an acceptable plan to remove the immediate jeopardy had been developed and implemented. The plan included:  * Updating the Abuse Policy and Procedure to meet regulatory guidelines and include injuries of unknown origin. * Investigation of injuries of unknown origin and implementation of the facility's abuse policy. * Educating staff on the new abuse policy and procedure to ensure injuries of unknown origin were reported and investigated as potential incidents of abuse and/or neglect.	F 226			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS  483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.  483.21 (b) Comprehensive Care Plans	F 279		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 279	<p>Continued From page 26</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to</p>	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 279	<p>Continued From page 27</p> <p>local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure care plans based on residents' comprehensive assessments were developed and implemented. This was true for 2 of 17 residents (#4 and #5) reviewed for initial care plans and created the potential for harm if residents received inappropriate or inadequate care. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 3/30/17 with multiple diagnoses, including coronary artery disease, hypertension (HTN), and hyperlipidemia.</p> <p>Resident #4's clinical record did not contain a cardiovascular care plan as of 8/25/17.</p> <p>2. Resident #5 was admitted to the facility on 7/3/17 with multiple diagnoses, including HTN, heart disease, hyperlipidemia, and diabetes mellitus.</p> <p>Resident #5's clinical record did not contain a cardiovascular care plan until 8/23/17.</p> <p>On 8/23/17 at 11:20 am, the Director of Nursing (DON) stated he could not locate the cardiovascular status care plans for Resident #4</p>	F 279	<p>F279 Resident Specific Resident #4 &amp; 5 have discharged from the facility.</p> <p>Other Residents The clinical management team reviewed other residents with cardiovascular issues for a comprehensive care plan to direct their care. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nursing staff, social services, dietary, and activities director are educated to comprehensive care plan process. Re-education was provided by the DON and/or designee to include but not limited to, medications, diagnosis, and cardiovascular issues included on the care plan to direct care. The system is amended to include review post admission, with order changes, and with MDS quarterly updates.</p> <p>Monitor The DON and/or designee will audit 5 care plans for inclusion of medication/diagnosis weekly for 4 weeks,</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 279	Continued From page 28 and Resident #5, both of whom had extensive cardiovascular issues.	F 279	then 2 weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:  (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.  (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.  (iv) The right to receive the services and/or items included in the plan of care.  (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280	Date of Compliance October 18, 2017	10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 280	<p>Continued From page 29</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21</p> <p>(b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's</p>	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 280	<p>Continued From page 30</p> <p>medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to revise and update care plans for 2 of 10 residents (#2 and #4) reviewed for care plan revision. This deficient practice created the potential for harm for Resident #2, whose care plan did not address recent medication changes, and for Resident #4, whose care plan failed to include targeted behavioral symptoms and relevant dialysis care interventions. Findings include:</p> <p>1. Resident #2 was readmitted to the facility on 4/12/17 with diagnoses that included schizophrenia.</p> <p>August 2017 Physician's Orders documented Resident #2 received Haloperidol (Haldol - antipsychotic medication) 70 milligrams (mg) intramuscularly (IM) every Thursday for schizophrenia, ordered 4/12/17.</p> <p>A physician's progress note, dated 7/27/17, documented Resident #2 had begun to</p>	F 280	<p>F280 Resident Specific The clinical management team reviewed resident #2s care plan to update with current antipsychotic medication use.</p> <p>Other Residents The clinical management team reviewed other residents for up-to-date care plans related to medication changes, dialysis, targeted behavioral symptoms, and other clinical updates. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nursing staff, social services, dietary and activities director are educated to initiate, review, and/or revise care plans. Re-education was provided by the DON and/or designee to include but not limited to, medication changes, dialysis, targeted behavioral symptoms, and other clinical update to be included</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 280	<p>Continued From page 31</p> <p>experience localized reactions ("sore shoulder") to the weekly IM injections of Haloperidol. The physician discontinued Resident #2's weekly Haloperidol injections and started the resident on Abilify (an oral antipsychotic medication) beginning 8/3/17.</p> <p>The August 2017 Medication Administration Record (MAR) documented the Haloperidol was discontinued and Resident #2 received the first dose of Abilify on 8/3/17 as ordered.</p> <p>Resident #2's Antipsychotic Medication Care Plan documented, "[Resident #2] is at risk for adverse side effects related to the use of antipsychotic medication Haldol."</p> <p>2. Resident #4 was admitted to the facility on 3/30/17 with multiple diagnoses, including chronic kidney disease with dialysis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/28/17, documented Resident #4 was cognitively intact and exhibited minimal signs and symptoms (s/s) of depression.</p> <p>a. A 3/30/17 Physician Order documented Resident #4 received Celexa 20 mg, an antidepressant, once a day. Resident #4's diagnoses did not include depression.</p> <p>Resident #4's MAR from 8/1/17 through 8/22/17 documented staff routinely administered the Celexa.</p> <p>Resident #4's Antidepressant Medications Side Effects Care Plan, dated 3/30/17, documented</p>	F 280	<p>on the care plan to direct care. The system is amended to include review post admission, with order changes, and with MDS quarterly updates.</p> <p>Monitor The DON and/or designee will audit 5 care plans for updates on medication changes, dialysis, targeted behavioral symptoms, and other clinical updates weekly for 4 weeks, then 2 weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 280	<p>Continued From page 32</p> <p>she was at risk for adverse side effects related to use of an antidepressant medication. The care plan did not identify resident-specific signs and symptom of depression or direct staff to monitor for signs and symptoms of depression.</p> <p>On 8/24/17 at 8:50 am, the Resident Services Coordinator (RSC) stated Resident #4's Depression Care Plan did not include the information above because the resident's Care Area Assessment did not document Resident #4 experienced depression.</p> <p>On 8/24/17 at 9:15 am, the DON stated Resident #4's Anti-Depression Care Plan should have more specifically identified signs and symptoms of depression so the physician could determine whether the resident's symptoms had increased or lessened.</p> <p>b. Resident #4's Dialysis Care Plan, dated 7/21/17, did not identify the location or type of access. Interventions included:</p> <ul style="list-style-type: none"> <li>* Staff was to monitor vital signs and respirations, and notify the physician of abnormal results.</li> <li>* Staff was to monitor, document, and report as needed any s/s of infection, to the access site, looking for redness, swelling, warmth, or drainage.</li> <li>* Staff was to monitor for s/s of renal insufficiency</li> <li>* Staff was to monitor Resident #4's weight.</li> <li>* Staff were to change the dialysis access dressing as ordered and as needed.</li> </ul> <p>Resident #4's Dialysis Care Plan did not include:</p> <ul style="list-style-type: none"> <li>* The type of dialysis Resident #4 received.</li> </ul>	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 280	Continued From page 33 * The type or location of Resident #4's dialysis access site. * Resident #4's dialysis schedule or transportation arrangements to the dialysis center. * Content of communication required between the dialysis center and the facility before and after dialysis. * Instructions for staff to monitor and respond to s/s of bleeding. * Instructions for staff to check thrill and bruit at the access site daily.  On 8/23/17 at 11:20 am, the DON stated Resident #4 received hemodialysis through a port in her left arm, although the dialysis center was considering using the resident's existing peritoneal port instead. The DON stated Resident #4 was transported by private company to the dialysis center on Tuesdays, Thursdays and Saturdays from 5:30 am - 1:00 pm. The DON stated the dialysis center managed the care of the dialysis port and changed the site's dressing and bandages. The DON stated facility staff assessed for thrill and bruit and documented their findings on the Treatment Administration Record. The DON stated facility staff monitored for signs of bleeding, however this information was not documented in the resident's clinical record.	F 280			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 281	<p>Continued From page 34</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure administration of medications and assessments of residents were completed according to accepted standards of practice for 2 of 17 residents (#4 and #5) reviewed for medication administration and neurological assessments. Specifically, the facility failed to:</p> <p>a) Monitor blood pressure prior to administering cardiac medications to Residents #4 and #5. b) Consistently complete neurological assessments for Resident #4. c) Ensure medications had clear indications for use as physician ordered for Resident #4.</p> <p>These failures created the potential for harm if residents received medication without indication for use, in a manner that caused undesirable changes in blood pressure, and/or experienced changes in neurological status that were undetected. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 3/30/17 with multiple diagnoses, including a history of falling, hypertension (HTN), and muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/28/17, documented Resident #4 was cognitively intact, required extensive assistance of 1 staff member for transfers, and had experienced 2 or more falls with no injuries.</p> <p>a. A Fall Scene Investigation Report, dated</p>	F 281	<p>F281 Resident Specific Resident #4 &amp; 5 have discharged from the facility</p> <p>Other Residents The clinical management team reviewed other residents for professional standard assessment with medication administration and consistent post fall/trauma neurological checks. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated to professional standards for medication administration. Re-education was provided by the DON and/or designee to include but not limited to, required assessment for cardiovascular medication, request for physician directives with long term use, physician directed labs as indicated, consistent completion of neurological assessment, and clear indication for use medication use identified. The system is amended to include reassessment of residents with long term cardiovascular medication use for physician directives and diagnosis during monthly recapitulation review, and inclusion of neurological assessment review in clinical meeting.</p> <p>Monitor</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 281	<p>Continued From page 35 4/16/17 at 11:40 pm, documented Resident #4 experienced an unwitnessed fall.</p> <p>Resident #4's neurological assessment for the 4/16/17 fall documented staff completed neurological assessments with the exception of 3 missing entries. There was no reason given for the missing or incomplete entries.</p> <p>On 8/23/17 at 2:52 pm, the Director of Nursing stated he was not sure why the neurological assessments were not completed. He stated the assessments should have been completed every 15 minutes for 1 hour, every hour for 4 hours, and every 4 hours for 19 hours.</p> <p>b. A 3/30/17 Physician Order documented Resident #4 received Celexa (antidepressant) 20 milligrams (mg) once daily. Resident #4's diagnoses did not include depression.</p> <p>c. According to the 2018 Nursing Drug Handbook, Atenolol, an antihypertensive, should not be administered orally without first assessing the apical pulse rate. If the apical heart rate is less than 60 beats per minute (bpm), the medication should be withheld and the physician contacted "immediately." The Handbook documented those receiving Torsemide should have their blood pressure (BP) and heart rate monitored "routinely."</p> <p>Resident #4's clinical record did not contain a cardiovascular care plan as of 8/25/17.</p> <p>Resident #4's August 2017 Physician Orders documented staff was to administer Atenolol 50 mg once a day, ordered 5/30/17, and Torsemide</p>	F 281	<p>The DON and/or designee will audit documentation of medication assessment directives and diagnosis for use with antihypertensive/diuretic medication weekly for 4 weeks, then one half weekly for 8 weeks. Post fall neurological assessment will be reviewed for completeness, as indicated post fall/trauma. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 281	<p>Continued From page 36 100 mg once a day, ordered 3/30/17.</p> <p>A Medication Administration Record (MAR) from 8/1/17 through 8/22/17 documented Resident #4 received Atenolol and Torsemide on a routine schedule each morning.</p> <p>A Daily Vitals Report documented Resident #4's vital signs were monitored daily with the exception of 8/6/17, 8/13/17 through 8/18/17, and 8/21/17.</p> <p>Similar findings were found on the June and July 2017 MAR and Daily Vitals Reports.</p> <p>On 8/23/17 at 11:20 am, the Director of Nursing (DON) stated it was not the facility's policy to routinely check blood pressure or heart rates for residents who had received oral antihypertensive therapy for long periods of time. The DON stated requirements to routinely assess heart rates and blood pressures was "specifically" intended for intravenous medications "only."</p> <p>2. Resident #5 was admitted to the facility on 7/3/17 with multiple diagnoses, including HTN, heart disease, hyperlipidemia, and diabetes.</p> <p>According to the 2018 Nursing Drug Handbook, "oral" Metoprolol, an antihypertensive, should not be administered without first assessing the apical pulse rate. If the apical heart rate is less than 60 bpm, the medication should be held and the physician contacted "immediately." The Handbook documented Metoprolol was "contraindicated" for people with heart rates less than 45 bpm and when systolic BP was less than 100 mmHg (millimeters pressure of mercury).</p>	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 281	<p>Continued From page 37</p> <p>The Handbook documented those with diabetes mellitus receiving Metoprolol should have their blood glucose monitored "closely" as the drug "masks" common signs and symptoms of hypoglycemia. The Handbook documented residents receiving Metoprolol should have their BP monitored "frequently." The Handbook also documented Lisinopril required "frequent" BP assessments.</p> <p>Resident #5's clinical record did not contain a cardiovascular care plan until 8/23/17.</p> <p>Resident #5's August 2017 Physician Orders documented staff was to provide Metoprolol 50 mg twice daily for HTN, ordered 7/4/17, and Lisinopril 40 mg once daily for HTN, ordered 7/4/17.</p> <p>Resident #5's MAR from 8/1/17 through 8/22/17 documented Metoprolol and Lisinopril were administered routinely as ordered by the physician.</p> <p>Resident #5's Daily Skilled Nursing Notes documented vital signs were monitored twice daily except on 8/1/17, 8/2/17, 8/9/17 through 8/13/17, and 8/18/17.</p> <p>On 8/10/17, Resident #5 received Metoprolol despite a pulse of 19 bpm; the resident's physician was not notified.</p> <p>On 8/14/17, Resident #5 received Metoprolol despite a pulse assessed twice at 58 bpm; the resident's physician was not notified.</p> <p>Similar findings were true for Resident #5's July</p>	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 281	Continued From page 38 2017 MAR and Daily Skilled Nursing Notes.  On 8/23/17 at 11:20 am, the Director of Nursing (DON) stated it was not the facility's policy to routinely check blood pressure or heart rates for residents who had received oral antihypertensive therapy for long periods of time. The DON stated requirements to routinely assess heart rates and blood pressures was "specifically" intended for intravenous medications "only."  On 8/23/17 at 2:50 pm, the DON provided prescribing information for intravenous Metoprolol. The prescribing information documented Metoprolol was "contraindicated" for those whose heart rates were less than 45 bpm and when systolic BP was less than 100 mmHg.	F 281			
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.  483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 309	<p>Continued From page 39 care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure residents diagnosed with diabetes mellitus received care consistent with their needs, care plans, current standards of practice, and facility policy. This was true for 2 of 5 (#4, #5) residents reviewed for diabetic management. As a result:</p> <ul style="list-style-type: none"> <li>* Residents did not have blood glucose (BG) monitoring orders</li> <li>* Hypoglycemic BG levels were not reported to physicians</li> <li>* The facility did not have a policy addressing overall diabetic care</li> <li>* Staff did not follow the facility's hypoglycemia protocol</li> <li>* Insulin was not administered per MD orders</li> </ul>	F 309	<p>F309 Resident Specific Resident #4 &amp; 5 have discharged from the facility Other Residents The clinical management team reviewed other residents with diabetes to clarify physician orders related to insulin use and diabetic management. Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to diabetic management by the DON and/or designee to include but not limited to, physician orders on frequency of BG checks, hypoglycemia management with 15/15 rule, physician notification of hypo/hyperglycemia as indicated, use of long acting insulin, and laboratory testing</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 309	<p>Continued From page 40</p> <p>This deficient practice placed residents with diabetes at risk of further health complications as a result of inadequate diabetic management. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 3/30/17 with multiple diagnoses, including diabetes mellitus, Stage V chronic kidney disease, hypertension, coronary artery disease, hyperlipidemia, and muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/28/17, documented Resident #4 was cognitively intact and received insulin 7 days a week.</p> <p>Resident #4's Diabetes Care Plan, dated 3/30/17, documented staff were to initiate the hypoglycemic protocol as needed. The care plan did not direct staff to initiate the hyperglycemic protocol as needed.</p> <p>Resident #4's August 2017 Physician Orders documented staff were to administer Lantus SoloStar 20 units injection once a day, ordered 3/30/17.</p> <p>Resident #4's Physician Orders did not include:</p> <ul style="list-style-type: none"> <li>* How often staff were to assess BG levels.</li> <li>* Parameters directing staff when to hold long acting insulin.</li> <li>* Parameters for when staff was to notify the physician of elevated BGs levels.</li> </ul> <p>An 8/3/17 Physicians Order documented BG levels less than 80 mg/dl (milligrams per deciliter) required staff to implement the "hyperglycemic/</p>	F 309	<p>frequency. The system is amended to include updated policy on diabetic management including hypo/hyperglycemia.</p> <p>Monitor The DON and/or designee will audit BG checks and documentation related to diabetes care for diabetic residents twice weekly for 4 weeks, then 3 residents weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 309	<p>Continued From page 41 hypoglycemic protocol" and document interventions in the nurses notes as needed (PRN).</p> <p>Resident #4's Medication Administration Records (MAR) from 8/1/17 through 8/22/17 documented Lantus was routinely administered except on 8/4/17 and 8/16/17 when it was withheld "due to low BG."</p> <p>Resident #4's MAR from 8/1/17 through 8/22/17 included a hand written undated entry which documented, "Check BG every morning." Resident #4's BG levels were greater than 80 mg/dl except as follows:</p> <ul style="list-style-type: none"> <li>* 8/4/17 - 76 mg/dl</li> <li>* 8/15/17 - 74 mg/dl</li> <li>* 8/16/17 - 52 mg/dl (insulin not administered)</li> </ul> <p>For the three BG levels below 80 mg/dl, Resident #4's clinical record did not contain documentation the BG level was reassessed, interventions attempted, or the physician notified.</p> <p>On 8/23/17 at 11:20 am, the Director of Nursing (DON) stated staff were to follow the facility's hypoglycemic protocol and administer carbohydrates when residents experienced a low BG level. The DON stated he could not explain why the protocol was not followed for Resident #4's identified low BG levels on the dates above.</p> <p>On 8/23/17 at 2:52 pm, the DON stated a nurse administered orange juice and rechecked the BG level on 8/16/17, but did not document her actions. The DON stated staff response to the resident's BG levels on 8/4/17 and 8/15/17 was</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 309	<p>Continued From page 42</p> <p>not investigated because the facility was in the process of changing the hypoglycemic parameter to 70 mg/dl.</p> <p>2. Resident #5 was admitted to the facility on 7/3/17 with multiple diagnoses, including HTN, heart disease, hyperlipidemia, and diabetes mellitus.</p> <p>Resident #5's Diabetes Care Plan, dated 3/30/17, documented staff were to initiate the hypoglycemic protocol as needed. The care plan did not direct staff to initiate the hyperglycemic protocol as needed.</p> <p>A 7/4/17 physician order documented Resident #5 was to receive Glipizide 10 mg every morning before breakfast, and Metoprolol 50 mg twice daily for HTN.</p> <p>An 8/4/17 physician order directed staff to monitor Resident #5 for signs and symptoms of hypo/hyperglycemia every shift and that staff "may" assess the resident's BG if signs and/or symptoms of hypo/hyperglycemia were observed.</p> <p>An 8/4/17 physician order documented staff were to implement the facility's "hyperglycemic/hypoglycemic protocol" when Resident #4's BG was assessed at less than 80 mg/dl and document the interventions in the nurses notes as needed.</p> <p>Resident #5's Physician Orders did not include established parameters for when staff was to notify the physician of elevated BG levels.</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 309	<p>Continued From page 43</p> <p>On 8/23/17 at 11:20 am, the DON stated the facility did not monitor Resident #5's BG levels, but instead monitored the resident for signs and symptoms of hypoglycemia.</p> <p>The 2018 Nursing Drug Handbook documented that those with diabetes and receiving Metoprolol should monitor blood glucose levels "closely" as Metoprolol "masks" common signs and symptoms of hypoglycemia.</p> <p>3. An undated Hyperglycemia/Hypoglycemia Protocol documented staff were to accomplish the following when residents' with BGs less than 80 mg/dl could swallow:</p> <ul style="list-style-type: none"> <li>* Administer 15-20 grams of fast-acting carbohydrates</li> <li>* Recheck BG in 15 minutes</li> <li>* When BG was less than 80 mg/dl, provide a low-fat meal or snack</li> <li>* When BG remained less than 80 mg/dl, repeat the treatment and recheck BG in 15 minutes</li> <li>* When BG remained less than 80 mg/dl after the second treatment, administer oral glucose and call the physician for further instruction</li> </ul> <p>The American Diabetes Association, Standards of Medical Care in Diabetes - 2016, Diabetes Care Journal, Volume 39 Supplement 1, documented BG levels should fall within the 100-180 mg/dl range for those in poor health and with an "end stage chronic illness." The journal documented BG levels in the elderly who were "complex" with multiple co-morbidities should have BG levels maintained in the 90-150 mg/dl range. The journal documented older adults with diabetes in a Long-Term Care facility were at</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 309	Continued From page 44 higher risk of experiencing hypoglycemic episodes, and providers should be called "immediately" in case of hypoglycemic episodes or when BG levels were less than 70 mg/dl.	F 309			
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  (c) Mobility.  (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 1 of 3 residents (#6) reviewed for treatment and services related to ROM and created the potential for harm when Resident #6 did not receive passive ROM (PROM) as care planned to prevent deterioration of existing ROM limitations. Findings include:  Resident #6 was readmitted to the facility on 2/22/17 with multiple diagnoses including, contractures of the right forearm, cerebrovascular accident (CVA), aphasia, dementia, muscle weakness, abnormal posture, hemiplegia and hemiparesis affecting the right side, and	F 318	F318 Resident Specific The clinical management team reviewed resident #6. The physician ordered for therapy to assist with setting up a pertinent range of motion program; however, the resident is unwilling to participate. Adjustments are made to resolve his foot position while in his wheelchair. A plan to re-approach is established.  Other Residents The clinical management team reviewed other residents for range of motion needs, care plans, implementation, and documentation. Adjustments have been	10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 318	<p>Continued From page 45 dependence on a wheelchair for locomotion.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 7/19/17, documented Resident #6 experienced moderate cognitive impairment, required the extensive assistance of 1 staff for transfers and bed mobility, experienced unilateral ROM impairment in the upper- and lower extremity, and no PROM was performed during the assessment period.</p> <p>Physical Therapy Discharge Summary Notes, dated 12/14/16, documented Resident #6 had attained his maximum potential with therapy and was referred to the Restorative Nursing Program.</p> <p>The Activities of Daily Living (ADL) Care Plan, dated 7/25/17, documented Resident #6 required staff assistance with ADL's due to impaired mobility related to hemiplegia and used his foot to self-propel a wheelchair as his primary mode of locomotion.</p> <p>Resident #6's PROM Care Plan, dated 7/31/17, documented a risk for contractures due to a lack of mobility related to hemiplegia; staff were to provide PROM exercises for the resident's neck, arm/shoulder, hand/wrist, hips/knees, ankles, and toes for 15 minutes a day with cares and 5 minutes per shift. The care plan did not document Resident #6 refused PROM exercises.</p> <p>On 8/22/17 at 8:47 am, Resident #6 was observed self-propelling a wheelchair down a hallway with his right foot dragging on the ground slightly under his foot pedal. Resident #6 stopped in front of his room and attempted to raise his foot onto the foot pedal, but could not extend his</p>	F 318	<p>made as indicated.</p> <p>Facility Systems Clinical staff are responsible for the restorative nursing program. Education was provided by the MDS nurse and/or designee to include but not limited to, assessment for range of motion needs, establishing a care plan, documentation, and plans to address non-compliance. In addition, the therapist has trained clinical staff on range of motion exercises to maintain function. The system is amended to include oversight by the MDS nurse with review in clinical meeting and monthly/quarterly as indicated.</p> <p>Monitor The DON and/or designee will audit 5 residents on restorative nursing program for implementation and documentation weekly for 4 weeks, then 2 residents and those with order changes weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 318	<p>Continued From page 46</p> <p>leg high enough to place it on the foot pedal. Resident #6 attempted to raise his foot another 3 times before stopping and then propelling himself down the hall with his foot dragging on the floor and slightly under the foot pedal.</p> <p>On 8/23/17 at 2:52 pm, the Director of Nursing (DON) stated Resident #6's PROM was completed when staff changed his clothes in the morning and at night. The DON stated he could not provide documentation that Resident #6's PROM was provided as care planned. The DON noted Resident #6 often declined PROM activities in the past, but could not provide documentation of these refusals. The DON stated he expected staff to provide care and services as described on the care plan, which did not direct staff to provide PROM while dressing the resident.</p> <p>Resident #6's clinical records did not contain documentation PROM exercises were completed as care planned or include documentation of the resident refusing PROM.</p> <p>On 8/24/17 at 2:18 pm, the Rehab Director stated PROM exercises outlined on Resident #6's care plan were not the same as dressing and undressing the resident. She stated Certified Nursing Assistants (CNAs) assisting the resident to dress and undress usually attempted to prevent the resident from rotating too much to avoid pain. The Rehab Director stated Resident #6 did not currently receive Physical-Occupational- or Speech Therapy services.</p> <p>On 8/24/17 at 2:19 pm, the facility's Restorative Aide, CNA #2, stated she did not provide</p>	F 318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 318	Continued From page 47	F 318			
F 323 SS=D	restorative services to Resident #6. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free from accident hazards as is possible; and  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  (1) Assess the resident for risk of entrapment from bed rails prior to installation.  (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to minimize the risk of injury for 2 of 21 residents (#6 and #17) reviewed for supervision and assistive devices. This deficient practice created the potential for harm if residents did not receive adequate supervision or safe assistive devices to	F 323		10/18/17	
			F323 Resident Specific The ID team reviewed resident #17 for safety while being outdoors independently. Physical therapy increased evaluation to include safety, crossing the street, and awareness of car		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 323	<p>Continued From page 48 avoid injury. Findings include:</p> <p>1. Resident #17 was admitted to the facility with diagnoses that included non-Alzheimer's dementia, anxiety, lack of coordination, and generalized muscle weakness.</p> <p>Resident #17's Impaired Cognition Care Plan, dated 3/4/16, documented, "Impaired cognition related to dementia. [The] resident will maintain [his] highest level of cognitive functioning as evidence (sic) by being able to make his wants and needs known, able to understand verbal cues and direction from staff, and remain alert and orientated (sic) to self, place, and others through the next review." Staff were to monitor Resident #17 for changes in cognition and provide "reorientation/validation as needed."</p> <p>A 5/30/16 Physician's Telephone Order, countersigned by the physical therapist and a nurse, documented Resident #17 was assessed as safe to walk outside the facility without an assistive device or supervision.</p> <p>A Physical Therapy Discharge Summary, dated 5/31/16, documented Resident #17 met all long-term goals for treatment and could enter and exit the facility without an assistive device or supervision. The Summary documented Resident #17 could independently inform staff he was leaving the facility, sign the log book before leaving, and walk more than 500 feet on varied surfaces before requiring a rest.</p> <p>A Fall Prevention Care Plan, dated 12/6/16, documented Resident #17 was at risk for falls due to impaired cognition, and that staff were to</p>	F 323	<p>traffic. Care plan is updated to show stable ambulation and limited fall risk. An alternate notification system is being evaluated to update staff when resident anticipates leaving the facility property.</p> <p><b>Other Residents</b> The ID team reviewed other residents for safety in leaving the facility property unattended. No other residents with low BIMs scores leave the facility unattended.</p> <p><b>Facility Systems</b> Staff are educated to monitoring safety risk of residents who leave the facility unattended. Re-education was provided by the Director of Compliance and/or designee to include but not limited to, documented physical and cognitive function, assessment of safety, crossing the street, and awareness of car traffic. The system is amended to include quarterly and/or change of condition as indicated documented assessment.</p> <p><b>Monitor</b> The MDS nurse and/or designee will audit residents with low BIM scores that leave the facility grounds independently for safety once monthly for 2 months, then quarterly. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 323	<p>Continued From page 49</p> <p>complete quarterly fall risk assessments as well as observe the resident for changes in cognition/functional status.</p> <p>Resident #17's quarterly Minimum Data Set assessment, dated 7/21/17, documented moderate cognitive impairment, antianxiety medication therapy, and supervision and set-up assistance required for all activities of daily living (ADLs), including transfers and ambulation.</p> <p>On 8/22/17 at 10:26 am, Resident #17 was observed walking out the front door of the facility alone. The resident did not tell staff he was leaving the facility nor did he sign the facility's "sign-out" book. Resident #17 crossed the facility's parking lot and walked down the driveway, which had an approximately 15-degree slope and led to a street in front of the facility. The resident lit a cigarette and then walked down the street to an intersection that led to a two-lane highway. Resident #17 walked to the intersection at the highway, turned, and walked along the left side of the highway for approximately 40 feet, the last 15 feet of which had no shoulder. The resident then approached an overturned orange street construction cone lying in the road, which he picked up and repositioned on the side of the road. At that time, Resident #17 stood at the end of the road and continued to smoke the cigarette. At 10:28 a.m., Certified Nursing Assistant (CNA) #1 drove by in her car and waved at Resident #17. Shortly after, Resident #17 returned to the facility.</p> <p>On 8/22/17 at 11:15 am, Resident #17 stated he had a cigarette lighter in his pocket that he used to light his cigarette. He stated he liked to smoke</p>	F 323	Date of Compliance October 18, 2017		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 323	<p>Continued From page 50</p> <p>by the highway. The resident stated he liked to go out and walk, and that he usually walked to a "log pile" one mile up the road and then back. The resident stated he was supposed to sign out or tell staff whenever he left the building, but that he forgot to tell staff when he left the building at 10:26 am.</p> <p>On 8/22/17 at 11:38 am, Licensed Practical Nurse (LPN) #1 stated Resident #17 was the only resident in the facility who was allowed to leave the facility's ground and and walk by himself. She stated residents were required to be independent with ADLs, cognitively intact, not be at risk for falls, and assessed as safe by a physical therapist to walk outside the facility without supervision. LPN #1 stated she did not believe Resident #17 was allowed to walk along the highway, and said she thought Resident #17 was to remain on the facility's property.</p> <p>On 8/22/17 at 11:45 am, CNA #1 stated she saw Resident #17 by the highway and thought it was suspicious because he usually stayed on the facility grounds or walked in the surrounding area. CNA #1 stated she would need to ask the Director of Nursing (DON) to determine whether it was safe for Resident #17 to be near the highway.</p> <p>On 8/22/17 at 12:00 pm, the DON stated Resident #17 was encouraged to walk outside, but that he would not want Resident #17 to walk along the highway as he had at 10:26 am. The DON stated residents who walk outside the facility were supposed to sign out or tell the front office staff they were leaving the facility. The DON said Resident #17 did not always sign out</p>	F 323			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 323	<p>Continued From page 51 when he left the facility.</p> <p>An 8/22/17 letter from the facility's Medical Director documented he had been asked to review Resident #17's "status of having both outside and off-grounds privileges, both without assistive devices and unaccompanied." The Medical Director stated the request was in response to concerns the resident's "diagnosis of dementia and a marginal score on a mental status exam." The Medical Director stated Resident #17 had a physician's order that allowed him to be outside and off facility grounds without supervision or the use of an assistive device, and added that Physical Therapy had also recommended the order. The Medical Director noted the order had been issued with the support of physical therapists and wrote in the letter that "the order is appropriate."</p> <p>On 8/22/17 at 4:00 pm, the facility's Therapy Department Director stated Resident #17 had not been recently evaluated for safety awareness or walking outside near cars and that therapists did not evaluate residents for safety in crossing roads where traffic was present.</p> <p>2. Resident #6 was readmitted to the facility on 2/22/17 with multiple diagnoses, including contractures of the right forearm, cerebrovascular accident (CVA - stroke), aphasia, dementia, muscle weakness, abnormal posture, hemiplegia and hemiparesis affecting the right side, and dependence on a wheelchair for locomotion.</p> <p>The Quarterly MDS assessment, dated 7/19/17, documented Resident #6 experienced moderate</p>	F 323			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 323	<p>Continued From page 52</p> <p>cognitive impairment and required the extensive assistance of 1 staff member for transfers and bed mobility. The MDS documented the resident required supervision with wheelchair locomotion and experienced unilateral range-of-motion (ROM) impairment affecting both the upper and lower extremities.</p> <p>Resident #6's ADL Care Plan, dated 7/25/17, documented staff assistance was required with ADLs due to impaired mobility related to hemiplegia and that the resident used his foot to self-propel his wheelchair.</p> <p>A Skin Prevention Care Plan, dated 4/26/17, documented Resident #6 was at risk for skin breakdown related to wheelchair dependence and impaired mobility and that he was to wear antiembolic hose to his right leg when he was out of bed.</p> <p>An Incident /Accident (I&amp;A) Report, dated 4/26/17, documented, Resident #6 sustained a "recent" injury of unknown origin (skin tear), which was described as "dry," the size of a nickel, and with "edges [that] do not approximate easily." The I&amp;A documented the wheelchair pedal's rough edges may have contributed to Resident #6's skin tear, which was discovered during a shower on the bottom of his foot, and measured 2 centimeters (cm) x 1.2 cm x 0.1 cm. The I&amp;A documented Physical Therapy would evaluate the foot pedal to ensure the resident's safety.</p> <p>On 8/22/17 at 8:47 am, Resident #6 was observed self-propelling a wheelchair down the hallway with his right foot dragging on the ground</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 323	Continued From page 53 slightly under the foot pedal. Resident #6 stopped his wheelchair in front of his room and attempted to raise his foot onto the foot pedal, but could not extend his leg high enough to place his foot on the foot pedal. Resident #6 attempted to raise his foot another 3 times before once again self-propelling the wheelchair down the hall with his foot dragging on the floor slightly under the foot pedal.  On 8/23/17 at 2:52 pm, the DON stated he thought Resident #6's skin tear was caused by the wheelchair pedal or from dragging his foot on the ground. The DON stated Physical Therapy evaluated the wheelchair foot pedal to ensure Resident #6's safety.  The clinical record did not contain documentation that a physical therapist evaluated Resident #6's wheelchair foot pedal.  On 8/24/17 at 2:00 pm, the facility's Rehabilitation Director stated she was not aware Physical Therapy received a referral to evaluate Resident #6's wheelchair foot pedal in April 2017.	F 323			
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--  (1) In excessive dose (including duplicate drug therapy); or  (2) For excessive duration; or	F 329		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	<p>Continued From page 54</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>(2) Residents who use psychotropic 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 interview and record review, it was determined the facility failed to ensure 3 of 10 residents (#3, #4, and #6) received psychotropic medications only when medically indicated for the treatment of specific conditions. This deficient practice created the potential for harm should residents receive antipsychotic medications they did not require or in inadequate- or excessive doses. Findings include:</p>	F 329	<p>F329 Resident Specific The clinical management team reviewed resident #3 &amp; 6 updating diagnosis, specific behaviors to support medication management for psychoactive drug classifications, individualized non-drug interventions, care plan revisions, medication side effect monitoring, and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	<p>Continued From page 55</p> <p>1. Resident #3 was admitted to the facility on 11/16/11 with diagnoses that included dementia with behavioral disturbance, mood disorder, delusional disorder, and Alzheimer's disease.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/22/17, documented Resident #3 was cognitively intact; exhibited no signs or symptoms of delirium, depression, psychosis, or behaviors; and received antipsychotic and antidepressant medications.</p> <p>Resident #3's August 2017 Physician's Orders documented the following psychotropic medications:</p> <ul style="list-style-type: none"> <li>* Divalproex (Depakote) DR (antiseizure medication also used as a mood stabilizer) 500 milligrams (mg) twice daily for mood disorder, ordered 9/2/16;</li> <li>* Divalproex DR 250 mg daily at noon for mood disorder, ordered 9/2/16;</li> <li>* Escitalopram (Lexapro- antidepressant) 10 mg daily for mood disorder, ordered 1/25/13; and</li> <li>* Quetiapine fumarate (Seroquel- antipsychotic) 50 mg twice daily for paranoia, ordered 8/14/15.</li> </ul> <p>A Behavior Management Care Plan, revised 9/18/16, documented Resident #3 may express "inappropriate behavior" due to diagnoses of dementia with mood disorder and had expressed "paranoid accusations towards other residents and staff." The care plan directed staff to monitor the efficacy and potential side effects of</p>	F 329	<p>timely GDR review/documentation.</p> <p>Resident #4 has been discharged from the center.</p> <p><b>Other Residents</b> The clinical management team reviewed other residents for management of psychoactive medications. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Nursing staff and social services designee are educated to psychoactive medications. Re-education was provided by the Director of Compliance and/or designee to include but not limited to, behaviors that support medication management by drug classification, medication side effect monitoring, monitors for routine documentation, individualized care plans, and process for GDR management. The system is amended to include routine documentation and review in clinical meeting for new/changes in resident psychoactive medication regime.</p> <p><b>Monitor</b> The DON and/or designee will audit behavior management program for 5 residents weekly for 4 weeks, then residents with change in behaviors or medication weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	<p>Continued From page 56 medications.</p> <p>An Antipsychotic Medication Care Plan, dated 9/18/16, documented Resident #3 was at risk for adverse side effects from the use of Seroquel. Staff were to observe the resident for signs and symptoms of increased or decreased behaviors and adverse effects, which were to then be reported to the resident's physician.</p> <p>An Antidepressant Care Plan, dated 9/18/17, documented Resident #3 was at risk for adverse side effects from the Lexapro and staff were directed to "observe for desired effect."</p> <p>There was no care plan for the mood stabilizing medication, Divalproex, in Resident #3's clinical record directing staff assessment and evaluation of the medication's effectiveness in treating the resident's mood disorder symptoms.</p> <p>A May/June 2017 Behavior Symptom Monitoring Flow Record documented Resident #3 accused others of taking his personal belongings, believed staff was "plotting against him," and noted a history of "physical aggression" related to a "change in routine or environment [and] pain." Non-Pharmacological Interventions included assisting Resident #3 search for missing items, validate the resident's concerns, provide one-to-one companionship, offer reassurance, and assess for pain. The Flow Record area for staff to document behavioral symptoms, causes/triggers, interventions attempted, and results was blank.</p> <p>Interdisciplinary Progress Notes for May and June 2017 included only two entries, 5/26/17 and</p>	F 329	<p>committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	<p>Continued From page 57 6/22/17, neither of which addressed behavioral monitoring.</p> <p>A July/August 2017 Behavior Symptom Monitoring Flow Record listed the same behaviors, causes/triggers, non-pharmacological and pharmacological interventions as the "May/June 2017 Flow Record and the area for staff to document behavioral symptoms, causes/triggers, interventions attempted, and results was blank.</p> <p>Interdisciplinary Progress Notes did not include staff documentation related to Resident #3's behavioral monitoring for July 2017. On 8/13/17, the first Progress Note since 6/22/17 documented Resident #3 exhibited increased delusions, which were reported to the resident's physician. In response, the physician increased Resident #3's midday dose of Depakote from 250 mg to 500 mg daily at noon.</p> <p>On 8/24/17 at 10:50 a.m., the Director of Nursing (DON) stated Resident #3 sometimes experienced a "spike" in his psychosis, but he was "usually pretty stable" and did not often exhibit behaviors. The DON stated nurses were to document behaviors on the behavior monitoring forms and Nurses' Notes. The DON stated staff documented behaviors only when exhibited by the resident. When asked how he determined whether the resident did not exhibit behaviors on a given day or whether the absence of documentation indicated staff did not monitor, the DON stated, "We all know our residents pretty well."</p> <p>The facility's Psychoactive Medications policy</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	<p>Continued From page 58 and procedure, dated 11/30/14, documented, "Residents with behaviors will be monitored using a behavior symptom flow record when behaviors are present."</p> <p>2. Resident #4 was admitted to the facility on 3/30/17 with multiple diagnoses, including chronic kidney disease with dialysis.</p> <p>The Quarterly MDS assessment, dated 6/28/17, documented Resident #4 was cognitively intact and had minimal signs and symptoms of depression.</p> <p>An Antidepressant Medications Side Effects Care Plan, dated 3/30/17, documented Resident #4 was at risk for adverse side effects related to use of an antidepressant medication, but did not identify resident-specific signs and symptom of depression for staff to monitor.</p> <p>A 3/30/17 Physician Order documented Resident #4 received Celexa (an antidepressant) 20 mg daily, however Resident #4's diagnoses did not include depression.</p> <p>Resident #4's Medication Administration Record (MAR) from 8/1/17 through 8/22/17 documented staff routinely administered Celexa. The MAR during this period did not include direction for staff to monitor the medication's potential side effects.</p> <p>An August 2017 Behavior Monitor was initiated on 8/24/17.</p> <p>On 8/24/17 at 3:30 pm, a Resident Services</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	<p>Continued From page 59</p> <p>Coordinator (RSC) stated Resident #4 did not register with depression on the Care Area Assessment and therefore did not have a complete depression care plan, behavior monitors, or medication side effect monitor in place.</p> <p>Resident #4's clinical record did not contain evidence that persistent signs and symptoms of depression, behaviors, and medication efficacy were monitored by staff.</p> <p>On 8/24/17 at 9:15 am, the DON stated Resident #4's depression presented as increased hopelessness, irritability, self-isolation, and sleepiness. The DON stated staff should monitor Resident #4 for signs and symptoms of depression for the physician to determine whether the medication was still clinically indicated. The DON stated Resident #4's Anti-Depression Care Plan should have been more specific identifying Resident #4's signs of depression.</p> <p>3. Resident #6 was readmitted to the facility on 2/22/17 with multiple diagnoses, including obsessive compulsive disorder (OCD) and depression.</p> <p>A Behavior Management Care Plan, dated 11/20/16, documented Resident #6 had the potential for inappropriate behaviors related to irritability and evidenced by physical aggression toward other residents, including hitting, as well as hoarding, moving dining room tables, and moving other residents when they were in his way.</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 329	Continued From page 60 A 2/22/17 Physician Order documented Resident #6 received Celexa 15 mg once a day for OCD.  Resident #6's Quarterly MDS assessment, dated 7/19/17, documented moderate cognitive impairment, no signs and symptoms of depression, and an inability to communicate verbally.  Resident #6's Behavior Monitor from 7/1/17 through 8/25/17 did not include any documented incidents of inappropriate behavior.  Resident #6's clinical record did not contain evidence of quarterly reviews to determine whether Celexa was effective in treating (undiagnosed) depression, whether the medication was still necessary to manage depression, and to determine if Resident #6 experienced any adverse consequences related to Celexa.  On 8/24/17 at 8:50 am, the RSC stated she could not locate the most recent quarterly review of Resident #6's Celexa medication, which last occurred in February 2017.	F 329			
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (ii) This provision does not prohibit or prevent	F 371		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 371	<p>Continued From page 61</p> <p>facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 7 areas of the kitchen had cleanable surfaces and patent safeguards in place to prevent pests from entering the kitchen. This had the potential to affect 16 of 17 (#s 1-9 and 11-17) residents and all residents who dined in the facility and created the potential for food-borne illness if bacteria remained on unsanitary surfaces. Findings include:</p> <p>a. On 8/21/17 at 1:20 pm, the kitchen was observed with multiple uncleanable surfaces as follows:</p> <p>* 60-percent of the white cabinet surfaces next to the steam table were observed with flaking paint and a filmy greasy substance. * 60-percent of the white cupboards above the steam tables were observed with flaking paint</p>	F 371	<p>F371 Resident Specific The following kitchen sanitation items are completed as protection for facility residents as cited: " Cabinets were cleaned and sanitized. Purchase order #8-111 is approved for replacement with stainless steel. Anticipated installation of the new cabinets will occur on 1/9/2018. " The floor in the refrigerator is repaired and provides a cleanable surface. " The kitchen and dry storage floors are approved for replacement with purchase order #8-112. Anticipated installation of the new flooring will occur on 1/9/2018. " The backdoor brush guard is replaced to reduce rodent and insect access. (Delayed compliance date is due</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 371	<p>Continued From page 62 and a filmy greasy substance.</p> <p>* A white shelf under the prep-table next to the oven and stove tops was observed with a thick yellow greasy substance in the left corner. The paint was flaking off in sections covering approximately 40% of the surface.</p> <p>* The floor in the refrigerator was observed with a hole approximately 6 inches by 4 inches in size that exposed wood and ice build-up.</p> <p>* Three 2-inch cracks in the floor of the dry food storage area.</p> <p>* The floor near the entrance to the kitchen was observed with a 24 inch by 24 inch patch that was soft when stepped upon.</p> <p>Each of the surfaces described above presented potential areas for bacterial growth and subsequent spread of food-borne illness.</p> <p>b. On 8/24/17 at 9:18 am, the back door of the kitchen was observed with approximately a 2 inch gap in the brush guard and threshold through which rodents or insects could gain access to the kitchen and food.</p> <p>The Food Service Director (FSD) stated the cupboards, shelf, and cabinets were cleaned and scrubbed regularly, but the scrubbing sometimes made them appear "worse" and encourage the flaking of paint. The FSD said the back door did not seal completely and insects and rodents could get into the kitchen. The FSD stated the identified areas of concerns created the potential for mold and bacterial growth.</p>	F 371	<p>to the availability to get a contractor to complete the work any sooner)</p> <p>Other Residents Administrative kitchen rounds do not show any additional physical plant items in need of replacement.</p> <p>Facility Systems Kitchen staff are educated to maintain cleanable surfaces and manage pest control. Re-education was provided by the Executive Director and/or designee to include but not limited to, completion of maintenance requests when areas are in need of repair and reporting of non-cleanable surfaces. The system is amended to include kitchen rounds with the Executive Director.</p> <p>Monitor The Executive Director and/or designee will audit kitchen sanitation for maintenance needs and cleanable surface management weekly for 12 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 18, 2017</p>		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 441	<p>Continued From page 63</p> <p>(a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation,</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 441	<p>Continued From page 64 depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, infection control record review and policy review, it was determined the facility failed to ensure an active infection control program included surveillance of infectious organisms affecting residents within the facility. This had the potential to affect the health of all residents in the facility, including 17 of 17 (#s 1 - 9 &amp; 11 - 17) residents reviewed for infection control practices. Findings included:</p>	F 441	<p>F441 Specific Residents The Infection Preventionist completed the infection control log and added mapping for current resident issues. The infection control committee then reviewed for trending, documented minutes, and developed a plan as indicated.</p> <p>Other Residents</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 441	<p>Continued From page 65</p> <p>"Urinary Tract Infection (UTI) Event for Long-term Care Facilities" from the Centers for Disease Control and Prevention (CDC), dated January 2017, documented surveillance for urinary tract infections (UTIs) should be performed facility-wide. The article documented a UTI discovered after the second calendar day from a resident's admission to a long-term care facility would be considered to have been acquired within the facility.</p> <p>An undated Performance Improvement Infection Control Monthly Summary documented the number of UTIs per month within the facility as follows:</p> <ul style="list-style-type: none"> <li>* 5 UTIs for January 2017</li> <li>* 4 UTIs for February 2017</li> <li>* 6 UTIs for March 2017</li> <li>* 2 UTIs for April 2017</li> <li>* 5 UTIs for May 2017</li> <li>* 5 UTIs for June 2017</li> </ul> <p>The facility's Infection Control Log for May 2017 documented 4 residents with UTI's due to the organism Escherichia coli (E-coli), commonly associated with fecal contamination. The facility identified 2 of the infections as hospital acquired, however the Infection Control Log documented those two residents were admitted to the facility 4 to 7 days prior to their UTI diagnosis. The other two residents were identified as acquiring the E-coli UTIs in the facility.</p> <p>The facility's June 2017 Infection Control Log documented 5 residents acquired UTIs in the facility, including one resident diagnosed with an E-coli caused UTI in both May and June 2017.</p>	F 441	<p>The facility residents were affected as noted above, no additional adjustments are indicated.</p> <p><b>Facility System</b> The Infection Preventionist and nursing staff are educated to the infection control system of surveillance for identification, prevention of recurrence, investigation, and control of facility acquired infections. Re-education was provided by the Director of Compliance and/or designee to include but not limited to, adopting the 2017 CDC timeline for hospital or community acquired infections, update infection monitoring with McGeer criteria, logging infection data to include the organism, mapping, care implementation surveillance, and infection control committee trending. The system is amended to include periodic update and review throughout the month in clinical meeting and care implementation surveillance.</p> <p><b>Monitor</b> The Infection Preventionist and/or designee will audit infection control log for completion, monitor care implementation surveillance tools, and review trends weekly for 12 weeks. Starting the week of October 9, 2017 the review will be documented on the infection control log and PI audit tools. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 441	<p>Continued From page 66</p> <p>The Infection Control Log did not identify the infectious organism for 3 of the 5 residents with UTI to determine a possible source of the infection; 1 of 5 organisms was documented as E-coli; and 1 of the 5 UTI organisms was identified as streptococcus viridians. The 5 UTI Infection Report Forms for June 2017 documented all five residents were placed on antibiotics without supporting documentation explaining how the residents met the criteria necessary for antibiotic therapy. The June 2017 Infection Control Summary did not document this data was reported to the facility's Infection Control/Performance Improvement Committee.</p> <p>The facility's July 2017 Infection Control Log was not completed as of 8/24/17.</p> <p>An All Staff Education Attendance Sheet for perineal care, catheter care, urinary care and hand washing, dated 7/18/17, identified 47 staff members were required to attend. The sign in sheet contained 8 staff signatures.</p> <p>On 8/24/17 at 5:00 pm, the Director of Nursing (DON), who served as the facility's Infection Control Nurse, stated he determined whether an infection was acquired in the facility by the type of infection and organism involved. He stated he would classify a UTI as acquired in the community if it was discovered within 7 days of a resident's admission to the facility. The DON stated infection control issues were presented monthly to the facility's Quality Assurance /Performance Improvement Committee and that he did not believe poor pericare or dehydration was the cause of UTIs in the facility. The DON stated CNAs (Certified Nursing Aides) were</p>	F 441	<p>appropriate.</p> <p>Date of Compliance October 18, 2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 441	Continued From page 67 provided education and he would observe the provision of pericare services to ensure CNAs used proper technique.  The facility failed to ensure a system of surveillance was utilized to identify, prevent reoccurrence, investigate, and control facility-acquired infections. Refer to F494 as it related to staff training and competency upon hire.	F 441			
F 463 SS=E	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  (g) Resident Call System  The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -  (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a reliable communication system from residents' rooms to the nursing station was available. This was true for 5 of 10 (#3, #4, #17, #20, and #25) resident rooms observed for call lights and created the potential for harm if residents could not alert staff for assistance when needed. Findings include:  On 8/23/17 at 3:40 pm, the call lights did not audibly or visually activate outside Room #s 3, 4, 17, 20, and 25 when the Maintenance Director depressed the bedside and/or in-room bathroom call light activation button.	F 463	F463 Resident Specific As noted in the CMS-2567 the maintenance director replaced the call light cords for resident #3, 4, 17, 20, & 25 at the time of testing and they were identified as operational.  Other Residents The maintenance director completed a full review of call light function for resident rooms. Adjustments have been made as indicated.	10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 463	Continued From page 68  The Maintenance Director unsuccessfully attempted to remedy the call light malfunction in the five rooms by disconnecting and reconnecting the call light cord from the outlet several times. The call light system in the five rooms became functional when the activation cords were replaced.  The facility did not test its call system for functionality.  On 8/23/17 at 4:50 pm, the Maintenance Director stated the facility did keep a log of its call light system functionality because the facility did not routinely check the call light system.  On 8/25/17 at 7:30 pm, the Executive Director stated he was not aware the call light system was not working properly as repairs were accomplished on an as-needed basis. The Executive Director stated he was not aware the facility's call light system was not routinely monitored for functionality and repair.	F 463	Facility Systems The maintenance director is educated by the Executive Director and/or designee to include call light functioning to his monthly preventative maintenance testing and document results.  Monitor The Executive Director and/or designee will audit the preventative maintenance logs for call light function monthly for 3 months. Starting the October 2017 the review will be documented on the preventative maintenance log. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.  Date of Compliance October 18, 2017		
F 490 SS=L	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies and procedures, resident grievances, and resident and staff interviews, it was determined	F 490	F 490 For resident #s 7 <input type="checkbox"/> 9 and resident #s 11 <input type="checkbox"/> 16 and for all residents in the facility the	10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 490	<p>Continued From page 69</p> <p>the facility failed to follow and update policies to reflect current regulatory guidelines and standards of practice regarding abuse and neglect; train and verify staff competency in the provision of care and services; and ensure infection control programs were implemented to protect residents from infection. This failed practice placed the health and safety of 9 of 17 (#'s 7 - 9 and #'s 11 - 16) residents and all other residents in the facility in immediate jeopardy of serious harm, impairment or death from staff abuse or neglect. Findings include:</p> <p>1. Immediate Jeopardy was identified in the following areas:</p> <p>* Refer to F225 as it related to ensure injuries of unknown origin and resident allegations of possible neglect were recognized, investigated, and reported to the State Agency and facility Abuse Coordinator as potential indicators of abuse and/or neglect. The facility additionally failed to ensure staff received abuse/neglect training upon hire and annually.</p> <p>* Refer to F226 as it related to update and operationalize policies and procedures to prevent, identify, investigate, protect against, and report potential incidents of resident abuse, neglect, and/or misappropriation of property.</p> <p>* Refer to F520 as it related to ensuring the facility's Quality Assessment and Assurance program effectively monitored facility care processes to protect residents from potential harm and previously identified deficient practices did not recur.</p>	F 490	<p>facility ED shall ensure that policies and procedures are operationalized. Additionally, those policies and procedures shall be reviewed/ revised on a regular schedule and as necessary when regulatory updates occur. Special attention shall be given to the abuse prevention program, verifying staff competency in the provision of care and services, and ensuring the infection control program is thoroughly implemented and up to date.</p> <p>The facility Executive Director shall ensure that staff are trained in the abuse prevention program prior to their next shift and completed no later than 8/29/2017. The Director of Compliance will perform the education.</p> <p>The facility Executive Director shall ensure than any allegation of abuse, neglect, exploitation, injury of unknown origin, or misappropriation of property when reported to him will be immediately reported to the State on-line portal and to the Director of Operations and Director of Compliance.</p> <p>The facility Executive Director shall ensure that at regularly scheduled standup meetings Monday through Friday at 9:00 am the Executive Director specifically asks if anyone at the meeting is aware of any allegations of abuse, neglect, exploitation, injury of unknown origin, or misappropriation of property.</p> <p>The facility Executive Director shall ensure the Activities Director shall have a Resident Council meeting 8/28/2017 and the facility Executive Director shall attend</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 490	<p>Continued From page 70</p> <p>On 8/24/17 at 3:37 pm, the Executive Director stated injury of unknown origin investigations were "a clinical thing" for which the Executive Director had no responsibility other than to review the investigations to ensure they were complete. The Executive Director stated he now realized injuries of unknown origin should be reported to the State Agency.</p> <p>On 8/25/17 at 7:30 am, the Executive Director stated facility procedure required the Director of Nursing (DON) to notify the Executive Director of injuries of unknown origin only when neglect or abuse was suspected. The Executive Director said the facility's Assistant Director of Nursing (ADON) was not aware he/she was expected to investigate and report these type of incidents when the DON was absent from the facility.</p> <p>On 8/25/17 at 11:15 am, the DON stated he could not provide evidence that staff received abuse/neglect training prior to working in the facility and that the facility currently had staff working in the building who had not received abuse/neglect training. The DON stated the facility did not yet have a scheduled employee training developed for newly hired staff and there were no individual staff training records available for review.</p> <p>The facility was notified in writing of the Immediate Jeopardy and the need to formulate and implement a plan of removal on 8/25/17 at 9:48 am.</p> <p>On 9/1/17 at 11:59 pm, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and</p>	F 490	<p>this meeting and ensure the resident population that he is the abuse prevention coordinator in the facility and that he has an open door policy and wants residents to share any and all concerns with and specifically concerning when they have concerns about allegations of abuse, neglect, exploitation, injury of unknown origin, or misappropriation of property. For those residents who cannot attend a resident council meeting and understand the content of the meeting, the facility Executive Director shall discuss with the resident representative, family, or responsible party the same information. This may also be provided to these identified individuals in a letter. The facility ED shall ensure that the DON and anyone acting on behalf of or instead of the DON has a daily (Monday through Friday) Stand down meeting to ensure oversight. This plan will be presented to the QA committee on Monday 8/28/17 for evaluation and further comment. The committee will recommend specific Performance Improvement Plans as indicated.</p> <p>QA Component The facility Executive Director shall ensure that QA meetings are held monthly The facility Executive Director shall ensure that adverse events allegations of abuse, neglect, exploitation, injury of unknown origin, or misappropriation of property are reported on a monthly basis to the QA committee for their review.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 490	<p>Continued From page 71 implemented. The plan included:</p> <ul style="list-style-type: none"> <li>* Administrative staff received education related to abuse, neglect and injuries of unknown origin by the Director of Compliance, who would also educate all staff prior to their next shift.</li> <li>*The Executive Director would report all allegations of potential abuse and neglect to the State Agency.</li> <li>* The Executive Director would ensure the facility investigated injuries of unknown origin and implement the facility's abuse policy.</li> </ul> <p>2. Non-Immediate Jeopardy deficiencies were identified in the following areas:</p> <ul style="list-style-type: none"> <li>* Refer to F279 as it related to the development of comprehensive care plans.</li> <li>* Refer to F280 as it related to the revision of care plans based on residents' needs.</li> <li>* Refer to F309 as it related to diabetic management.</li> <li>* Refer to F323 as it related to adequate supervision and safety assessments.</li> <li>* Refer to F329 as it related to targeted behaviors, indications for the use of psychotropic medications, and monitoring of psychotropic medication usage.</li> <li>* Refer to F441 as it related to infection control.</li> <li>* Refer to F463 as it related to resident call light</li> </ul>	F 490	<p>Additionally, the Executive Director shall ensure staff competencies are reviewed by the QA Committee and that trending is completed to ensure that staff competencies are complete and necessary remediation is provided timely. Finally, infection control shall be reviewed monthly by the QA Committee. The Medical Director may give input related to specific ongoing infection issues, such as UTIs. The QA Committee shall review infection control trending and mapping and make appropriate recommendations for performance improvement plans if indicated.</p> <p>This plan will be presented to the QA committee on Monday 8/28/17 for evaluation and further comment. The committee will recommend specific Performance Improvement Plans as indicated.</p> <p><b>Infection Control Component</b> The facility Executive Director will ensure that Infection Control logs are brought current and kept current going forward. The facility Executive Director will inspect the logs on Friday to ensure that the log is being kept up to date. The Director of Compliance will function as a resource to the individual responsible for the infection control tracking as well as the DON and the Executive Director.</p> <p>This plan will be presented to the QA committee on Monday 8/28/17 for evaluation and further comment. The committee will recommend specific Performance Improvement Plans as</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 490	Continued From page 72 system function and monitoring.  * Refer to F494 as it related to staff abuse and neglect training.  * Refer to F498 as it related to the completion of Certified Nursing Assistant (CNA) competencies.	F 490	indicated. Please refer to the POC at the following tags for additional corrective action descriptions: 1. F225; 2. F226; 3. F520; 4. F279; 5. F280; 6. F309; 7. F441; 8. F463; 9. F494; and 10. F498 Responsible: Executive Director		
F 494 SS=E	483.35(d)(1)(2) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY  (d)(1) General rule A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless--  (i) That individual is competent to provide nursing and nursing related services; and  (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or  (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).  (d)(2) Non-permanent employees A facility must not use on a temporary, per diem,	F 494		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 494	<p>Continued From page 73</p> <p>leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of employee records and staff interview, it was determined the facility failed to ensure Nursing Aides were provided education and training, and had successfully passed an approved competency test within 4 months of hire or prohibited from providing direct resident care and services. This was true for 1 of 1 CNA (#4) who worked in the facility for more than 4 months prior to becoming certified. This failure had the potential to expose residents to substandard and/or unsafe care. Findings include:</p> <p>On 8/25/17 at 10:40 am, CNA #4 said she had not received training on abuse and neglect, or "any" other subject, from the facility upon- or since her hire in April of 2017.</p> <p>CNA #4's employee file did not include a training record for any topic or competency.</p> <p>An All Staff Education Attendance Sheet documented 48 staff members were to attend dementia and behavior training on 5/16/17. The attendance sheet documented 7 staff members attended the training; CNA #4 was not among those in attendance.</p> <p>An All Staff Education Attendance Sheet on Resident Abuse, dated 7/18/17, documented 13 of 47 staff members required to attend were at the training. CNA #4 was not among those in</p>	F 494	<p>F494 Staff Specific The ID team reviewed training for employee #4 and verified that she has a current CNA registration, has completed new hire education to include abuse/neglect policy, and passed her CNA competencies.</p> <p>Other Staff The ID team reviewed other new hire employees for training. Adjustments have been made as indicated to complete training and competencies within 4 months of hire.</p> <p>Facility Systems The Executive Director and Nurse Educator are educated by the Director of Compliance and/or designee to provide a new hire orientation on hire and validate competencies within 4 months of hire. The system is amended to include tracking per employee for inservice education and competencies. Total number of hours are monitored ongoing and validated at three months and annually.</p> <p>Monitor The Director of Compliance and/or designee will audit new hires for timely</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 494	Continued From page 74 attendance.  An All Staff Education Attendance Sheet on Perineal Care, Catheter Care, Urinary Care and Hand washing, dated 7/18/17, documented 8 of the 47 staff required to receive this training were in attendance; individuals were required to attend. CNA #4 did not attend this training.  On 8/25/17 at 11:15 am, the Director of Nursing (DON) stated he could not provide evidence that CNA #4 received training on abuse and neglect prior to starting her employment at the facility in April 2017. The DON stated there were other staff currently working in the facility who also had not received abuse/neglect training. The DON stated he could not provide evidence that CNA #4 had received training on any topic related to her job at the facility.	F 494	training and competencies monthly for 3 months. Starting October 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.  Date of Compliance October 18, 2017		
F 497 SS=F	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE  (d)(7) Regular In-Service Education  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop and implement a nurse aide training program that provided at least 12 hours per year of in-service education. This failure affected all residents in the facility and increased the risk that nurse aides	F 497	F497 Staff Specific The ID team reviewed CNAs currently employed for documentation of 12 hours of in-service education based on hire date. Training has been provided as	10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 497	<p>Continued From page 75</p> <p>were not fully able to provide care to residents. Findings include:</p> <p>Review of facility in-service education documentation revealed the facility did not monitor its in-service education program to ensure Certified Nursing Assistants (CNAs) completed 12 hours of in-service education based on performance evaluations.</p> <p>An All Staff Education Attendance Sheet on Abuse and Neglect, dated 1/12/17 from 4:10 pm -4:25 pm, identified 60 staff were required to attend. The attendance sheet contained 25 signatures from staff. An All Staff Education Attendance Sheet on Resident Abuse, dated 1/12/17 from 4:25 pm - 4:35 pm, identified 60 staff were required to attend. The attendance sheet contained the same 25 signatures from the training at 4:10 pm to 4:25 pm.</p> <p>An All Staff Education Attendance Sheet on Dementia and Behavior Training, dated 5/16/17, identified 48 staff were required to attend. The attendance sheet contained 7 staff member signatures.</p> <p>An untimed All Staff Education Attendance Sheet on Perineal Care, Catheter Care, Urinary Care and Hand washing, dated 7/18/17, identified 47 staff were required to attend. The attendance sheet contained 8 staff signatures.</p> <p>A second All Staff Education Attendance Sheet on Resident Abuse, dated 7/18/17 and scheduled to last 15 minutes, identified 47 individuals were required to attend. The attendance sheet contained 13 staff signatures.</p>	F 497	<p>indicated.</p> <p><b>Other Staff</b> The facility CNAs were affected as noted above, no additional adjustments are indicated.</p> <p><b>Facility Systems</b> CNA staff are provided no less than 12 hours of in-service education annually. Re-education was provided by the DON and/or designee to include but not limited to, CNA responsibility to attended educational sessions, process to record educational sessions, and responsibility for completion with resulting consequences. The system is amended to include an educational calendar and recording process for individual CNA educational sessions.</p> <p><b>Monitor</b> The nurse trainer and/or designee will audit review CNA staff approaching their annual review for evidence of 12 hours of in-service education monthly for 3 months. Starting October 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p><b>Date of Compliance</b> October 18, 2017</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 497	Continued From page 76	F 497			
F 520 SS=L	<p>On 8/25/17 at 11:15 am, the Director of Nursing (DON) stated he could not provide evidence that CNAs had received training and the facility did not not have employee training developed for new hires. The DON stated the All Staff Education Training Records submitted for review were "all" the training records the facility was able to provide.</p> <p>483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of</p>	F 520		10/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 520	<p>Continued From page 77 action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure the Quality Assessment and Assurance Program (QAA) identified deficient practices, and developed and implemented effective plans of action to protect residents related to potential abuse and neglect, identification of injuries of unknown origin, infection control, and quality of care issues that placed the health and safety of 9 of 17 (#'s 7 - 9 and #'s 11 - 16) residents in the facility in Immediate Jeopardy of serious harm, impairment or death. The QAA program additionally failed to ensure prior deficient practice did not recur. The lack of an effective ongoing QAA processes placed all residents in the facility at risk of serious harm, impairment, or death. Findings include:</p> <p>1. The following deficiencies were identified at Immediate Jeopardy during the survey:</p> <p>* Refer to F225 as it related to injuries of</p>	F 520	<p>F 520 For resident #s 7, 8, and 9, and resident #s 11 □ 16, the facility through the Executive Director shall ensure that the QAPI committee is operational and actively engaged in identifying potential/actual deficient practices, developing and implementing performance improvement plans related specifically to abuse prevention, identification of injuries of unknown origin, infection control, and quality of care issues. The facility Executive Director shall ensure that QA meetings are held monthly. The facility Executive Director shall ensure that adverse events, allegations of abuse, neglect, exploitation, injury of unknown origin, misappropriation of property are reported on a monthly basis to the QA committee for their review. Additionally the Executive Director shall</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 520	<p>Continued From page 78</p> <p>unknown origin and resident allegations of possible neglect and/or abuse and staff training. The facility was previously cited at F225 during the prior recertification survey of 6/10/16.</p> <p>* Refer to F226 as it related to the operationalization of facility policies and procedures for the protection of residents and the prevention, identification, investigation, and reporting of potential abuse, neglect, and injuries of unknown origin.</p> <p>* Refer to F490 as it related to the oversight of daily operations related to resident care.</p> <p>The facility was notified in writing of the Immediate Jeopardy and the need to formulate and implement a plan of removal on 8/25/17 at 9:48 am.</p> <p>On 9/1/17 at 11:59 pm, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented. The plan included:</p> <p>* The Executive Director would ensure infection control logs were current and concerns were brought forward to the QAA committee meetings.</p> <p>* The facility would review the updated abuse policy and procedure through the QAA committee, and the QAA committee would ensure the facility investigated injuries of unknown origin appropriately and ensure the facility implemented the facility's abuse policy.</p> <p>2. Additionally, the facility's QAA program did not provide sufficient monitoring to maintain ongoing</p>	F 520	<p>ensure that infection control tracking is reported monthly to the QA committee for their review. Quality of care issues identified in the facility shall also be reviewed by the QA Committee. The QA Committee shall review for trends and recommend performance improvement plans as indicated.</p> <p>This plan will be presented to the QA committee on Monday 8/28/17 for evaluation and further comment. The committee will recommend specific Performance Improvement Plans as indicated.</p> <p>The QA Committee will actively review audits and correction action activity related to any survey findings. The Committee may extend the length of audits and/or corrective actions as it believes necessary to ensure the facility remains in a position of compliance. Responsible: Executive Director and members of the QA Committee</p>		

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 520	<p>Continued From page 79</p> <p>compliance and had the potential to harm all residents in the facility if care and services were not provided in a safe and effective manner as follows:</p> <ul style="list-style-type: none"> <li>* Refer to F279 as it related to the development of comprehensive care plans. The facility was previously cited at F279 during the prior recertification survey of 6/10/16.</li> <li>* Refer to F280 as it related to the revision of care plans based on residents' needs. The facility was previously cited at F280 during the 8/26/16 revisit survey .</li> <li>* Refer to F309 as it related to diabetic management. The facility was previously cited at F309 during the April 2012, August 2013, October 2014, and June 2016 recertification surveys, as well as the August 2016 revisit survey. No surveys were completed at the facility during calendar year 2015.</li> <li>* Refer to F323 as it related to supervision and safety assessments. The facility was previously cited at F323 during the April 2012, October 2014, and June 2016 recertification surveys. No surveys were completed at the facility during calendar year 2015.</li> <li>* Refer to F329 as it related to the administration of medications with specific target behaviors identified for monitoring, specific indications for use, clinical rational and justification for the continued use of a medication, and effectiveness monitoring. The facility was previously cited at F329 during August 2013, October 2014, and June 2016 recertification surveys, as well as the</li> </ul>	F 520			

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

PRINTED: 10/12/2017  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/28/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER OF CASCADIA</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	
F 520	<p>Continued From page 80</p> <p>August 2016 revisit survey. No surveys were completed at the facility during calendar year 2015.</p> <p>* Refer to F441 as it related to infection control. The facility was previously cited at F441 during the June 2016 recertification surveys.</p> <p>On 8/25/17 at 7:30 am, the Executive Director stated each department audited another department in the facility as part of the QAA process. The Executive Director could not explain how audits would incorporate return demonstration and ensure correct procedures were performed when, for example, the Maintenance Director audited a clinical area and vice versa. The Executive Director stated this audit system had not identified the issues above or other concerns brought forth through survey.</p>	F 520			