



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 24, 2018

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

Provider #: 135048

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Welker:

On **April 11, 2018**, a Facility Fire Safety and Construction survey was conducted at **Clearwater of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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April 24, 2018
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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 7, 2018**. Failure to submit an acceptable PoC by **May 7, 2018**, may result in the imposition of civil monetary penalties by **May 27, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 16, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 16, 2018**. A change in the seriousness of the deficiencies on **May 16, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 16, 2018**, includes the following:

Denial of payment for new admissions effective **July 11, 2018**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 11, 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 & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 11, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

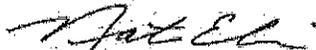
BFS Letters (06/30/11)

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

This request must be received by **May 7, 2018**. If your request for informal dispute resolution is received after **May 7, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 04/23/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1: PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	X2: MULTIPLE CONSTRUCTION A: BUILDING 01 - ENTIRE BUILDING B: WING _____	X3: DATE SURVEY COMPLETED 04/11/2018
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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(K) 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
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K 000 INITIAL COMMENTS

K 000

The facility is a single story type V (111) building built in 1969 with a basement that houses a maintenance shop storage areas and boiler room. The facility is protected by a complete automatic sprinkler system in accordance with NFPA 13. The fire alarm system is interconnected and was replaced in 2001. Currently the facility is licensed for 60 beds, with a census of 36 on the date of the survey.

The following deficiencies were cited during the annual life safety code survey conducted on April 11, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

K 161 Building Construction Type and Height
SS=E CFR(9): NFPA 101

K 161 K 161

Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5

Construction Type
1 I (442), I (332), II (222) Any number of stories
non-sprinklered and
sprinklered

2 II (111) One story

1. SPECIFIC ISSUE:

The facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Specifically failure to seal penetrations in rated construction areas.

2. OTHER RESIDENTS:

All residents, staff and visitors are potentially affected by deficient practice.

RECEIVED
MAY 15 2018
FACILITY STANDARDS

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

[Signature]

TITLE

ED

(X6) DATE

5-8-18

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 30 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135049		X3 MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		X1. DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD DROFINO, ID 83544				
Q1 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)		X2 COMPLETION DATE
K 161	Continued From page 1 non-sprinklered sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies between floors, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces. This deficient practice potentially affected residents staff and visitors on the ground floor of the facility on the date of the survey. Findings include:			K 161	3. SYSTEMIC CHANGES: Contractor was contracted to repair the hole penetrations in the ceiling of maintenance shop, medical records and basement hallway by 5/11/18. Building was inspected by Maintenance Director for any other wall penetrations and repaired. 4. MONITOR: Executive Director or designee will ensure quarterly audits of potential smoke penetrations in compliance with NFPA 101 thru monthly audits. Results of audits will be reviewed in QAPI. 5. Date of Compliance:		5/16/18

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

Printed 04/23/2018
FORM APPROVED
OMB NO 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048		A2. MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		X3. DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION:			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 161	Continued From page 2 During the facility tour conducted on April 11, 2018 from approximately 11:30 AM to 12:30 PM, the following unsealed penetrations were revealed in the one-hour rated ceiling construction of the partial basement: 1) One (1) hole approximately three feet by two feet and one (1) hole approximately eight inches by twelve inches in the ceiling of the maintenance shop, exposing the underside and the floor cavity between joists, of the main floor above. 2) One (1) unsealed approximately two foot by three foot hole in the ceiling of the hall outside the maintenance shop in the partial basement, exposing the underside and the floor cavity between joists, of the main floor above. 3) Two (2) approximately twelve inch diameter holes in the ceiling of the storage area of the partial basement, exposing the underside and the floor cavity between joists, of the main floor above. When asked about these unsealed holes, the POM (Plant Operations Manager) stated the previous POM had been working on leaks in the floor above. Actual NFPA standard: 19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used			K 161			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<input checked="" type="checkbox"/> PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">135049</p>	<input checked="" type="checkbox"/> MULTIPLE CONSTRUCTION # BUILDING 01 - ENTIRE BUILDING \$ WING _____	<input checked="" type="checkbox"/> DATE SURVEY COMPLETED <p style="text-align: center;">04/11/2018</p>
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFIND, ID 83544
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K 161 Continued From page 3
 in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.

8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3.

8.3.5.6 Membrane Penetrations
 8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.5.2.

K 161

K 291 Emergency Lighting
 SS=E CFR(s): NFPA 101

Emergency Lighting
 Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1
 This REQUIREMENT is not met as evidenced by:
 Based on record review and observation, the facility failed to provide emergency lighting in accordance with NFPA 101. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice potentially affected residents, staff and visitors using the main dining room on the date of the survey.

Findings include:

K 291 **K291**

- 1. SPECIFIC ISSUE:**
 The facility failed to provide emergency lighting in accordance with NFPA 101.
- 2. OTHER RESIDENTS:**
 All residents, staff and visitors have the potential to be affected by deficient practice.
- 3. SYSTEMIC CHANGES:**
 Facility has installed lighting per NFPA guidelines. Facility has been inspected for compliance for proper emergency lighting for egress doors specifically the side exit door from the dining hall has been provided with battery backup emergency lighting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		K1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115048		K2 MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		K3 DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83644				
K4 ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			K5 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		K6 COMPLETION DATE
K 291	Continued From page 4 During the facility tour conducted on April 11, 2018 from 1:00 - 3:00 PM, observation of the facility exit doors, revealed the side exit door from the dining hall was equipped with a delayed egress component for the magnetic locking arrangements. Further observation established the facility was not providing battery backup emergency lighting for this exit. Actual NFPA standard: 19.2.9 Emergency Lighting 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9 Emergency Lighting 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2.			K 291	4. MONITOR: Monitoring of this system will be added to the weekly preventative maintenance check. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. Executive Director and/or designee will validate that all doors are equipped with appropriate lighting and battery back-up per NFPA guidelines for egress monthly for 3 months. 5. DATE OF COMPLIANCE: 5/16/18		
K 353	Sprinkler System - Maintenance and Testing			K 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	1) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	2) DATE SURVEY COMPLETED 04/11/2018
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE OF COMPLETION
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K 353 Continued From page 5
SS=F CFR(s): NFPA 101

K 353 K353

Sprinkler System - Maintenance and Testing
Automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25. Standard for the Inspection, Testing and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

a) Date sprinkler system last checked

b) Who provided system test

c) Water system supply source

Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.

9.7.5, 9.7.7, 9.7.8, and NFPA 25

This REQUIREMENT is not met as evidenced by:

Based on record review and observation, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 36 residents, staff and visitors on the date of the survey.

Findings include:

1) During review of provided facility inspection and testing records conducted on 4/11/18 from 8:30 - 10:00 AM, no records were available indicating the dry system gauges were inspected on a weekly basis.

1. SPECIFIC ISSUE

Facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25.

2. OTHER RESIDENTS

All residents, staff and visitors have the potential to be affected by deficient practice.

3. SYSTEMIC CHANGES:

Weekly task on Tels is in place for dry system gauges. Fire Sprinkler Company tested fire system and provided proper documentation for quarterly inspection. Facility obtained proper amount of extra sprinkler heads per NFPA 25. Ordered 4 sprinkler heads for a total of 12. Post Indicator Valve (PIV) handle was secured and locked.

4. MONITOR:

Executive director and/or designee will validate proper documentation of round to check sprinkler heads are free of paint after new paint projects, and validate proper amount of sprinklers are onsite for use monthly for 3 months. Additional education will be provided as necessary. Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. Monitoring of this system will be added to the preventative maintenance check.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER SUPPLIER'S IDENTIFICATION NUMBER 135048	MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	DATE SURVEY COMPLETED 04/11/2018
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD ORFINO, ID 83544
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LXI 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)	DATE COMPLETION DATE
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K 353 Continued From page 6

K 353

5. DATE OF COMPLAINT:

5/16/18

Interview of the POM revealed he was not aware of this requirement.

2) During review of provided facility inspection and testing records conducted on 4/11/18 from 8:30 AM - 10:00 AM, no records were available for 3 of 4 quarterly inspections to date.

3) During the facility tour conducted on 4/11/18 from 1:00 - 3:00 PM, observation of the spare sprinkler pendants at the main riser revealed only eight (8) spare pendants.

4) During the facility tour conducted on 4/11/18 from 1:00 - 3:00 PM, observation of the outside Post Indicator Valve (PIV) revealed the valve was not secured.

Actual NFPA standard:

NFPA 25

5.2.4 Gauges.

5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.

5.3.3 Waterflow Alarm Devices.

5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.

5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows:

- (1) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers
- (2) For protected facilities having 300 to 1000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	K1. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	K2. MULTIPLE CONSTRUCTION A. BUILDING OR ENTIRE BUILDING: B. WING: _____	K3. DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
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K 353	Continued From page 7 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.2* The Valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification	K 353	
K 374	Subdivision of Building Spaces - Smoke Barrier 55-F CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that smoke barrier doors would resist the passage of smoke. Failure for smoke barrier doors to resist the passage of	K 374	<p>1. SPECIFIC ISSUE: The facility failed to ensure that smoke barrier doors would resist the passage of smoke.</p> <p>2. OTHER RESIDENTS: All residents, staff and visitors are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Facility will have its annual Fire Door inspection by 5/16/18 by licensed contractor. Inspection will include a detailed check that the smoke barrier doors will resist the passage of smoke and shall be self-closing or automatic closing in accordance with NFPA 101.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	X2 MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	X3 DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) X5 COMPLETION DATE
K 374	<p>Continued From page 8</p> <p>smoke could allow smoke and dangerous gases to pass between smoke compartments during a fire, eliminating the ability to defend in place. This deficient practice affected 23 residents, staff and visitors in 2 of 4 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 11, 2018 from approximately 1:00 - 3:00 PM, observation and operational testing of the smoke barrier doors separating "C" Hall to the main nurse's station and "A" hall, revealed a gap between the two doors measuring approximately 1-1/2 inches when the doors were fully activated.</p> <p>Actual NFPA standard:</p> <p>19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel.</p> <p>8.5.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3.4 in. (19 mm).</p>	K 374	<p>4. MONITOR: Executive Director or designee will ensure that the inspection and corrections are completed by 5/16/18. Smoke barrier doors will be checked for compliance during quarterly inspection. Any issues will be reported in QAPI.</p> <p>5. Date of Compliance: 5/16/18</p>
K 911 SS-D	<p>Electrical Systems - Other CFR(s): NFPA 101</p> <p>Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but</p>	K 911	<p>1. SPECIFIC ISSUE: Facility failed to ensure the Essential Electrical System (EES) generator was equipped with a man remote stop station in accordance with NFPA 110</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">135048</p>	MULTIPLE CONSTRUCTION A - BUILDING 01 - ENTIRE BUILDING B - WING _____	DATE SURVEY COMPLETED <p style="text-align: center;">04/11/2018</p>
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD DORFINO, ID 83544	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 911	<p>Continued From page 9</p> <p>are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote stop located outside of the room housing the prime mover, potentially hinders staff ability to shut down the generator if required during an emergency. This deficient practice affected 36 residents, staff and visitors, on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/11/18 from approximately 1:00 - 3:00 PM, a remote manual stop for the EES generator was not located.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.</p> <p>5.6.5.6.1 The remote manual stop station shall be labeled.</p> <p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Alarm Annunciator</p>	K 911	<p>2. OTHER RESIDENTS: This deficient practice affected 36 residents, staff and visitors.</p> <p>3. SYSTEMIC CHANGES: Facility has contracted for the installation of the remote manual stop for the Essential Electrical System Generator.</p> <p>4. MONITOR: Executive Director or designee will validate that the remote manual stop is in compliance standards with NFPA 110 monthly for 3 months. Monitoring of this system will be added to the preventive maintenance check and reported to QAPI monthly for 3 months.</p> <p>5. Date of Compliance: 5/16/18</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">135048</p>	NO. MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING: _____	NO. DATE SURVEY COMPLETED <p style="text-align: center;">04/11/2018</p>	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X) 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)	% COMPLETION DATE
K 916	<p>Continued From page 10</p> <p>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator in accordance with NFPA 99. Failure to provide a remote annunciator could result in a lack of awareness to system failures during a power outage or other emergency when this system is required. This deficient practice affected 35 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 11, 2018 from approximately 1:00 - 3:00 PM, a remote annunciator for the EES was not located at any normally staffed location.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm</p>	K 916	<p>K916</p> <ol style="list-style-type: none"> 1. SPECIFIC ISSUE: The facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote annunciator in accordance with NFPA 99. 2. OTHER RESIDENTS: All residents have potential to be affected by deficient practice. 3. SYSTEMIC CHANGES Facility has contracted for the installation of the remote annunciator for the Essential Electrical System Generator. 4. MONITOR Executive Director and/ or designee will validate that the remote annunciator is in compliance standards with NFPA 99 monthly for 3 months. Monitoring of this system will be added to the preventive maintenance check and reported to QAPI monthly for 3 months. 5. DATE OF COMPLIANCE 5/16/18 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	NPI PROVIDER SUPPLIER OR IDENTIFICATION NUMBER 135048	N1 MULTIPLE CONSTRUCTION 4 BUILDING 01 - ENTIRE BUILDING 5 WING _____	DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
NIR OR REFERRAL 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) DATE COMPLETION
K 916	Continued From page 11 conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916	
K 923	Gas Equipment - Cylinder and Container Storage SS=D CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr fire protection rating Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923	1. SPECIFIC ISSUE: The Facility failed to ensure cryogenic oxygen cylinders were secured in accordance with NFPA 99. 2. OTHER RESIDENTS: All residents, staff and visitors are at risk to be affected by deficient practice. 3. SYSTEMIC CHANGES: The cryogenic oxygen cylinders were immediately secured by chain following survey in accordance with NFPA 99.

8. STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		9. PROVIDER'S, SUPPLIER'S OR IDENTIFICATION NUMBER 135048		10. ALLIABLE CONSTRUCTION A. BUILDING OR ENTIRE BUILDING B. WING		11. DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544				
12. ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES - EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			13. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION - EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY:		14. COMPLETION DATE
K 923	Continued From page 12 or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION OXIDIZING GASES) STORED WITHIN NO SMOKING " Storage is planned so cylinders are used in order of which they are received from the supplier; Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure cryogenic oxygen cylinders were secured in accordance with NFPA 99. Failure to secure liquid oxygen cylinders has the potential for cylinder damage from falling, increasing the risk of fires and explosions. This deficient practice affected staff and visitors on the date of the survey Findings include: During the facility tour conducted on 4/11/18 from 1:00 - 3:00 PM, observation of the oxygen storage room at the rear of the facility, revealed three (3) LOX (Liquid Oxygen) cylinders unsecured by either a cart, rack or chained. Interview of the Plant Operations Manager revealed he was unaware of the requirement for securing LOX cylinders. Actual NFPA standard:			K 923	4. MONITOR: Executive Director and/or designee will validate that the cryogenic oxygen cylinders are secured and in compliance standards with NFPA 99 monthly for 3 months. Monitoring of this system will be added to the preventive maintenance check.		5/16/18
				5.	Date of Compliance:		5/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135043	IC MULTIPLE CORRECTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	IC DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
IC ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IC COMPLETE DATE
K 923	Continued From page 13 11.7 Liquid Oxygen Equipment 11.7.3 Container Storage, Use, and Operation 11.7.3.3 Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 923		
K 926	Gas Equipment - Qualifications and Training SS=E CFR(s) NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by Based on record review and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated and hinders staff response with the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.	K 926	K 926 1. SPECIFIC ISSUE: The Facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. 2. OTHER RESIDENTS: All residents, staff and visitors are at risk to be affected by deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1. PROVIDER SUPPLIER, CLIA IDENTIFICATION NUMBER: 135048	2. MULTIPLE CORRECTIONS: A. BUILDING 01 - ENTIRE BUILDING B. WING _____	3. DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
X1 TO PREPARE 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) DATE COMPLETED
K 925	Continued From page 14	K 926	
	<p>Findings include:</p> <p>During review of provided training records on 4/11/18 from 8:30 - 10:00 AM, no records were provided for annual oxygen training. Interview of 3 of 3 staff members on 4/11/18 from 12:45 - 1:30 PM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases.</p> <p>Actual NFPA standard</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers 11.5.2.1 Qualification and Training of Personnel 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>		<p>3. SYSTEMIC CHANGES: Facility education calendar updated to include annual training of application, maintenance and handling of medical gases and cylinders including associated risks. Additionally, the same training program is updated for facility orientation of new employees. Staff Development Coordinator educated by Executive Director on or before 5/16/18 to ensure oxygen training and education of above mentioned requirements are provided upon orientation and annually to employees.</p> <p>4. MONITOR: Executive Director or designee will audit facility orientation and annual trainings weekly x 3 then monthly x 3 to ensure ongoing compliance. Results will be reviewed at monthly QAPI meetings and addressed.</p>
			<p>5. Date of Compliance: 5/16/18</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	11. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	12. MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	13. DATE SURVEY COMPLETED 04/11/2018
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 000 Initial Comments

E 000

The facility is a single story type V (111) building built in 1969 with a basement that houses a maintenance shop storage areas and boiler room. The facility is protected by a complete automatic sprinkler system in accordance with NFPA 13. The fire alarm system is interconnected and was replaced in 2001. The facility is located in a rural fire district with both public and volunteer resources available. Currently the facility is licensed for 60 beds, with a census of 36 on the date of the survey.

The following deficiencies were cited during the emergency preparedness survey conducted on April 11, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

E 007 EP Program Patient Population:
SS=F CFR(s): 483.73(a)(3)

E 007

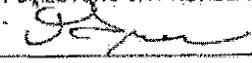
(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**

*Note: ("Persons at risk" does not apply to ASC.

1. SPECIFIC ISSUE:
Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee and community emergency personnel to address resident population including persons at risk, staff succession planning, delegation of authority, and facility's ability to provide services in an emergency.

RECEIVED
MAY 15 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ES	(X6) DATE 5-8-18
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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: 04/23/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048		X3) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 007	Continued From page 1 hospice, PAGE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures, addressing the resident population, including persons at risk and the types of services the facility has the ability to provide during an emergency. Failure to address the facility's at-risk population and types of services available, has the potential to hinder continuity of care and emergency management response during an emergency. This deficient practice affected 36 residents, staff and visitors on the date of the survey. Findings include: On 4/11/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency, or specify as to the unique vulnerabilities of the resident population in the event of a disaster. Reference: 42 CFR 483.73 (a) (3)			E 007	2. OTHER RESIDENTS: All residents, staff and visitors are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Plan was updated to address unique vulnerabilities of the resident population including residents at risk, facility's ability as well as types of services provided in the event of an emergency. Staff will be educated on or before 5/16/18 by Executive Director and/or designee. 4. MONITOR: Upon completion of initial education with staff, Executive Director and or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated and reported to QAPI. 5. DATE OF COMPLIANCE: 5/16/18		
E 009	Local, State, Tribal Collaboration Process SS=F CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts			E 009			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER, SUPPLIER, CLIA IDENTIFICATION NUMBER 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD DROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 009	<p>Continued From page 2</p> <p>to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.</p> <p>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include.</p> <p>On 4/11/18 from 8:30 AM - 3:00 PM, review of provided policies, procedures and the emergency plan, no documentation was provided indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including</p>	E 009	<p>1. SPECIFIC ISSUE: Clearwater Health and Rehabilitation of Casacdia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee emergency personnel to include comprehensive collaboration with multi-jurisdictional entities and will include documentation of the facilities efforts to contact such officials.</p> <p>2. OTHER RESIDENTS: All residents, staff and visitors are affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Policies and procedures were updated to include a hazard risk assessment including collaboration with local emergency authorities. Such collaboration will be documented. Staff will be educated on or before 5/16/18 by Executive Director and/or designee.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcome to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan will be updated as indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 009	Continued From page 3 such involvement as participation in county EMS or regional healthcare coalition meetings. Reference: 42 CFR 483.73 (a) (4)	E 009	5. DATE OF COMPLIANCE: 5/16/18		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) {(b) Policies and procedures. The {facilities} must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.} At a minimum, the policies and procedures must address the following: (2) A system to track the location of on-duty staff and sheltered patients in the {facility's} care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the {facility} must document the specific name and location of the receiving facility or other location. *{For PRTFs at §441.184(b), LTC at §483.73(b), ICF/HIDs at §483.475(b), PACE at §460.84(b).} Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the {PRTF's, LTC, ICF/HID or PACE} care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the {PRTF's, LTC, ICF/HID or PACE} must document the specific name and location of the receiving facility or other location. *{For Inpatient Hospice at §418.113(b)(6).} Policies and procedures.	E 018	1. SPECIFIC ISSUE: Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee and community emergency personnel to update site-specific policy and procedures to include a staff and resident tracking system to be used during an emergency. 2. OTHER RESIDENTS: All residents, staff and visitors are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Policies and procedures have been developed to include a tracking system for staff and residents. Staff will be educated on or before 5/16/18 by Executive Director and/or designee regarding facility's updated policies regarding tracking systems for both residents and staff during an emergency which will include but not limited to evacuation and shelter-in-place scenarios.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		4. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 133048		3. MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		3. DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA				STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544			
(X4) ID PREFIX TAG		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
E 018		Continued From page 4 (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *(For CMHCs at §405.920(b):) Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *(For OPOs at § 486.360(b):) Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records *(For ESRD at § 494.52(b):) Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an		E 018		4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan will be updated as indicated. 5. DATE OF COMPLIANCE: 5/16/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		N. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048		X. MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		Y. DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544				
IMD 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)		REG. COMPLETION DATE
E 018	Continued From page 5 emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the 36 residents, staff and visitors in the facility on the date of the survey. Findings include: On 4/11/18 from 9:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency. Reference: 42 CFR 483.73 (b) (2)			E 018			
E 022	Policies/Procedures for Sheltering in Place SS=F CFR(s): 483.73(b)(4) {(b) Policies and procedures. The {facilities} must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: {4} A means to shelter in place for patients, staff, and volunteers who remain in the {facility}. {(4) or (2),(3),(5),(6)} A means to shelter in place for patients, staff, and volunteers who remain in the {facility} *For Inpatient Hospices at §418.113(b) Policies and procedures.			E 022	1. SPECIFIC ISSUE: Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee and community emergency personnel to include policies and procedures that insure plans for sheltering are in place. 2. OTHER RESIDENTS: All residents, staff and visitors are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: A plan, policy and procedure has been developed that address sheltering, including provisions for resources needed to continue care during an emergency.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 022	Continued From page 6 (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy, procedure or plan for sheltering in place. Failure to provide a plan for sheltering in place has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected 16 residents, staff and visitors on the date of the survey. Findings include: On 4/11/18 from 8:30 AM to 3:00 PM; review of provided emergency plan, policies and procedures, failed to reveal information for sheltering in place. Reference: 42 CFR 483.73 (b) (4)	E 022	continued from pg. 6 Staff will be educated on or before 5/16/18 by Executive Director and/or designee regarding facility's updated policies and procedures for sheltering residents during an emergency. 4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as needed. 5. DATE OF COMPLIANCE: 5/16/18.		
E 030 55-D	Names and Contact Information CFR(s): 483.73(c)(1) (c) The [facility, except RNHCs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.	E 030	1. SPECIFIC ISSUE: Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee and community emergency personnel to include updated and site-specific contact list that includes staff, entities providing services, patient physicians, other facilities, and volunteers.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135045	X2. MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	X3. DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544	
X4. ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) X5. COMPLETION DATE
E 030	<p>Continued From page 7</p> <p>(ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other (facilities). (v) Volunteers.</p> <p>*[For RNHCs at §403.743(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCs. (v) Volunteers.</p> <p>*[For ASCs at §415.45(a)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §410.113(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other hospices.</p> <p>*[For OPCs at §486.360(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.</p>	E 030	<p>2. OTHER RESIDENTS: All residents, staff and visitors are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: A communication plan has been developed to include contact list that will include all pertinent contact information including staff, resident physicians and other LTC facilities. Staff educated on or before 5/16/18 by Executive Director and/or designee regarding facility's updated communication plan and contact list.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview and review of contact list to validate numbers are current. Outcomes will be provided to QAPI committee monthly for the next 3 months. Plan will be reviewed annually thereafter. Additional education will be provided as necessary. Plan will be updated as indicated.</p> <p>5. DATE OF COMPLIANCE: 5/16/18.</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	XI. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135040	XII. MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	XIII. DATE SURVEY COMPLETED 04/11/2018
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD ORFIND, ID 83544
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(N) 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
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E 030 Continued From page 8
(ii) Entities providing services under arrangement
(iii) Volunteers.
(iv) Other OPOs.
(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).
This REQUIREMENT is not met as evidenced by:
Based on record review, it was determined the facility failed to document a communication plan which included contact information for staff, resident physicians, other facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 36 residents, staff and visitors on the date of the survey.

Findings include:

On 4/11/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for resident physicians, staff and other LTC (Long Term Care Facilities).

Reference:
42 CFR 483.73 (c) (1)

E 030

E 033 Methods for Sharing Information
SS=F CFR(s): 483.73(c)(4)-(5)

E 033

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048		X2 MULTIPLE CONSTRUCTION: A. GUILD NO. _____ B. WING _____		X3 DATE SURVEY COMPLETED 04/11/2018	
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 033	Continued From page 9			E 033			
	<p>(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.</p> <p>(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.58(c), and RHCs/FQHCs under §491.12(c)]</p> <p>(B) ((4) or (5))A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).</p> <p>*[For RNHCs at §403.740(c)] (4) A method for sharing information and care documentation for patients under the RNHC's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.</p> <p>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a plan demonstrating the method for sharing information during an emergency. Failure to share information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice affected 36</p>				<p>1. SPECIFIC ISSUE: Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policies regarding method of sharing information and medical documentation with other healthcare providers in the event of an emergency, the release of patient information including general condition and transfer location, if indicated.</p> <p>2. OTHER RESIDENTS: All residents are potentially affected by deficient practice.</p> <p>3. SYSTEMIC CHANGES: Plan has been updated to address the sharing of patient information with other healthcare providers. Staff will be educated on or before 5/16/18 by Executive Director and/or designee regarding facility's policy for sharing information regarding patient condition, location and method of sharing information with other healthcare providers.</p> <p>4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management plan through staff interview.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135040	NO MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	X51 COMPLETION DATE	
E 033	Continued From page 10 residents, staff and visitors on the date of the survey. Findings include: On 4/11/18 from 8:30 AM to 3:00 PM, review of provided emergency plan, policies and procedures, referenced IT security and failed to demonstrate a policy which identified how the facility would share information for the care of residents with other healthcare providers, only the policies and procedures as related to the security of data and equipment assigned or delegated to company staff. Reference: 42 CFR 483.73 (c) (4)-(6) See also: E-0034	E 033	continued from pg 10. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan will be updated as indicated. DATE OF COMPLIANCE: 5/16/18		
E 034	Information on Occupancy/Needs 55=F CFR(s) 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 418.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 034			

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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS CITY STATE ZIP CODE 1204 SHRIVER ROAD CROFTON, ID 83544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 034	Continued From page 11 *(For Inpatient Hospice at §418.113.) (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide a communication plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Failure to provide a plan to share information with emergency personnel on the facility's needs and abilities to provide assistance during a disaster, has the potential to hinder response assistance and continuation of care for the 38 residents housed on the date of the survey. Findings include: On 4/11/18 from 8:30 AM to 3:00 PM, review of provided policies, procedures and emergency plans failed to indicate what method the facility would use to share information on its needs or capabilities when communicating with emergency management officials. Provided information on Information Technology, referred only to those procedures for securing data and equipment such as laptops issued or delegated to staff. Reference: 42 CFR 483.73 (c) (7) See Also: E-0033			E 034	1. SPECIFIC ISSUE: Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 5/16/18 by facility QAPI committee and community emergency personnel to include updated and site-specific policies regarding means of providing information about the facilities occupancy, needs and/or ability to provide assistance with Incident Commander or designee. 2. OTHER RESIDENTS: All residents, staff and visitors are potentially affected by deficient practice. 3. SYSTEMIC CHANGES: Plan has been updated to include how the facility would share information as well as the needs or capabilities when communicating with emergency management officials. Staff will be educated on or before 5/16/18 by Executive Director and/or designee regarding facility's procedure to provide information to incident commander or designee. 4. MONITOR: Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness and provide outcomes to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan will be updated as indicated. 5. DATE OF COMPLIANCE: 5/16/18.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2018
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NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V (111) building built in 1969 with a basement that houses a maintenance shop storage areas and boiler room. The facility is protected by a complete automatic sprinkler system in accordance with NFPA 13. The fire alarm system is interconnected and was replaced in 2001. Currently the facility is licensed for 60 beds, with a census of 36 on the date of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on April 11, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K 161 SS=E	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p>	K 161		5/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		05/08/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 161	Continued From page 1 2 II (111) One story non-sprinklered sprinklered Maximum 3 stories 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies between floors, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces. This deficient practice potentially affected residents staff and visitors on the ground floor of the facility on the	K 161			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 161	<p>Continued From page 2 date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 11, 2018 from approximately 11:30 AM to 12:30 PM, the following unsealed penetrations were revealed in the one-hour rated ceiling construction of the partial basement:</p> <p>1) One (1) hole approximately three feet by two feet and one (1) hole approximately eight inches by twelve inches in the ceiling of the maintenance shop, exposing the underside and the floor cavity between joists, of the main floor above.</p> <p>2) One (1) unsealed approximately two foot by three foot hole in the ceiling of the hall outside the maintenance shop in the partial basement, exposing the underside and the floor cavity between joists, of the main floor above.</p> <p>3) Two (2) approximately twelve inch diameter holes in the ceiling of the storage area of the partial basement, exposing the underside and the floor cavity between joists, of the main floor above.</p> <p>When asked about these unsealed holes, the POM (Plant Operations Manager) stated the previous POM had been working on leaks in the floor above.</p> <p>Actual NFPA standard:</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited</p>	K 161			

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K 161	Continued From page 3 to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters. 8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3. 8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.5.2.	K 161			
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to provide emergency lighting in accordance with NFPA 101. Failure to provide	K 291		5/16/18	

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K 291	<p>Continued From page 4</p> <p>emergency lighting for doors equipped with delayed egress potentially hinders identification of exits affecting resident egress during an emergency. This deficient practice potentially affected residents, staff and visitors using the main dining room on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 11, 2018 from 1:00 - 3:00 PM, observation of the facility exit doors, revealed the side exit door from the dining hall was equipped with a delayed egress component for the magnetic locking arrangements. Further observation established the facility was not providing battery backup emergency lighting for this exit.</p> <p>Actual NFPA standard:</p> <p>19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.</p> <p>7.9 Emergency Lighting. 7.9.1 General. 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed-egress locks (5) Stair shafts and vestibules of smokeproof</p>	K 291			

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K 291	Continued From page 5 enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment. (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply. (6) New access-controlled egress doors in accordance with 7.2.1.6.2.	K 291			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components	K 353		5/16/18	

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K 353	<p>Continued From page 6</p> <p>has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility inspection and testing records conducted on 4/11/18 from 8:30 - 10:00 AM, no records were available indicating the dry system gauges were inspected on a weekly basis.</p> <p>Interview of the POM revealed he was not aware of this requirement.</p> <p>2) During review of provided facility inspection and testing records conducted on 4/11/18 from 8:30 AM - 10:00 AM, no records were available for 3 of 4 quarterly inspections to date.</p> <p>3) During the facility tour conducted on 4/11/18 from 1:00 - 3:00 PM, observation of the spare sprinkler pendants at the main riser revealed only eight (8) spare pendants.</p> <p>4) During the facility tour conducted on 4/11/18 from 1:00 - 3:00 PM, observation of the outside Post Indicator Valve (PIV) revealed the valve was not secured.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge</p>	K 353			

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K 353	Continued From page 7 systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. 5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers - no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers 13.3 Control Valves in Water-Based Fire Protection Systems. 13.3.2 Inspection. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification	K 353			
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374		5/16/18	

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K 374	<p>Continued From page 8</p> <p>bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and operational testing, the facility failed to ensure that smoke barrier doors would resist the passage of smoke. Failure for smoke barrier doors to resist the passage of smoke could allow smoke and dangerous gases to pass between smoke compartments during a fire, eliminating the ability to defend in place. This deficient practice affected 23 residents, staff and visitors in 2 of 4 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 11, 2018 from approximately 1:00 - 3:00 PM, observation and operational testing of the smoke barrier doors separating "C" Hall to the main nurse's station and "A" hall, revealed a gap between the two doors measuring approximately 1-1/2 inches when the doors were fully activated.</p> <p>Actual NFPA standard:</p> <p>19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following:</p>	K 374			

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K 374	Continued From page 9 (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel. 8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3.4 in. (19 mm).	K 374			
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote stop located outside of the room housing the prime mover, potentially hinders staff ability to shut down the generator if required during an emergency. This deficient practice affected 36 residents, staff and visitors on the date of the survey. Findings include:	K 911		5/16/18	

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K 911	Continued From page 10 During the facility tour conducted on 4/11/18 from approximately 1:00 - 3:00 PM, a remote manual stop for the EES generator was not located. Actual NFPA standard: NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled.	K 911			
K 916 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator in accordance with NFPA 99. Failure to provide a	K 916		5/16/18	

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K 916	<p>Continued From page 11</p> <p>remote annunciator could result in a lack of awareness to system failures during a power outage or other emergency when this system is required. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on April 11, 201 from approximately 1:00 - 3:00 PM, a remote annunciator for the EES was not located at any normally staffed location.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(1) Individual visual signals shall indicate the following:</p> <p>(a) When the emergency or auxiliary power source is operating to supply power to load</p> <p>(b) When the battery charger is malfunctioning</p> <p>(2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <p>(a) Low lubricating oil pressure</p> <p>(b) Low water temperature (below that required in 6.4.1.1.11)</p>	K 916			

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K 916	Continued From page 12 (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916			
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		5/16/18	

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K 923	<p>Continued From page 13</p> <p>cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure cryogenic oxygen cylinders were secured in accordance with NFPA 99. Failure to secure liquid oxygen cylinders has the potential for cylinder damage from falling, increasing the risk of fires and explosions. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/11/18 from 1:00 - 3:00 PM, observation of the oxygen storage room at the rear of the facility, revealed three (3) LOX (Liquid Oxygen) cylinders unsecured by either a cart, rack or chained. Interview of the Plant Operations Manager revealed he was unaware of the requirement for securing LOX cylinders.</p> <p>Actual NFPA standard:</p> <p>11.7 Liquid Oxygen Equipment. 11.7.3 Container Storage, Use, and Operation.</p> <p>11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity:</p>	K 923			

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K 923	Continued From page 14 (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 923			
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated and hinders staff response with the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey. Findings include: During review of provided training records on 4/11/18 from 8:30 - 10:00 AM, no records were	K 926		5/16/18	

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K 926	Continued From page 15 provided for annual oxygen training. Interview of 3 of 3 staff members on 4/11/18 from 12:45 - 1:30 PM, revealed none had participated in any continuing education program on the risks associated with the storage, handling or use of medical gases. Actual NFPA standard: NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926			

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E 000	<p>Initial Comments</p> <p>The facility is a single story type V (111) building built in 1969 with a basement that houses a maintenance shop storage areas and boiler room. The facility is protected by a complete automatic sprinkler system in accordance with NFPA 13. The fire alarm system is interconnected and was replaced in 2001. The facility is located in a rural fire district with both public and volunteer resources available. Currently the facility is licensed for 60 beds, with a census of 36 on the date of the survey.</p> <p>The following deficiencies were cited during the emergency preparedness survey conducted on April 11, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000		
E 007 SS=F	<p>EP Program Patient Population CFR(s): 483.73(a)(3)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]</p> <p>(3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**</p>	E 007		5/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 05/08/2018
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 007	Continued From page 1 *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures, addressing the resident population, including persons at risk and the types of services the facility has the ability to provide during an emergency. Failure to address the facility's at-risk population and types of services available, has the potential to hinder continuity of care and emergency management response during an emergency. This deficient practice affected 36 residents, staff and visitors on the date of the survey. Findings include: On 4/11/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, revealed the plan failed to define what types of services the facility had the ability to provide during an emergency, or specify as to the unique vulnerabilities' of the resident population in the event of a disaster. Reference: 42 CFR 483.73 (a) (3)	E 007			
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]	E 009		5/16/18	

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E 009	Continued From page 2 (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document collaboration with local, tribal, regional, State and Federal EP officials and integrated emergency response efforts. Failure to develop a collaborative planning effort with multi-jurisdictional entities, has the potential to limit the facilities options during a disaster. This deficient practice affected 36 residents, staff and visitors on the date of the survey. Findings include:	E 009			

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E 009	Continued From page 3	E 009			
E 018 SS=C	<p>On 4/11/18 from 8:30 AM - 3:00 PM, review of provided policies, procedures and the emergency plan, no documentation was provided indicating collaborative involvement with local, tribal, regional State and Federal EP officials, including such involvement as participation in county EMS or regional healthcare coalition meetings.</p> <p>Reference: 42 CFR 483.73 (a) (4)</p> <p>Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]</p> <p>(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.</p> <p>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE]</p>	E 018		5/16/18	

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E 018	<p>Continued From page 4</p> <p>care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.</p> <p>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.</p> <p>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p>	E 018			

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E 018	Continued From page 5 *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the 36 residents, staff and visitors in the facility on the date of the survey. Findings include: On 4/11/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency. Reference: 42 CFR 483.73 (b) (2)	E 018			
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and	E 022		5/16/18	

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E 022	<p>Continued From page 6</p> <p>procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].</p> <p>*[For Inpatient Hospices at §418.113(b):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to provide a policy, procedure or plan for sheltering in place. Failure to provide a plan for sheltering in place has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/11/18 from 8:30 AM to 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal information for sheltering in place.</p> <p>Reference: 42 CFR 483.73 (b) (4)</p>	E 022			

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E 030 SS=D	<p>Names and Contact Information CFR(s): 483.73(c)(1)</p> <p>[(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]</p> <p>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.</p>	E 030		5/16/18	

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E 030	<p>Continued From page 8</p> <p>(iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a communication plan which included contact information for staff, resident physicians, other facilities and volunteers. Failure to have a communication plan which includes contact information for those parties assisting in the facility's response and recovery during a disaster, has the potential to hinder both internal and external emergency response efforts. This deficient practice affected 36 residents, staff and visitors on the date of the</p>	E 030			

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E 030	Continued From page 9 survey. Findings include: On 4/11/18 from 8:30 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for resident physicians, staff and other LTC (Long Term Care Facilities). Reference: 42 CFR 483.73 (c) (1)	E 030			
E 033 SS=F	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted	E 033		5/16/18	

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E 033	<p>Continued From page 10 under 45 CFR 164.510(b)(4).</p> <p>*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.</p> <p>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to document a plan demonstrating the method for sharing information during an emergency. Failure to share information with other health care providers has the potential to hinder the facility's ability to continue care during a disaster. This deficient practice affected 36 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/11/18 from 8:30 AM to 3:00 PM, review of provided emergency plan, policies and procedures, referenced IT security and failed to demonstrate a policy which identified how the facility would share information for the care of residents with other healthcare providers, only the policies and procedures as related to the security of data and equipment assigned or delegated to company staff.</p>	E 033			

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E 033	Continued From page 11	E 033			
E 034 SS=F	<p>Reference: 42 CFR 483.73 (c) (4)-(6)</p> <p>See also: E-0034 Information on Occupancy/Needs CFR(s): 483.73(c)(7)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.</p> <p>*[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide a communication plan for sharing information on needs, occupancy and its ability to</p>	E 034		5/16/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2018
NAME OF PROVIDER OR SUPPLIER CLEARWATER OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 034	<p>Continued From page 12</p> <p>provide assistance with emergency management officials. Failure to provide a plan to share information with emergency personnel on the facility's needs and abilities to provide assistance during a disaster, has the potential to hinder response assistance and continuation of care for the 36 residents housed on the date of the survey.</p> <p>Findings include:</p> <p>On 4/11/18 from 8:30 AM to 3:00 PM, review of provided policies, procedures and emergency plans failed to indicate what method the facility would use to share information on its needs or capabilities when communicating with emergency management officials. Provided information on Information Technology, referred only to those procedures for securing data and equipment such as laptops issued or delegated to staff.</p> <p>Reference: 42 CFR 483.73 (c) (7)</p> <p>See Also: E-0033</p>	E 034		