



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

March 19, 2020

Andrew Schiller, Administrator  
Clearwater Health & Rehabilitation of Cascadia  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

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

Dear Mr. Schiller:

On **March 9, 2020**, a Facility Fire Safety and Construction survey was conducted at Clearwater Health & Rehabilitation of Cascadia by the Bureau of Facility Standards/Department of Health & Welfare 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 the facility in compliance with 42 CFR Part 483, Subpart B, Long Term Care Requirements. Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing no Medicare/Medicaid deficiencies. This form is for your records only and does not need to be returned.

Also enclosed is a Statement of Deficiencies/Plan of Correction, State Form, listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. Please provide ONLY ONE completion date for each State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign the State Form Statement of Deficiencies, in the space provided, and return the original to this office.**

Andrew Schiller, Administrator  
March 19, 2020  
Page 2 of 2

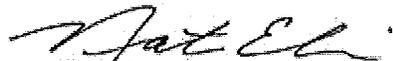
Your Plan of Correction (POC) for the deficiencies must be submitted by **April 1, 2020**.

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,
- Provide dates when corrected action will be completed.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office 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: 04/06/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single-story type V (111), built in 1969, with a basement containing a maintenance shop, storage area 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 Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is licensed for 60 beds and had a census of 41 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on March 9, 2020. 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>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE **03/31/2020**

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.

PRINTED: 03/19/2020  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
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NAME OF PROVIDER OR SUPPLIER  
CLEARWATER HEALTH & REHABILITATION OF

STREET ADDRESS, CITY, STATE, ZIP CODE  
1204 SHRIVER ROAD  
CROFNO, ID 83844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 000

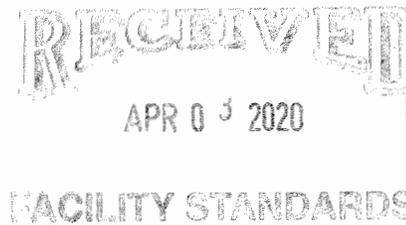
INITIAL COMMENTS

C 000

The facility is a single-story type V (111), built in 1969, with a basement containing a maintenance shop, storage area 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 Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is licensed for 60 beds and had a census of 41 on the date of the survey.

The following deficiency was cited during the annual Fire/Life Safety survey conducted on March 9, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.

The survey was conducted by:  
  
Linda Chaney  
Health Facility Surveyor  
Facility Fire Safety and Construction



C 446

02:120,13,c Hot Water Temps 105-120 Degrees F

C 446

c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.  
This Rule is not met as evidenced by:  
Based on observation and interview, the facility failed to ensure water temperatures were maintained between 105 and 120 degrees.

C445

**Resident Specific**  
On March 9, 2020, adjustments were made to domestic hot water supply and temperatures were determined to be between 105 to 120 degrees.

**Other Residents**  
On March 9, 2020, adjustments were made to domestic hot water supply and temperatures were determined to be between 105 and 120 degrees.

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Andrew Schiltz*

TITLE

Administrator/ceo 3/31/2020

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MO8001148</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE BUILDING</b>  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/09/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION OF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID, 83644</b>
--	--

(X4) ID-PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID-PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 445

Continued From page 1

Failure to provide water temperatures in accordance to the rule, could result in accidental scalding during routine washing or bathing. This deficient practice affected 41 residents and staff on the date of the survey.

Findings Include:

During the facility tour conducted on March 9, 2020, from approximately 4:30 PM to 5:40 PM, observation of water temperatures taken in resident rooms revealed the hot water temperature was 130 degrees. When asked, the Maintenance Supervisor stated he was not aware the water temperatures were over 120 degrees and immediately turned it down.

Actual IDAPA standard:

IDAPA 16.03.11.120.13 (c)

c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.

C-445

**Facility Systems**  
On March 9, 2020, one on one training/education was provided to facility maintenance director. Re-education was provided by Chief Nursing Officer and Resource Maintenance Director to include, but not limited to, IDAPA 16.03.11.12.13 standards and on process to monitor temperature of hot water used by residents. The system has been amended to include oversight from Chief Nursing Office and IDT daily as needed.

**Monitor**  
The Chief Executive Officer and/or designee will audit compliance for hot water temperatures between 105 and 120 degrees daily for 2 weeks, then twice per week for 2 weeks, then weekly as required. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.

**Date of Compliance**  
April 13, 2020

4/13/2020



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

March 19, 2020

Andrew Schiller, Administrator  
Clearwater Health & Rehabilitation of Cascadia  
1204 Shriver Road  
Orofino, ID 83544-9033

Provider #: 135048

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Schiller:

On **March 9, 2020**, an Emergency Preparedness survey was conducted at **Clearwater Health & Rehabilitation of Cascadia** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with 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. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 1, 2020**. Failure to submit an acceptable PoC by **April 1, 2020**, may result in the imposition of civil monetary penalties by **April 23, 2020**.

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 **April 13, 2020**, (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 . A change in the seriousness of the deficiencies on **May 3, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 13, 2020**, includes the following:

Denial of payment for new admissions effective **June 9, 2020**.  
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 **September 9, 2020**, 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 **March 9, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

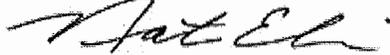
2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

Andrew Schiller, Administrator  
March 19, 2020  
Page 4 of 4

This request must be received by **April 1, 2020**. If your request for informal dispute resolution is received after **April 1, 2020**, 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

REVISED: 03/19/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION 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
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E 000 Initial Comments

The facility is a single-story type V (111), built in 1969, with a basement containing a maintenance shop, storage area 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 Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is licensed for 60 beds and had a census of 41 on the date of the survey.

The following deficiencies were cited during the annual Emergency Preparedness Survey conducted on March 9, 2020. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The survey was conducted by:

Linda Chaney  
Health Facility Surveyor  
Facility Fire Safety & Construction

E 004  
SS=F Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)

The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.

The emergency preparedness program must include, but not be limited to, the following elements:

E 000

RECEIVED  
APR 03 2020  
FACILITY STANDARDS

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.

E004

**Resident Specific**

The Emergency Response Plan (ERP) was reviewed and updated on March 24, 2020.

**Other Residents**

The Emergency Response Plan (ERP) was reviewed and updated by Chief Executive Officer and Interdisciplinary Team on March 24, 2020. Updated policies and procedures were reviewed in QAPI and added to ERP.

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

*Andrew Schiller*

TITLE

Administrator/CEO 3/31/2020

(X8) DATE

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: 03/19/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  138048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/09/2020
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION 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 004	<p>Continued From page 1</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to demonstrate the Emergency Plan (EP) had been reviewed and updated annually. Failure to update the EP annually has the potential to provide information not relevant to the facility procedures and hinder staff emergency response and training during a disaster. This deficient practice affected 41 residents and staff on the date of the survey.</p> <p>Findings include:</p>	E 004	<p><b>Facility Systems</b> One on one training/education was provided to facility maintenance director. Re-education was provided by Chief Nursing Officer and Resource Maintenance Director to include, but not limited to, annual review of policies and procedures in ERP, review any updates during monthly QAPI meeting, and update review sheet placed in ERP binder. Staff Development Coordinator will monitor as necessary ensuring the need for staff education based on policy and procedure updates. The system has been amended to include oversight from Chief Nursing Office and IDT daily as needed.</p> <p><b>Monitor</b> The Chief Executive Officer and/or designees will audit compliance for updating ERP policies and procedures monthly for 3 months, then annually ensuring all updates to ERP are reviewed with IDT. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.</p> <p><b>Date of Compliance</b> April 10, 2020</p>	4/10/2020

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

PRINTED: 03/19/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/09/2020
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION 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 004	Continued From page 2 During review of the provided EP conducted on March 9, 2020, from approximately 1:00 PM - 4:30 PM, no documentation was provided showing an annual review had been conducted on the Emergency Plan since 2018.  Reference: 42 CFR 483.73 (a)	E 004		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(b)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  (2) Include strategies for addressing emergency events identified by the risk assessment.  *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.  *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be	E 006	Resident Specific The Hazard and Vulnerability Assessment (HVA) was updated on March 24, 2020, to include policies and procedures for Missing Resident and Emerging Infectious diseases.  Other Residents The HVA was updated on March 24, 2020, to include policies and procedures for Missing Resident and Emerging Infection diseases.	

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

PRINTED: 03/19/2020  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/09/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION OF CASCADIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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**E 006** Continued From page 3  
reviewed, and updated at least every 2 years. The plan must do the following:  
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.  
(2) Include strategies for addressing emergency events identified by the risk assessment.

\* [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:  
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.  
(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.  
This REQUIREMENT is not met as evidenced by:  
Based on record review and interview, it was determined the facility failed to conduct a facility-based and community-based risk assessment which included federally mandated hazards. Failure to include required hazards to the risk assessment has the potential to hinder staff response. This deficient practice affected 41 residents and staff on the date of the survey.

Findings include:  
During review of the provided Emergency Plan conducted on March 9, 2020, from approximately 1:00 PM - 4:30 PM, review of the provided

**E 006** Facility Systems  
One on one training/education was provided to facility maintenance director on March 23, 2020. Re-education was provided by Chief Nursing Officer and Resource Maintenance Director to include, but not limited to, annual review and update of HVA, ensure policy and/or procedure for high risk areas, and education of staff on new policies and procedures. Staff Development Coordinator will monitor as necessary ensuring the need for staff education based on policy and procedure updates and/or additions. The system has been amended to include oversight from Chief Nursing Office and IDT daily as needed.

**Monitor**  
The Chief Executive Officer and/or designee will audit compliance for updating HVA including addition/updates of policies and procedures monthly for 3 months, then annually ensuring all updates to HVA are reviewed with IDT. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.

**Date of Compliance**  
**April 13, 2020**

4/13/2020

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

PRINTED: 03/19/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION OF CASCADIA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
E 006	Continued From page 4 Hazard Vulnerability Assessment (HVA) revealed the facility had not included missing resident and emerging infectious diseases to their HVA as required by CMS. When asked, at approximately 4:00 PM, the Maintenance Supervisor stated the facility had a strategy for response for these hazards and was unaware they were not identified on the HVA.  Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 007 SS=D	EP Program Patient Population CFR(s): 483.73(a)(3)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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.**  *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC 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,	E 007	E007  Resident Specific On March 31, 2020, the facility resident profile, surge capacity and services capable of providing in the event of an emergency policies and procedures were updated and added to ERP manual.  Other Residents On March 31, 2020, the facility resident profile, surge capacity and services capable of providing in the event of an emergency policies and procedures were updated and added to ERP manual to include process for continuation of operations.		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION 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)	(X6) COMPLETION DATE
E 007	Continued From page 5 hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency plan that addressed the resident population, including persons at risk and the type of services the facility would be able to provide in an emergency. Failure to provide information on the resident population served within the facility, their unique vulnerabilities in the event of a disaster, and services the facility has the ability to provide in an emergency, could potentially hinder evacuation, continuation of resident care and a community integrated response during an emergency. This deficient practice affected 41 residents and staff on the date of the survey.  Findings include:  On March 9, 2020, from approximately 1:00 PM - 4:30 PM, review of the provided Emergency Plan (EP) revealed the resident population, including persons at risk was not addressed in the plan. Additionally, the facility had not identified the services they could provide in an emergency. When asked, the Maintenance Supervisor stated the facility was unaware of this requirement.  Reference: 42 CFR 483.73 (a) (3)  E 015 Subsistence Needs for Staff and Patients SS=F CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 007	<b>Facility Systems</b> On March 31, 2020, the facility resident profile, surge capacity and services capable of providing in the event of an emergency policies and procedures were updated and added to ERP manual. Services capable of providing in the event of an emergency policy and procedure were updated to include process for continued operations addressing all healthcare services. Staff Development Coordinator will monitor as necessary ensuring the need for staff education based on policy and procedure updates and/or additions. The system has been amended to include oversight from Chief Executive Officer and IDT as needed.  <b>Monitor</b> The Chief Executive Officer and/or designee will audit compliance for updating ERP including addition/updates of policies and procedures monthly for 3 months, then annually ensuring all updates are reviewed with IDT. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Chief Executive Officer will review all tools during IDT meetings.  <b>Date of Compliance</b>  April 13, 2020	A/13/2020

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
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NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION 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 015 : Continued From page 6  
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 every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

- (i) Food, water, medical and pharmaceutical supplies
- (ii) Alternate sources of energy to maintain the following:
  - (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
  - (B) Emergency lighting.
  - (C) Fire detection, extinguishing, and alarm systems.
  - (D) Sewage and waste disposal.

\*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.

(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

- (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
  - (A) Food, water, medical, and pharmaceutical supplies.
  - (B) Alternate sources of energy to maintain the following:
    - (1) Temperatures to protect patient

E 015 E015

**Resident Specific**  
On March 31, 2020, the ERP was updated with Emergency Food Services and Pharmaceutical Supply policies and procedures.

**Other Residents**  
On March 31, 2020, the ERP was updated with new policies and procedures including Emergency Food Services and Pharmaceutical Supplies.

**Facility Systems**  
On March 31, 2020, the Emergency Food Services and Pharmaceutical Supplies policies and procedures were updated and added to ERP manual. The Emergency Food Service and Pharmaceutical Supplies policy and procedure was updated to include process for continued operations addressing subsistence provisions for residents and staff as necessary. Staff Development Coordinator will monitor as necessary ensuring the need for staff education based on policy and procedure updates and/or additions. The system has been amended to include oversight from Chief Executive Officer and IDT daily as needed.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
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NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83544
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E 015 Continued From page 7  
health and safety and for the safe and sanitary storage of provisions.  
(2) Emergency lighting.  
(3) Fire detection, extinguishing, and alarm systems.  
(C) Sewage and waste disposal.  
This REQUIREMENT is not met as evidenced by:  
Based on record review and interview, the facility failed to provide an emergency plan which included subsistence provisions for residents and staff in the event of a disaster. Failure to provide subsistence necessities in the event of a disaster has the potential to limit the facility's ability to provide continuity of care in an emergency. This deficient practice affected 41 residents and staff on the date of the survey.

Findings include:

On March 9, 2020, from approximately 1:00 PM - 4:30 PM, review of the provided emergency plan for the facility revealed current policies did not include provisions for food and pharmaceutical supplies for residents and staff in the event of evacuation or shelter in place. When asked, at approximately 4:15 PM, the Maintenance Supervisor stated the Kitchen Manager had food stored and alternate menus to be used in the event of an emergency. He further stated there was also a plan in place for pharmaceutical supplies and was unaware these plans were not in the emergency plan.

E 015  
**Monitor**  
The Chief Executive Officer and/or designee will audit compliance for Emergency Food Services and Pharmaceutical Supply policies and procedures monthly for 3 months, then annually ensuring all updates to ERP updates are reviewed with IDT. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.

Date of Compliance  
April 13, 2020

4/13/2020

E 034 Reference:  
42 CFR 483.73 (b) (1)  
Information on Occupancy/Needs

E 034

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION 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 SS=D	<p>Continued From page 8 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 every 2 years (annually for LTC).] 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(c):] (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 41 residents housed on the date of the survey.</p>	E 034	<p>E034</p> <p><b>Resident Specific</b> On March 31, 2020, the Emergency Surge Capacity Plan was updated to include process for communicating with emergency management officials.</p> <p><b>Other Residents</b> On March 31, 2020, the Emergency Surge Capacity Plan was updated to include process for communicating with emergency management officials.</p> <p><b>Facility Systems</b> On March 31, 2020, the Emergency Surge Capacity Policy and Procedure was updated and added to ERP manual. The Emergency Capacity Policy and Procedure to include process of communicating with emergency management officials in terms of the facility's needs and capacity. Staff Development Coordinator will monitor as necessary ensuring the need for staff education based on policy and procedure updates and/or additions. The system has been amended to include oversight from Chief Nursing Office and IDT daily as needed.</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/09/2020
NAME OF PROVIDER OR SUPPLIER  CLEARWATER HEALTH & REHABILITATION OF CASCADIA		STREET ADDRESS, CITY, STATE, ZIP CODE 1204 SHRIVER ROAD OROFINO, ID 83844	

(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 034

Continued From page 9

Findings include:

On March 9, 2020, from approximately 1:00 PM - 4:30 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)

E 034

**Monitor**  
The Chief Executive Officer and/or designee will audit compliance for Emergency Surge Capacity policies and procedures monthly for 3 months, then annually ensuring all updates to ERP updates are reviewed with IDT. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Chief Executive Officer will review all tools during clinical meetings.

**Date of Compliance**  
April 13, 2020

4/13/2020