



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

April 3, 2019

Thomas 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 **March 27, 2019**, 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

Thomas Welker, Administrator  
April 3, 2019  
Page 2 of 4

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 **April 16, 2019**. Failure to submit an acceptable PoC by **April 16, 2019**, may result in the imposition of civil monetary penalties by **May 8, 2019**.

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 1, 2019**, (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 **June 25, 2019**. A change in the seriousness of the deficiencies on **May 11, 2019**, may result in a change in the remedy.

Thomas Welker, Administrator  
April 3, 2019  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2019**, includes the following:

Denial of payment for new admissions effective **June 27, 2019**.  
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 27, 2019**, 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 27, 2019**, 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:

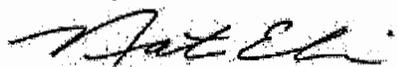
BFS Letters (06/30/11)

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

This request must be received by **April 16, 2019**. If your request for informal dispute resolution is received after **April 16, 2019**, 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

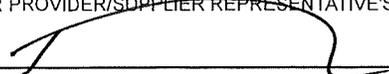
Printed: 04/02/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>CLEARWATER OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>
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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><b>INITIAL COMMENTS</b></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 42 on the date of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on March 27, 2019. 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	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Clearwater Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	
K 324 SS=E	<p><b>COOKING FACILITIES</b> CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> <li>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</li> <li>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</li> <li>* cooking facilities in smoke compartments with</li> </ul>	K 324	<p><b>SPECIFIC ISSUE:</b> The facility failed to provide documentation of required semi-annual inspections of suppression system equipment for cooking ventilation systems</p> <p><b>OTHER RESIDENTS:</b> All residents are potentially affected.</p>	<p><b>RECEIVED</b> <b>APR 22 2019</b> <b>FACILITY STANDARDS</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>4/16/19</b>
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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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K 324	<p>Continued From page 1</p> <p>30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that cooking facilities were maintained in accordance with NFPA 96. Failure to ensure semi-annual inspections of suppression system equipment for cooking ventilation systems, has the potential to hinder system response and increase the risk of fires associated with grease-laden vapors. This deficient practice affected staff and vendors of the main Kitchen and those residents using the main dining hall on the date of the survey.</p> <p>Findings include:</p> <p>During review of inspection and maintenance documentation conducted on 3/27/19 from 8:30 - 10:30 AM, records indicated only 1 of 2 semi-annual inspections for the Kitchen hood fire suppression were performed within the previous twelve months.</p> <p>Asked about the missing documentation, the Plant Operations Manager stated that he was not aware of the missed inspection prior to the date of the survey.</p>	K 324	<p><b>3. SYSTEMIC CHANGES:</b> The facility Maintenance Director will be educated by Executive Director or designee on or before 4/16/19 to ensure that semi-annual inspections of suppression system equipment for cooking ventilation systems are scheduled and happen.</p> <p><b>4. MONITOR:</b> Executive Director or designee will audit that inspections of suppression system equipment for cooking ventilation systems are semi-annual and results reported to QAPI.</p> <p><b>5. Date of Compliance:</b> 4/16/19</p>

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K 324	Continued From page 2 Actual NFPA standard:  NFPA 96  Chapter 11 Procedures for the Use, Inspection, Testing, and Maintenance of Equipment  11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems. 11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.	K 324	
K 353 SS=D	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	K 353	K 353  1. <b>SPECIFIC ISSUE:</b> Facility failed to ensure fire suppression system sprinkler pendants were maintained in accordance with NFPA 25. 2. <b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.  3. <b>SYSTEMIC CHANGES:</b> All sprinkler pendants were visually inspected on 4/15 and those needing replacement will be replaced on or before 6/15/19 by licensed contractor.

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K 353	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression systems has the potential to hinder system response during a fire event. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/27/19 from 1:00 - 3:00 PM, observation of installed fire suppression system sprinkler pendants revealed the following: Three (3) corroded sprinklers in the main Kitchen.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 353	<p>4. <b>MONITOR:</b> Executive Director or designee will ensure annual inspection and maintenance is completed. Results of audit will be reviewed in QAPI to ensure systems being followed. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b> 6/15/19</p>
K 712	Fire Drills	K 712	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2019</b>
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K 712 SS=F	<p>Continued From page 4 CFR(s): NFPA 101</p> <p><b>Fire Drills</b> Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted in accordance with NFPA 101. Failure to perform fire drills quarterly for each shift has the potential to hinder staff response in the event of a fire. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p><b>Findings include:</b></p> <p>During review of provided facility maintenance records conducted on 3/27/19 from 8:30 - 10:30 AM, records revealed the facility had missed the fire drills for the noc shift of the second quarter and the day shift of the fourth quarter.</p> <p>Interview of the Plant Operations Manager revealed he was aware the facility had missed fire drills.</p> <p>Actual NFPA standard:</p> <p>19.7* Operating Features. 19.7.1 Evacuation and Relocation Plan and Fire</p>	K 712	<p><b>K 712</b></p> <ol style="list-style-type: none"> <li><b>SPECIFIC ISSUE:</b> The facility failed to provide documentation of required fire drills, one per shift per quarter.</li> <li><b>OTHER RESIDENTS:</b> All residents are potentially affected.</li> <li><b>SYSTEMIC CHANGES:</b> The facility Maintenance Director will be educated by Executive Director or designee on or before 4/16/19 to ensure that fire drills be conducted quarterly.</li> <li><b>MONITOR:</b> Executive Director or designee will audit that fire drills are <del>being conducted per NFPA</del> quarterly and results reported monthly QAPI meeting for 3 months.</li> <li><b>Date of Compliance:</b> 4/16/19</li> </ol>

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

Printed: 04/02/2019  
FORM APPROVED  
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K 712	Continued From page 5 Drills.  19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712		
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April 3, 2019

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

Provider #: 135048

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

Dear Mr. Welker:

On **March 27, 2019**, an Emergency Preparedness 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 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.

Thomas Welker, Administrator

April 3, 2019

Page 2 of 4

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 16, 2019**. Failure to submit an acceptable PoC by **April 16, 2019**, may result in the imposition of civil monetary penalties by **May 8, 2019**.

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;
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- 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 1, 2019**, (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 18, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 1, 2019**, includes the following:

Denial of payment for new admissions effective **June 27, 2019**.  
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.

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Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 27, 2019**, 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 27, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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BFS Letters (06/30/11)

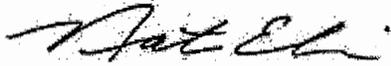
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April 3, 2019  
Page 4 of 4

This request must be received by **April 16, 2019**. If your request for informal dispute resolution is received after **April 16, 2019**, 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

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>03/27/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>CLEARWATER OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD OROFINO, ID 83544</b>
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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

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 42 on the date of the survey.

The following deficiencies were cited during the emergency preparedness survey conducted on March 27, 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 000

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

E 030 Names and Contact Information  
SS=D CFR(s): 483.73(c)(1)

[(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:]

(1) Names and contact information for the following:

- (i) Staff.
- (ii) Entities providing services under arrangement.
- (iii) Patients' physicians
- (iv) Other [facilities].

E 030

E 030

1. **SPECIFIC ISSUE:**  
Clearwater Health and Rehab of Cascadia's Emergency Management Plan was reviewed and updated on or before 4/16 by the Administrator to include updated and site-specific contact list that includes the missing volunteer contact.

**RECEIVED**

**APR 22 2019**

**FACILITY STANDARDS**

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

 **Executive Director** 4/16/19

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 030	<p>Continued From page 1</p> <p>(v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Next of kin, guardian, or custodian.</p> <p>(iv) Other RNHCIs.</p> <p>(v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Hospice employees.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p>	E 030	<p><b>2. OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.</p> <hr/> <p><b>3. SYSTEMIC CHANGES:</b> Staff educated on or before 4/16 by Executive Director and/or designee regarding facility's updated contact list.</p> <p><b>4. MONITOR:</b> Upon completion of initial education with staff, Executive Director and/or designee will</p> <p>monitor the effectiveness of the emergency management plan by review of the contact list to validate numbers are current. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p><b>5. Date of Compliance:</b> 4/16/19</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 04/02/2019  
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>03/27/2019</b>
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E 030	<p>Continued From page 2</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 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 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/27/19 from 8:30 - 10:30 AM, review of provided emergency plan, policies and procedures, failed to reveal a communication plan that included contact information for volunteers.</p> <p>Reference: 42 CFR 483.73 (c) (1)</p>	E 030	
E 031 SS=D	<p>Emergency Officials Contact Information CFR(s): 483.73(c)(2)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws</p>	E 031	<p>E 031</p> <p><b>1. SPECIFIC ISSUE:</b> Clearwater Health and Rehabilitation of Cascadia's</p>

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E 031	<p>Continued From page 3 and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(2) Contact information for the following:</p> <p>(i) Federal, State, tribal, regional, and local emergency preparedness staff.</p> <p>(ii) Other sources of assistance.</p> <p>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following:</p> <p>(i) Federal, State, tribal, regional, or local emergency preparedness staff.</p> <p>(ii) The State Licensing and Certification Agency.</p> <p>(iii) The Office of the State Long-Term Care Ombudsman.</p> <p>(iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:</p> <p>(i) Federal, State, tribal, regional, and local emergency preparedness staff.</p> <p>(ii) Other sources of assistance.</p> <p>(iii) The State Licensing and Certification Agency.</p> <p>(iv) The State Protection and Advocacy Agency.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the communication plan of the EOP. Failure to provide contact information for the State Licensing and Certification Agency and State Ombudsman has the potential to hinder facility response and continuity of care for the 42 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p>	E 031	<p>Emergency Management Plan was reviewed and updated on or before 4/16 by facility administrator to include current contact information for emergency management officials and other resources of assistance. Specifically state licensing and certification agency and ombudsman contact information.</p> <p><b>2. OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.</p> <p><b>3. SYSTEMIC CHANGES:</b> Staff educated on or before 4/16 by Executive Director and/or designee regarding facility's updated emergency officials contact information.</p> <p><b>4. MONITOR:</b> Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through a review of emergency officials contact information list to validate numbers are current. Outcomes will be</p>

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E 031	Continued From page 4 On 3/27/19 from 8:30 - 10:30 AM, review of the provided EOP, failed to demonstrate the phone numbers for both the State Licensing and Certification agency and the State Long-Term Care Ombudsman were included in the contact information.  Reference: 42 CFR 483.73 (c) (2)	E 031	provided to QAPI committee monthly for the next 3 months- Additional education will be provided as necessary. Plan to be updated as indicated.  5. <b>Date of Compliance:</b> 4/16	
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d)  (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.  *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).  *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency	E 036	E 036  1. <b>SPECIFIC ISSUE:</b> Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 4/16 by facility administrator to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually and will include documentation and staff competency completion. See also E 037.  2. <b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.	

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E 036	<p>Continued From page 5</p> <p>preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a program which tests staff knowledge of topics covered in the EOP, has the potential to hinder staff response during a disaster. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/27/18 from 8:30 - 10:30 AM, review of the provided EOP, along with associated inservices, found no documentation demonstrating the facility had a current testing program for staff based on training's associated with EOP contents.</p> <p>Interview of the Administrator conducted on 3/27/19 from 1:30 - 3:00 PM, established the facility had yet to implement a testing process in conjunction with EOP contents.</p> <p>Reference: 42 CFR 483.73 (d)</p>	E 036	<p><b>3. SYSTEMIC CHANGES:</b></p> <p>Staff educated on or before 4/16 by Executive Director and/or designee to validate understanding of current emergency preparedness plan. Additional education to be provided as indicated. Maintenance Director educated on or before 4/16 by Executive Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p><b>4. MONITOR:</b></p> <p>Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through staff interview and disaster drills. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p><b>5. Date of Compliance:</b> 4/16</p>
E 037 SS=D	<p>EP Training Program CFR(s): 483.73(d)(1)</p> <p>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices,</p>	E 037	

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E 037	<p>Continued From page 6 and dialysis facilities] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with</p>	E 037	<p>E 037</p> <p>1. <b>SPECIFIC ISSUE:</b> Clearwater Health and Rehabilitation of Cascadia's Emergency Management Plan was reviewed and updated on or before 4/16 by the facility administrator to include updated and site-specific policy regarding training and testing of employees for Emergency Management plan upon orientation and annually and will include documentation and staff competency completion. See also E 036.</p> <p>2. <b>OTHER RESIDENTS:</b> All residents are potentially affected by deficient practice.</p> <p>3. <b>SYSTEMIC CHANGES:</b> Staff educated on or before 4/16 by Executive Director and/or designee to validate understanding of current emergency preparedness plan. Additional education to be provided as indicated. Maintenance director educated on or before 4/16 by Executive</p>

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E 037	<p>Continued From page 7 special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p>	E 037	<p>Director to validate training and testing program is available and offered upon orientation and annually to employees (annual training calendar to include updates).</p> <p>4. <b>MONITOR:</b> Upon completion of initial education with staff, Executive Director and/or designee will monitor the effectiveness of the emergency management through staff interview and disaster drills. Outcomes will be provided to QAPI committee monthly for the next 3 months. Additional education will be provided as necessary. Plan to be updated as indicated.</p> <p>5. <b>Date of Compliance:</b> 4/16</p>

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E 037. Continued From page 8

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

\*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

\*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least

E 037

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E 037	<p>Continued From page 9 annually. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide an emergency prep training program. Lack of a training program on the EOP for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 42 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 3/27/18 from 8:30 - 10:30 AM, review of provided EOP and available facility inservices, revealed no substantiating documentation demonstrating the facility had a training program for staff based on the contents of the plan which was conducted both during orientation and on a recurring, annual basis.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 037	