

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>06/04/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION OI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD</b> <b>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) COMPLETE DATE
{C 000}	<p><b>INITIAL COMMENTS</b></p> <p>On June 4, 2020, an off-site follow-up survey was conducted to verify correction of deficiencies noted at the survey of March 9, 2020. Clearwater Health &amp; Rehabilitation of Cascadia was found to be in substantial compliance with 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 as of March 13, 2020.</p> <p>The survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	{C 000}		

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

PRINTED: 06/05/2020  
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>R</b> <b>06/04/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLEARWATER HEALTH &amp; REHABILITATION OF CASCADIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1204 SHRIVER ROAD</b> <b>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}	<p>Initial Comments</p> <p>On June 4, 2020, an off-site follow-up survey was conducted to verify correction of deficiencies noted at the survey of March 9, 2020. Clearwater Health &amp; Rehabilitation of Cascadia was found to be in substantial compliance with Emergency Preparedness Rule established by CMS as of April 13, 2020.</p> <p>The surveyor completing this survey was:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire/Safety and Construction</p>	{E 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) 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.