STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135048	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Health & Rehabilitation of Cascadia	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on staff interview, record review, and review of the State Survey Agency's Long-Term Care Reporting Portal, it was determined the facility failed to ensure residents were free from misappropriation of a controlled pain medication. This was true for 1 of 1 resident (Resident #44) reviewed for misappropriation of resident property. This failed practice created the potential for all facility residents to experience uncontrolled pain if misappropriation of their controlled pain medications went undetected, or if their controlled pain medication was not administered. Findings include: The facility's Drug Diversion policy, revised on 9/22/22, documented facility management shall investigate and make every reasonable effort to reconcile reported controlled substance discrepancies. The policy documented investigations would include interviews, medical record review, observation of facility practices, identify negative outcomes with residents, and evaluate if the loss is associated with specific individuals. A facility reported incident, dated 10/26/24, included an investigation summary which documented LPN #1 had removed 3 tablets of Oxycodone (an opioid pain medication) 5 milligrams each and placed them in a medication cup. LPN #1 then replaced the 3 tablets of Oxycodone with unidentified tablets. She then proceeded to ask LPN #2 who was coming on shift to administer the medication to the resident when the resident returned to the facility. Upon the residents return, LPN #2 was going to administer the medications in the cup when she noticed the tablets did not match the description of the opioid in the pharmaceutical packaging. LPN #2 requested a second opinion from a fell ow licensed nurse who agreed the medication left in the cup did not match the medication in the packaging. LPN #2 contacted the supervisor who confirmed the 3 tablets left in the medication cup with the resident's initials did not match the medication that was in the pharmaceutical packaging and notified the DON. The investigation summary documented 2 staff interviews indicating the medication left in the medication cup by LPN #1 did not match the description of the medication in the residents pharmaceutical packaging. The investigation summary documented the narcotic log, and the MAR were compared, and no discrepancies were identified. The facility medication carts were inventoried and found 1 resident to be missing 3 tablets of Oxycodone 5 mg. (continued on next page)

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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 was terminated on 11/1/24 based on the results of the investigation. The facility notified the Idaho State Board of Nursing and the [NAME] Sheriff's Office of the alleged medication diversion. The nursing staff were provided training regarding the immediate reporting of anomalies in the narcotic log and medication administration. On 4/16/25 at 3:22 PM, during an interview with the DON and Administrator, the DON stated the investigation was determined to confirm misappropriation of resident property. There was sufficient evidence the facility corrected the non-compliance as of 11/1/24 as there were no further misappropriation reported after this date. At the time of the survey, the facility was in substantial compliance and therefore does not require a plan of correction.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure a residents Minimum Data Set assessment included correct information. This was true for 1 of 12 residents (Resident #29) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not monitored due to inaccurate assessments. Findings include: The RAI Manual, revised 10/1/24, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR Level II screening determined a resident had a serious mental illness and/or intellectual disability, or related condition. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder-depressive type, and generalized anxiety disorder. Resident #29's medical record included documentation of a PASRR Level I screening, dated 9/25/24 that identified he had a diagnosis of major mental illnesses, schizophrenia spectrum disorder and depressive disorder. Resident #29's medical record included documentation of a PASRR Level II screening, dated 9/27/24 that identified his major mental illness diagnoses and indicated he may benefit from specialized mental health services. Resident #29's medical record included documentation a PASRR MI (Mental Illness) Evaluation was conducted on 9/30/24. Resident #29's Admission MDS Assessment, dated 10/6/24, documented question A1500, PASRR Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability, or a related condition? The answer for this question was documented as no. On 4/16/25 at 4:17 PM, the MDS Coordinator stated she misinterpreted the question and answered A1500 no when it should have said yes.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on record review, and staff interview, it was determined the facility failed to ensure residents were offered non-pharmacological interventions while receiving opioid pain medication. This was true for 1 of 5 residents (Resident #7) reviewed for unnecessary medication. This failure created the potential for residents to experience adverse outcomes such as increased pain due to lack of offering non-pharmacological interventions. Findings include: Resident #7 was readmitted to the facility on [DATE], following a hip fracture with multiple diagnosis including history of falls, and history of osteoporosis with pathological fractures. Resident #7's care plan, revised on 4/8/25, documented Resident #7 was to use non-pharmacological interventions such as repositioning, reduced stimuli, warm towel, distraction, music, and massage to help manage their pain. A physician order, dated 10/21/19, documented non-pharmacological interventions were to be attempted prior to PRN pain medication administration. The order also documented this order was discontinued on 4/7/25. A physician order, dated 4/7/25, documented Hydrocodone-Acetaminophen 7.5-325 milligrams. Give 1 tablet by mouth every 8 hours as needed for a pain scale of 8 to 10 or severe pain. Resident #7's MAR documented the following as needed pain medication administrations: - 4/8/25 at 6:09 AM - 4/8/25 at 3:19 PM - 4/9/25 at 7:11 AM - 4/11/25 at 12:15 AM - 4/12/25 at 5:43 PM - 4/13/25 at 2:54 PM - 4/14/25 at 11:20 AM Resident #7's record did not contain documentation of non-pharmacological interventions attempted prior to pain medication administration. On 4/16/25 at 9:03 AM, the DON stated the record did not include documentation of non-pharmacological interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on observation and staff interview, it was determined the facility failed to ensure medications available to residents were dated after opened. This was true for 1 of 2 medication carts reviewed for storage and labeling. This failure created the potential for residents to receive expired medication with decreased efficacy. Findings include: On [DATE] at 9:15 AM, during inspection of a medication cart, one prescription eye drop labeled Latanoprost 0.005% (a medication used to reduce intraocular pressure) documented on the packaging discard after 42 days. However, the medication did not document the date the medication was opened. On [DATE] at 9:22 AM, CMA #1 stated, the eye drops did not have an open date, and she could not tell when it was opened.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48401 Based on observation, Food Drug Administration (FDA) Food Code, and staff interview, it was determined the facility failed to ensure kitchen equipment was maintained. This deficiency had the potential to affect the 35 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes due to contaminated food services equipment. Findings include: The FDA Code Section 4-602.12 Cooking and Baking Equipment documented: Food-contact surfaces of cooking equipment must be cleaned to prevent encrustation's that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use. On 4/17/25 at 8:03 AM, an aluminum baking sheet was observed being removed from the oven. The baking sheet was observed to have a dark film coating the pan and brown and black encrustation's with the hashbrowns being prepared. On 4/17/25 9:13 AM, the CDM stated the pans should be clean and should not have stains on them.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48402 Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure residents received physical therapy services as ordered by their physician. This was true for 1 of 3 residents (Resident #12) whose records were reviewed for rehabilitative services. This failure created the potential for Resident #12, who required physical therapy services, to experience decline in their physical functioning and ability to perform activities of daily living (ADL's) when these services were not provided consistently. Findings include: Resident #12 was readmitted to the facility on [DATE], with multiple diagnoses including muscle weakness, and gait and mobility abnormalities. On 4/14/25 at 4:46 PM, Resident #12 stated she did not have therapy services any more. A physician order, dated 3/7/25, documented Resident #12 was to receive physical therapy evaluation and treatment. Resident #12's care plan, dated 2/17/25, documented physical therapy as ordered. A Physical Therapy Evaluation and Treatment Plan, dated 3/28/25, documented Resident #12 was to have physical therapy 5 times a week for 8 weeks. On review of Resident #12's record, 5 out of 10 physical therapy sessions were provided. On 4/16/25 at 6:13 PM, the Rehabilitation Director stated Resident #12 did not receive all therapy sessions as per her physical therapy evaluation. She also stated Resident #12 should have been evaluated for therapy for 3 times a week based on her insurance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48402 Based on observation and staff interview, it was determined the facility failed to ensure appropriate infection control measures were maintained when handling an insulin pen. This was true for 1 of 1 (Resident #20) who was observed for insulin administration. This failed practice increased the potential for cross-contamination. Findings include: On 4/15/25 at 9:00 AM, during an insulin administration observation, RN #1 unlocked the safe box and removed the insulin pen in the medication room. She proceeded to verify the pharmacy label and the pen label. RN#1 sanitized the pen and applied a new needle. She then primed the insulin pen and began to set the correct units of insulin to administer on the insulin pen. RN #1 walked out of the med room and proceeded to the nurses' station to verify the physician order and the number of units to administer. After verifying the order and the amount to administer she proceeded to walk into the resident's room and placed the uncapped insulin pen on the sink ledge while she performed hand hygiene. RN #1 then walked over to the resident's bed, provided privacy and verified date of birth. She explained she would be administering insulin and proceeded with the administration. RN#1 activated the automatic needle cover on the pen needle, then walked over to perform hand hygiene at the sink and placed the uncapped insulin pen in her under arm to hold it while she washed her hands. On 4/15/25 at 9:14 AM, RN #1 stated the ledge of the sink was a sanitary surface to put the insulin pen because the house keepers clean it every day. She also stated her under arm was not a safe or sanitary place to put the pen.