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	06/26/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and review of the U.S. Food and Drug Administration 2022 Food Code, it was determined the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This was true for 1 of 2 garbage cans observed in the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. Findings include:U.S Food and Drug Administration 2022 Food Code, 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled.On 6/22/26 at 11:52 AM, a large gray garbage can on wheels was observed halfway under the dirty dish counter without a lid.On 6/22/26 at 3:01 PM, the Kitchen Manager stated she didn't know the garbage can needed to be covered and further stated she was under the impression it was okay to be stored under the counter without a lid.

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 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. Based on observation, review of the FDA Food Code, and staff interviews, it was determined the facility failed to ensure the kitchen equipment, ice machines, and cutting surfaces were maintained, clean, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 36 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: 1.The FDA Food Code Section 6-501.14 (A) documented cleaning ventilation systems intake and exhaust air ducts shall be cleaned so they are not a source of contamination by dust, dirt, and other materials.On 6/22/26 at 12:00 PM, the internal walk-in refrigerator fans were observed with a thick gray and fuzzy appearing build-up.On 6/22/26 at 3:05 PM, the Kitchen Manager stated maintenance cleans the fans in the refrigerator and confirmed the refrigerator fans were not clean. 2.The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded.On 6/22/26 at 12:02 PM, a closed storage tub dated 6/10/26, with a use by date of 6/17/26, and was labeled ckn [chicken] soup was observed on the top right-hand shelf near the back of the walk-in refrigerator.On 6/22/26 at 3:03 PM, when asked about expired food, the Kitchen Manager confirmed the soup should have been discarded on 6/17/26 and should not have been in the refrigerator. 3. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned in equipment such as ice bins and enclosed components of equipment such as ice makers, at a frequency specified by the manufacturer, or absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.The SOM Appendix PP revised 7/23/25, documented equipment can become contaminated in various ways including improper sanitation.On 6/22/26 at 3:09 PM, the ice machine was observed to have orange colored, rust-like round spots on the interior hood of the ice machine.On 6/22/26 at 3:11 PM, the Kitchen Manager stated It's icky and there were spots of discoloration in the ice machine and further stated maintenance was responsible for cleaning the ice machines. 4. The FDA Food Code Section 4-501.12 Cutting Surfaces documented cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms (organisms that cause diseases like bacteria, viruses, and fungi) transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.On 6/24/26 at 1:35 PM, white cutting boards were observed to be stored under the steam table and were scratched and scored with residue and debris.On 6/24/26 at 1:38 PM, when asked about the cutting boards, the Dietary Manager confirmed the white cutting boards had debris on them but stated the kitchen staff just received new colored cutting boards and were no longer using the white cutting boards. When asked about the new cutting boards, the Kitchen Manager stated the new colored cutting boards were received about 30 days ago. When asked when the old cutting boards should have been discarded, the Kitchen Manager stated she should have discarded the old white cutting boards when the new cutting boards arrived.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the State Operations Manual (SOM), record review, and staff interview, it was determined the facility failed to ensure residents exercised their right to formulate an Advanced Directive. This was true for 1 of 5 residents (Resident #5) whose records were reviewed. This failed practice created the potential for an adverse outcome if the residents' wishes were not followed. Findings include:The SOM, Appendix PP, revised 7/23/25, defined an Advance Directive is a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Physician Orders for Life-sustaining Treatment (or POLST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patient's treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advanced directive.Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including dementia with agitation, stroke (occurs when a blood vessel in the brain becomes blocked or severely narrowed), and pulmonary embolism (PE- Occurs when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung).A Care Conference Review Comprehensive dated 4/3/26 documented, Resident #5 had an advanced directive.Resident #5's advanced directive was unable to be located in his medical record.On 6/26/26 at 9:48 AM, a request for a copy of Resident #5's advanced directive was made.On 6/26/26 at 11:19 AM, the CEO confirmed Resident #5 did not have an advanced directive on file.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview it was determined the facility failed to provide a homelike environment when resident's walls were left unrepaired and baseboard heater coils were left exposed. This was true for 1 of 12 residents (Resident #13) whose rooms were observed. This created the potential for psychosocial harm and embarrassment if residents did not have a homelike environment if their walls and baseboard heaters were not repaired and did not have consistent wall paint. Findings include: The facility's Homelike Environment policy, revised on 9/17/25, documented the facility supports a resident's right to a safe, clean, comfortable, and homelike environment to promote dignity, independence, and quality of life. Interior and exterior surfaces necessary for the health, safety, and comfort of the residents shall be kept at the highest practicable level, clean and in good repair.Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including dementia, post-traumatic stress disorder (PTSD- a psychiatric or mental health condition that can develop in individuals who have experienced or witnessed a life-threatening, shocking, or terrifying traumatic event), traumatic brain injury (TBI-brain damage caused by an external physical force), anxiety, and major depressive disorder.On 6/22/26 at 2:31 PM, it was observed throughout Resident #13's room, large chipped grayish-blue paint exposing jagged, round, and vertical white patches. Large horizontal white and black scratches were observed near the lower portion of the bathroom wall and three large oblong, jagged areas exposing both white and brown patches were noted to the left side of the sink wall. A black baseboard heater was noted below the window exposing gray/silver-colored coils.On 6/25/26 at 3:44 PM, the CEO was asked about the maintenance process. The CEO stated if a resident discharges from the facility and another resident is admitting, the maintenance department would be notified in their stand-up meetings to make sure any holes were patched, and walls were painted.On 6/25/26 at 3:52 PM, the CEO accompanied the Surveyor to Resident #13's room. The CEO described Resident #13's room as having a lot of chipped paint and the baseboard heater cover needed to be moved over. The CEO confirmed the heating coils for the baseboard heater were exposed and stated the condition of Resident #13's room was not a homelike environment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure an allegation of resident abuse was reported to the State Survey Agency Portal within 2 - 24 hours. This was true for 1 of 3 residents (Resident #6) reviewed for abuse and neglect. This failure created the potential for harm if allegations were not acted upon in a timely manner and the resident abuse continued. Findings include:The State Operation Manual Appendix PP, issued 7/23/25, documented the reporting requirements of alleged abuse to the State Agency as follows:1.All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property.2.The results of all investigations of the alleged violations.3. Immediately but not later than 2 hours - if the alleged violation involves abuse or results in serious bodily injury.4.Not later than 24 hours - if the alleged violations involve neglect, exploitation, mistreatment, or misappropriation of resident property, and does not result in serious bodily injury.Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including dementia with psychotic disturbance, difficulty walking and heart disease.A Comprehensive MDS assessment dated [DATE], documented Resident #6 was severely cognitively impaired.On 6/24/26 at 2:12 PM, when asked if he was informed of an abuse allegation of a resident, the Social Services stated he received an email from the Ombudsman regarding a resident [Resident #6] and a staff member. The Social Services stated he called the CEO and was told by the CEO she would take care of it.On 6/23/2026 at 3:22 PM, the Surveyor spoke to the Travel Nurse over the phone. The Travel Nurse stated he was on a night shift when he saw CNA #1 push Resident #6's both legs to her chest. Resident #6 was flailing her arms and stated to CNA #1 You are hurting me. The Travel Nurse stated CNA #1 slapped Resident #6's arms and reported it to the nurse on call.On 6/24/26 at 2:32 PM, the CEO with the Clinical Resource Nurse present, stated she was informed by the ACNO regarding Resident #6 was slapped by CNA #1 as reported by the Travel Nurse. The CEO stated she interviewed CNA #1. The CNA stated was trying to put Resident #6 to bed. Resident #6 was flailing her arms and CNA #1 put her arm up to avoid herself from being hit by Resident #6. The CEO stated there was another CNA in the room attending to another resident who reported the same thing. The CEO stated she interviewed the Travel Nurse and asked what he saw. The CEO stated the Travel Nurse reported he saw CNA #1 putting her arm to Resident #6, when asked to explain further what he saw. The CEO stated the Travel Nurse stated there was so much happening. The CEO stated the Travel Nurse was unable to provide specific information to clarify what he saw. When asked if the incident was reported to the State Portal, the CEO stated she did not report the incident to the State Portal. The Clinical Resource Nurse stated It was very vague. There was no true allegation of abuse. On 6/24/26 at 3:30 PM, the MDS Nurse with the ACNO present, stated she received a call from the Travel Nurse (MDS Nurse unable to recall the date of the call) that a CNA slapped Resident #6. The MDS Nurse stated she called the ACNO who then called the CEO. The ACNO stated she and the CEO went to the facility in the morning and interviewed the CNA.The facility's investigation report dated 4/13/26, documented the CEO spoke to the CRN about the situation. It was determined it was not potential abuse, However conducted abuse investigation and education with residents and staff. The Clinical Resource Nurse educated CEO that any time abuse is alleged it must be reported even if ruled out in the first 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the SOM, and staff interview, it was determined the facility failed to ensure an allegation of abuse was investigated thoroughly for 1 of 3 residents (Resident #6) reviewed for abuse and neglect. This failure created the potential for residents to be subjected to ongoing abuse and risk of physical and psychosocial harm. Findings include:The SOM Appendix PP, issued 7/23/25, documented the facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment:1.Thoroughly investigate the alleged violation.2.Prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress.3.Take appropriate action, as a result of the investigation.Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including dementia with psychotic disturbance, difficulty walking and heart disease.A Comprehensive MDS assessment dated [DATE], documented Resident #6 was severely cognitively impaired.On 6/23/26 at 3:22 PM, the Surveyor spoke to the Travel Nurse over the phone. The Travel Nurse stated he was on a night shift when he saw CNA #1 push Resident 6's both legs to her chest. Resident #6 was flailing her arms and stated to CNA #1 You are hurting me. The Travel Nurse stated CNA #1 slapped Resident #6's arms and reported it to the nurse on call.On 6/24/26 at 2:12 PM, when asked if he was informed of an abuse allegation of a resident, the Social Services stated he received an email from the Ombudsman regarding a resident [Resident #6] and a staff member. The Social Services stated he called the CEO and was told by the CEO she would take care of it.On 6/24/26 at 2:32 PM, the CEO provided a copy of an investigation of Resident #6 alleged abuse by CNA #1. It documented the CNA #1; Travel Nurse and another CNA were interviewed regarding the alleged abuse to Resident #6. The investigation report documented that the Travel Nurse was standing in the doorway and watched CNA #1 putting her hand on the resident. When asked to clarify further the Travel Nurse was unable to provide more information. The report documented Resident #6 was having difficult time going to bed and was flailing her arms. CNA #1 was observed by another staff putting her hands up to block Resident #6 from hitting her. The report also documented that another CNA was called and confirmed Resident #6 was slightly agitated and was flailing her arms and legs.On 6/24/26 at 2:32 PM, the CEO stated when investigating an abuse allegation, she would typically get a written report from all the witnesses and make sure to assess the resident. The CEO stated she interviewed the CNA over the phone. The CEO stated the Travel Nurse was unable to provide specific information to clarify what he saw. When asked if the alleged abuse of Resident #6 was thoroughly investigated, the CEO stated Yes.The investigation report did not include interviews with another resident who were under the care of CNA #1, interviews of other staff who had worked with CNA #1, or an assessment of Resident #6 after the incident.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews, it was determined that the facility failed to provide hospital transfer documents for 2 of 3 residents (#8 and #42) reviewed for hospitalization. This deficient practice created the potential for residents to experience harm if they were not treated in a timely manner due to lack of information. Findings include:The facility's Discharge or Transfer policy revised 8/30/25, documented that if a resident was being transferred and return was expected, the following information should be conveyed to the receiving provider:1. Contact information of the practitioner who was responsible for the care of the resident;2. Resident representative information, including contact information;3. Advance directive information;4. Special instructions and/or precautions for ongoing care, as appropriate such as:a. Treatments and devices (oxygen, implants, IVs, tubes/catheters).b. Transmission-based precautions such as contact, droplet, or airborne;c. Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; 5. The resident's comprehensive care plan goals;6. All other information necessary to meet the resident's needs, which includes, but may not be limited to:a. Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;b. Diagnoses and allergies;c. Medications (including when it was last received);d. Most recent relevant labs, other diagnostic tests, and recent immunizations. The policy also documented, Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements. For residents being discharged (return not expected), the facility should convey all information listed above.The facility's Communication for Emergent Discharge/Transfer to Acute form, documented The marked boxes and clarifying information noted below is evidence that the information has been exchanged with the facility to which the resident is transferred, as well as to the individuals transporting the resident (if indicated). See progress notes for additional details. The form included the following items with check boxes next to each: Written Physician Order placed in PCC, Resident transfer form, face sheet, Order Summary Report, MARS, TARs, Care plan goals, Physician History and Progress Notes, Advanced Directive, POST.1.Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a progressive irreversible lung condition that restricts airflow, primarily caused by smoking or long-term exposure to lung irritants), dementia and repeated falls. A nursing progress note dated 3/4/26 at 12:45 PM documented that Resident #28 was transferred to the hospital via non-emergent transport for her hip. The face sheet, POST, and medications list were sent with the EMT. Family was aware of Resident #8's transfer to the hospital. On 6/24/26 at 9:40 AM, the CNO, with the CRN present, stated they were unable to find documentation indicating that the required documents were sent with Resident #8 when she was transferred to the hospital. When asked what should have been sent with Resident #8, the CNO stated that all documents listed on the Transfer form should have accompanied her during the transfer to the hospital. 2. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including iron deficiency anemia, hypertension, and duodenal (part of the small intestine) ulcer without hemorrhage or perforation.A nursing progress note dated 4/7/26 at 12:08 PM, documented around 6:10 AM staff went to Resident #42's room, while trying to help Resident #42, she stopped breathing for about 30 seconds. The nurse was called and notified the provider. The face sheet, discharge/transfer paperwork, and POST were sent with EMS.Resident #42's Communication for Emergent Discharge/Transfer to Acute form dated 4/7/26, did not have any boxes checked to indicate which documents were sent with her during transfer to the hospital.On 6/23/26 at 5:53 PM, the CNO, with the CRN present, reviewed Resident #28's Transfer form. The CNO stated there were no boxes checked on the Transfer form to identify which documents were sent when Resident #28 was transferred to the hospital.

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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** Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) Assessments included correct assessment information. This was true for 1 of 2 residents (Resident #13) whose MDS records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include:The RAI Manual, revised 10/1/2025, documented section A1500, Preadmission Screening and Resident Review (PASRR) was to be coded yes when a PASRR Level II screening determines a resident had a serious mental illness and/or intellectual ability, or related condition.Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including PTSD, TBI, anxiety, and major depressive disorder.Resident #13's admission MDS assessment dated [DATE], documented under A1500 in Section A, no for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? However, there was a PASRR Level II observed in his electronic medical record, dated 10/7/25.On 6/26/26 at 2:21 PM, the CEO with the MDS Nurse confirmed Resident #13's MDS assessment was coded that he did not receive a PASRR Level II, and it should have been coded yes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records, policy review, and staff interview, it was determined that the facility failed to ensure residents received further evaluation after being identified as having major mental illness. This was true for 1 of 2 residents (Resident #8) reviewed for PASRR Level II evaluations. This deficient practice created the potential for harm if residents specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: The facility's Pre-admission Screening & Resident Review (PASRR) Process policy revised 8/29/25, documented a positive Level I screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II. When a Level II PASARR screening is warranted, it should be obtained (as well as determination letter) prior to admission, unless otherwise authorized by such agency.Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including PTSD and major depressive disorder. A PASRR Level 1 assessment, dated 4/30/25, documented Resident #8 had personality disorder and PTSD which are both classified as major mental illness. Resident #8's record did not contain documentation indicating she was referred for PASRR Level II evaluation. On 6/25/26 at 5:02 PM, the CEO reviewed Resident #8's PASRR Level I assessment. The CEO stated, I could not determine if it was sent for Level II assessment. The CEO further stated it should have been sent for Level II evaluation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records review, policy review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included the target behavior being monitored for residents. This was true for 2 of 5 residents (#4 and #8) whose care plans were reviewed. This deficient practice created the potential for harm should residents receive inappropriate or inadequate care. Findings include:The facility's Comprehensive Care Plans & Conferences policy revised 9/3/25, documented, The facility will ensure that each resident has a timely, person-centered comprehensive care plan developed and maintained in accordance with professional standards of practice. The care plan will reflect the residents' individual conditions, risks, needs, behaviors, cultural values, and preferences, and will include measurable goals, appropriate interventions, and realistic timeframes.1. Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including major depressive disorder and other anxiety disorder.Resident #4's Behavior Monitoring directed staff to document the number of episodes per shift of the following target behavior 1. crying/tearful 2. suicidal ideations 3. poor appetite. The Behavior Monitoring also documented to monitor her for delusions/hallucinations.A review of Resident #4's care plan showed it did not address the identified behaviors.On 6/25/26 at 9:41 AM, the Social Services reviewed Resident #4's care plan. The Social Services stated Resident #4's signs of depression, delusions and hallucinations were not in the care plan and it should be.2. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including PTSD and major depressive disorder. Resident #8's Behavior Monitoring documented she exhibits potential mood disturbances and staff were directed to monitor her for crying, withdrawn, anger, irritability, anxiety and related behaviors.A review of Resident #8's care plan showed it did not address the identified behaviors.On 6/25/26 at 9:28 AM, the Social Services reviewed Resident #8's care plan. When asked if her target behavior were included in the care plan, Social Services stated, I don't see it currently on the care plan. The Social Services further stated, the target behavior should be in the care plan.

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	06/26/2026

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with respiratory services consistent with professional standards of practice. This was true for 1 of 2 residents (Resident #15) whose respiratory device was not stored properly. This deficient practice created the potential to cause contamination of respiratory equipment and increase the risk of respiratory infection for residents who require oxygen therapy. Findings include: The facility's Oxygen Administration, Safety, Storage, & Maintenance policy, revised on 10/10/25 documented to, Store oxygen and respiratory supplies in a plastic bag when not in use. Resident #15 was admitted to the facility on [DATE] with multiple diagnoses including COPD, congestive heart failure (CHF- a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), and obstructive sleep apnea (OSA-a chronic disorder where the upper airway repeatedly collapses during sleep, cutting off airflow.On 6/23/26 at 5:35 PM, Resident #15's wheelchair was observed sitting in the hallway next to Resident #15's bedroom door. The oxygen tubing was observed to be coiled and hanging around the right wheelchair handle, exposed and not in a bag. On 6/23/26 at 5:38 PM, CMA #2 was asked about the oxygen storage policy. CMA #2 stated oxygen tubing should be stored in a bag. CMA #2 then accompanied the Surveyor to Resident #15's room and confirmed Resident #15's oxygen tubing was hanging on the wheelchair and not stored in a bag. CMA #2 stated Resident #15's oxygen tubing should have been stored in a Ziploc or plastic bag that should have been attached to the back of Resident #15's wheelchair. On 6/23/26 at 5:51 PM, when asked about the oxygen storage policy, the CNO with the CRN present confirmed oxygen tubing should be stored in a bag when not in use.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on record review and staff interview, it was determined the facility failed to ensure nursing assistants (NAs) had completed or had enrolled in a stateˆapproved training and competency evaluation program within four months of hire. This was true for 1 of 6 NAs (NA #1) whose personnel file was reviewed. This failure had the potential to compromise the quality and safety of care provided to all residents living in the facility. Findings include:NA #1 was hired on 12/15/26 and had not obtained their CNA certification and had not enrolled in a CNA program within four months of hire. On 6/26/26 at 12:16 PM, the HR Manager confirmed NA #1 had not completed state approved training and competency evaluation program. The HR Manager further stated NA #1 last worked on 4/30/26 and confirmed NA #1 should not have been working after 4/15/26.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 3 of 3 residents (#4, #28, and #35) whose medications were reviewed. This deficient practice created the potential for Resident #4 to develop hypoglycemia when she did not receive her insulin. Resident #28 was at risk of worsening infection when he did not receive two doses of his antibiotic. Resident #35 was at risk of treatment failure when his cholestyramine was administered at the same time as his other medications, Findings include:The facility's Medication Administration policy, revised 9/10/25, documented that staff responsible for medication administration should follow the ten rights of medication administration.a. Right Medicationb. Right Residentc. Right Dosed. Right Routee. Right Time and Frequencyf. Right Documentationg. Right Assessmenth. Right to Refusei. Right Evaluationj. Right Education 1.Resident #4 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including diabetes, chronic kidney disease, and major depressive disorder. A physician order dated 12/16/25 documented Resident #4 was to receive Insulin lispro subcutaneously before meals and at bedtime for diabetes. Give even if residents do not eat. Inject per sliding scale as follows:-if 150 - 180 = 4 units181 - 220 = 6 units221 - 260 = 8 units261 - 400 = 10 unitsResident #4's June 2026 MAR documented she did not receive sliding scale of insulin lispro on 6/5/26 and 6/20/26.On 6/25/26 at 2:30 PM, the CRN stated they were unable to find documentation explaining why the insulin lispro was not administered to Resident #4. 2. Resident #28 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including stroke with hemiplegia and hemiparesis (paralysis and weakness of one side of the body), and aphasia (a language disorder that impairs a person's ability to speak, understand, read, and write).A physician's order dated 6/10/26 documented Resident #28 was to receive Cephalexin (antibiotic) 500 mg four times a day for infection.Review of Resident #28's June [DATE], documented he did not receive the 5:00 PM dose of Cephalexin on 6/15/26 and 6/16/26.On 6/25/26 at 2:34 PM, the CNO stated she spoke to RN #1, who said she did not administer the Cephalexin to Resident #28. The CNO stated RN #1 left it for the next shift nurse to administer, but unfortunately RN #1 did not inform the next shift nurse. 3. Resident #35 was admitted to the facility on [DATE], with multiple diagnoses including heart disease, dementia and PTSD.A physician order, dated 4/11/25, documented Resident #35 was to receive cholestyramine (used to treat chronic diarrhea caused by bile acid malabsorption) oral packet 4 grams. Give one packet by mouth before meals and at bedtime for chronic diarrhea mix in 4-6 oz of liquid. Hold for constipation. Take at least one hour prior to other medications or give other medications 4-6 hours after administration of cholestyramine.On 6/24/26 at 7:35 AM, CMA #1 administered Resident #35's cholestyramine along with his other 11 oral medications.On 6/25/26 at 9:58 AM, when asked how she administered Resident #35's cholestyramine, CMA #1 stated she administered it along with his other oral medications. CMA #1 stated, Yes, I am giving his medications all at the same time.Review of Resident #35's June [DATE], documented his cholestyramine was administered by CMA #1 in 52 out of 96 opportunities along with his other oral medications.On 6/25/26 at 10:02 AM, the CNO reviewed Resident #35's physician order for cholestyramine and was informed that the cholestyramine had been administered to Resident #35 along with his other oral medications. The CNO stated the physician's order should have been reviewed prior to administering the medications.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and staff interview, it was determined the facility failed to provide a minimum of 12 hours of in-service education per year for 1 of 5 CNAs (CNA #2) reviewed for sufficient and competent CNA staffing. This failure placed residents at risk of receiving care from staff who are not adequately trained in competencies to meet residents' needs. Findings Include: On 6/25/26, the prior year's in-service training was requested for CNA #2.On 6/25/26 at 4:12 PM, the ACNO stated she was unable to provide documentation of CNA #2's 12-hour annual training.