



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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

FILE COPY

June 4, 2015

Jerrilynn R. Herrera, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Ms. Herrera:

On **May 22, 2015**, a survey was conducted at Oak Creek Rehabilitation Center of Kimberly by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.**

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 17, 2015**. Failure to submit an acceptable PoC by **June 17, 2015**, may result in the imposition of civil monetary penalties by **July 7, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 26, 2015 (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 26, 2015**. A change in the seriousness of the deficiencies on **June 26, 2015**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 26, 2015** includes the following:

Denial of payment for new admissions effective **August 22, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **November 22, 2015**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (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 **May 22, 2015** 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 **June 16, 2015**. If your request for informal dispute resolution is received after **June 16, 2015**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



NINA SANDERSON L.S.W., Supervisor
Long Term Care

NS/dmj
Enclosures

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

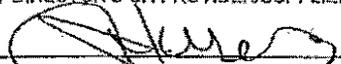
PRINTED: 08/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED Date 05/22/2015
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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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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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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the onsite follow up and annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Becka Watkins, RN</p> <p>The survey team entered the facility on May 18, 2015 and exited on May 22, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed</p>	F 000		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was</p>	F 323	<p>F 323 Free of accident hazards/Supervision/Devices The Facility will make every effort to ensure Resident safety and to ensure all light bulbs are covered with protective coverings and the front entrance ramp is free from trip hazards.</p>	<p>#1 7/10/15 #2 #3 6/24/15</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE MHA	(X6) DATE 6/18/15
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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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F 323	<p>Continued From page 1</p> <p>determined the facility failed to ensure the facility front entrance ramp was free of trip hazards and light bulbs were covered with protective coverings. This was true for 1 of 1 main entrance ramps, 1 of 11 resident rooms in the 200 hallway (#209), and 1 of 2 dining rooms in the facility. These failures created the potential for harm for any resident who frequented the main entrance ramp who could trip or fall and the main dining room and resident room 209 where light bulb breakage could cut a resident. Findings included:</p> <p>1. On 5/19/15 at 9:20 AM, the concrete ramp leading from the parking lot to the main entrance of the facility was observed. In the middle of the ramp was a 10 foot by 10 foot section of concrete, with a 10 foot long crack which ran vertically down the middle of the section. The concrete was pushed up higher than the adjoining sections of concrete by a half an inch at the bottom section of the crack and a quarter inch at the top section of the crack.</p> <p>On 5/19/15 at 9:43 AM, Psychiatric Technician #1 was observed to push Resident #2 and her wheelchair out of the building and down the front entrance ramp. When the resident's wheelchair went over the two areas in question, the wheelchair and resident bounced up and down at each area of concern. A few seconds later, the observation was repeated when the resident was pushed back up the ramp and back into the building.</p> <p>On 5/19/15 at 10:05 AM, Psychiatric Technician #1 was interviewed. When asked about the ramp, she stated, "There's a crack." She said the crack had been there a long time and she had always warned residents to pick up their feet before they</p>	F 323	<p>Affected Residents</p> <p>Finding #1 has the potential to affect all Residents who frequent the main entrance-ramp. There has been a caution cone placed on the ramp to alert Residents, Staff and visitors of the potential hazard. The crack on the ramp has also been painted with bright fluorescent paint to warn Residents, staff and visitors of the uneven area. The ramp will be repaired. There has been a proposal submitted that has been approved. The completion date for the ramp repair is 07/10/2015.</p> <p>Finding #2. Resident currently residing in room #209 had the potential to be affected by this citation. The Light bulb in room # 209 had a protective cover installed on it. The light in the main dining area had a protective cover installed on it.</p> <p>Corrective Action</p> <p>Finding #1 The entrance ramp will be repaired. There has been a proposal accepted and the completion date is 07/10/2015.</p> <p>Finding #2. The Maintenance man audited the entire Facility to ensure there are no other exposed light bulbs. There were no other missing protective covers.</p>		

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F 323	<p>Continued From page 2 went over the bump to avoid an accident.</p> <p>On 5/21/15 from 10:20 AM to 10:35 AM, the environmental tour was conducted with the Maintenance Supervisor. When shown the crack and the concrete in question, he acknowledged the concern and said the hazard was created by frost heaves, where water had gotten under the concrete, had frozen and had lifted the concrete up and had cracked it. He said that on 5/20/15, he had requested two bids from local contractors to fix the issue and had received an estimate from one of the contractors, which the Maintenance Supervisor provided to the surveyor on 5/21/15 at 11:15 AM.</p> <p>2. On 5/18/15 at 11:20 AM, resident room #209 was observed. The light bulb above the sink was found to be without a protective covering.</p> <p>On 5/21/15 from 10:20 AM to 10:35 AM, the environmental tour was conducted with the Maintenance Supervisor. When shown the uncovered light bulb, he stated, "I'll take care of it." He said he was not sure why the cover was missing, but he would fix it.</p> <p>3. On 5/19/15 at 11:10 AM, the main dining room was observed. A bank of 4 florescent light bulbs in the Northwest section of the dining room were uncovered.</p> <p>On 5/21/15 from 10:20 AM to 10:35 AM, the environmental tour was conducted with the Maintenance Supervisor. When shown the bank of light bulbs, he stated, "There's no covers." He said he would make sure they were covered.</p>	F 323	<p>Systematic Changes Weekly checks will be added to the maintenance weekly checklist to ensure there are protective coverings on all lights in the Facility. Maintenance Supervisor will also walk around the entire Facility weekly to check all entrance ramps to make sure they are in good repair. Staff were educated 06/19/2015 on filling out repair slips when they identify any maintenance needs. Weekly checks will begin on 6/24/15 x's 4, q2 weeks x4, then monthly x3.</p> <p>Monitoring The QAPI Committee will review the audits on a monthly basis to ensure compliance. The Maintenance Supervisor will be responsible for compliance.</p>		
	On 5/21/15 at 5:50 PM, the Administrator, DNS				

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F 323 F 327 SS=D	<p>Continued From page 3 and Systems Consultant were informed of the hazard issues. No further information was provided by the facility.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident's water mug was in reach to maintain adequate hydration. This was true for 1 of 6 (#6) residents sampled for hydration. This failure had the potential to cause physical harm from dehydration. Findings included:</p> <p>Resident #6 was readmitted to the facility on 6/16/14 with multiple diagnoses including electrolyte and fluid disorders.</p> <p>The resident's 3/22/15 quarterly MDS assessment documented the resident: -Was moderately cognitively impaired with a BIMS of 11; -Required extensive assistance with 2 persons for bed mobility and transfers; and, -Had range of motion impairments to both upper and lower sides.</p> <p>On 5/18/15 at 1:58 PM and 3:02 PM and on 5/19/15 at 8:10 AM, 9:15 AM; and 10:10 AM, the resident was observed asleep in bed. The resident's mug was observed to be full of water</p>	F 327	<p>F 327 Sufficient Fluid to maintain Hydration: The Facility will make every effort to ensure each Resident is provided with sufficient fluid intake to maintain proper hydration and health.</p> <p>Affected Residents Resident #6 was referred to and assessed by the Registered Dietician and the certified Medical Director. Labs were ordered and drawn which showed that Resident #6 was not dehydrated. Staff was educated on 6/10/2015 regarding ensuring that Resident #6 and all other Residents water mug with ice is always kept within reach. All Residents have the potential to be affected by this citation.</p> <p>Corrective Action The Director Of Nursing, IDT, RD and CDM reviewed the system process surrounding hydration to ensure adequate hydration has been maintained. The DNS conducted observation rounds to determine if the deficient practice affected other Residents in the Facility.</p>	6/24/15

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F 327	<p>Continued From page 4 with no ice and sat on top of a nightstand six feet away from the resident's bed.</p> <p>On 5/19/15 at 11:30 AM, three staff members were observed to leave the resident's room. The water mug was located at the same place as the prior observations, the resident was in bed and awake, but she said she had not been feeling well and wanted to go back to sleep. At 1:50 PM, the resident was asleep and the water mug was in the same place as the prior observations.</p> <p>On 5/19/15 at 2:20 PM, the resident was awake in bed and a tray table was next to the resident's bed with the water mug filled with ice water. When asked about the mug, Resident #6 said she told a nurse she was "thirsty" and the nurse brought a mug of ice water to her. When asked if staff offered her water on a regular basis, she said she really didn't know.</p> <p>On 5/20/15 at 8:40 AM, the resident was observed in her room in a wheelchair. The tray table had a water mug which was a quarter full of water, however the table was three feet away from the resident and the resident was unable to reach it. At 9:30 AM, a similar observation was made. At 9:40 AM, the tray table was in front of the resident with the water mug on top of it. The tray table also had a cup of chocolate milk and a cup of pineapple tidbits.</p> <p>On 5/21/15 at 11:47 AM, the DNS was interviewed regarding the observations. When informed of the observations, she stated, "I think I need to do an inservice." When asked what the expectation was of resident's hydration needs, she said, "That they would have their water within reach."</p>	F 327	<p>The conclusion of the observations indicated it was an isolated event. The Facilities Policy and Procedure on hydration was reviewed with staff at the all Staff meeting on 06/10/2015 to educate staff on the importance of ensuring that Residents water mugs are kept within reach at all times and the importance of hydration.</p> <p>Systematic Changes The DNS, Administrator or Designee will conduct documented Resident room audits to ensure compliance with this citation. The audits will be conducted weekly x 4, q2 weeks x 4, then monthly x 3 beginning on 06/24/2015.</p> <p>Monitoring The Facility will monitor these audits through quality Assurance Performance Improvement Committee (QAPI) on a monthly basis. The DNS or her Designee will be responsible for compliance.</p>		

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F 327	Continued From page 5				
F 328 SS=D	<p>On 5/21/15 at 5:50 PM, the Administrator, DNS and Systems Consultant were informed of the issues. No further information was provided by the facility.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 328	<p>F 328 Treatment/Care for Special Needs The Facility will make every effort to ensure Residents receive proper treatment and care.</p> <p>Affected Residents Resident # 3's care plan has been updated to include a care plan addressing Oxygen therapy. All Residents receiving Oxygen therapy could potentially be affected by this citation.</p> <p>Corrective Action The MDS Coordinator and DNS audited 100% of all records to ensure care plans are in place for Residents that have Physicians orders for Oxygen Therapy.</p> <p>Systematic Changes All new Physician orders for oxygen will be reviewed by</p>	6/24/15	
	Based on observation, record review and staff interview, it was determined the facility failed to ensure oxygen therapy was care planned for a resident. This affected 1 of 2 (#3) residents sampled for oxygen therapy. This practice created the potential for harm if residents were not given oxygen therapy when needed. Finding included:		Medical Records and discussed in the IDT meeting. The IDT and Medical Records clerk will ensure that an Oxygen care plan was created, implemented and placed in the Resident record. The DNS, Medical records Clerk or		
	Resident #3 was readmitted to the facility on 11/12/14 with multiple diagnoses including chronic obstructive asthma with exacerbation and chronic obstructive pulmonary disease.		Designee will conduct audits on care plans for Residents that have Oxygen Therapy to ensure appropriate care plans are in place weekly x 4, q2 weeks x 4,		
	The resident's 2/2/15 Physician orders and May		then monthly x 3. Audits will begin on 06/24/2015.		

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F 328	Continued From page 6 2015 MAR documented an oxygen order for oxygen to be administered via nasal cannula at 2 liters continuous. The MAR documented the resident received the oxygen as ordered. The resident's care plan under the focus of smoking supervision, documented an intervention, dated 1/8/15, "If using any O2 [Oxygen] source, it must remain in the building." The care plan did not document any other oxygen interventions of when or how the resident used oxygen. On 5/18/15 at 1:45 PM and 2:55 PM and on 5/19/15 at 8:20 AM, the resident was observed in her bed with a nasal cannula on and an oxygen concentrator set at 2 liters. On 5/19/15 at 8:55 AM, 10:12 AM, 11:07 AM, and 12:02 PM, the resident was observed in her wheelchair in the main dining room eating meals and participating in activities. The resident had a nasal cannula on and the oxygen tank was set at 2 liters.	F 328	Monitoring The QAPI Committee will review the audits on a monthly basis to ensure compliance. The DNS or her Designee are responsible for compliance.	
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	On 5/21/15 at 10:55 AM, the MDS nurse was interviewed. When asked where the oxygen care plan, she said, "There isn't" one On 5/21/15 at 5:50 PM, the Administrator, DNS and Systems Consultant were informed of the issue. No further information was provided by the facility.		F 364 Nutritive Value/Appear,	6/24/15
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is	F 364	Palatable/Prefer Temp The Facility will make every effort to ensure each Resident receives and the Facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive and at the proper temperature. Affected Residents All Residents have the potential be affected by this citation. Corrective Action RD	

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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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F 364	<p>Continued From page 7 palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the Resident Group interview, test tray evaluation and staff interview, it was determined the facility failed to prepare palatable food. This affected 3 out of 5 residents who attended the Resident Group interview and had the potential to affect all residents who dined in the facility. This failed practice created the potential to negatively affect the residents' nutritional status and psychosocial well-being related to unpalatable food. Findings included:</p> <p>On 5/19/15 at 1:00 PM, during the Resident Group interview, 3 of 5 residents said food was sometimes served cold, specifically breakfast. One of the residents said the scrambled eggs were served, "ice cold."</p> <p>On 5/20/15 at 7:52 AM, a breakfast meal test tray was evaluated by the survey team and by the Dietary Manager (DM). The test tray included scrambled eggs with a temperature of 108-degrees Fahrenheit (F) and the DM said the eggs were, "lukewarm." The sausage patty had a temperature of 100 F and the DM said, "The taste is good, but could be a little warmer." The eggs and sausage were determined not to be hot and were unpalatable.</p> <p>On 5/20/15 at 4:40 PM, the Administrator, DNS and Systems Consultant were informed of the issues. No further information was provided by the facility.</p>	F 364	<p>recommendation for maintaining appropriate food temperatures and palatability is to store food in smaller warming trays to ensure compliance with food temperatures, palatability and Resident satisfaction. Dietary staff were educated by CDM on 05/27/2015 regarding food palatability and Proper Temperatures. All staff were educated on 06/10/2015.</p> <p>Systematic Changes The Dietary Manager, DNS or Designee will request a test Tray 3 x's weekly of random meals throughout the day to ensure Residents are receiving palatable meals at the appropriate temperature beginning on 06/24/2015. Then weekly x4, q2 weeks x4, then monthly x4. Resident satisfaction surveys will be conducted weekly x 4, q2 weeks x 4 then monthly x 4 beginning on 06/24/2015.</p> <p>Monitoring The QAPI Committee will review audits on a monthly basis. Dietary Manager and or Administrator will be responsible for compliance.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371 F 371 SS=E	Continued From page 8 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This affected 9 of 9 sampled residents (#s 1-9) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease-causing pathogens. Findings included: On 5/20/15 from 11:15 to 11:33 AM, during the observation of the kitchen and food temperatures, with the Dietary Manager (DM) present, the Area Manager of Dietary Services (AMDS) was observed in the kitchen without a facial restraint to cover his goatee beard, which was approximately 1 to 2 inches in length. At 11:20 AM, the Registered Dietician was observed to enter the kitchen. At 11:25 AM, the AMDS was observed next to the steam table to watch the cook measure food temperatures. On 5/20/15 at 11:32 AM, the DM was asked how	F 371	F 371 Food Procure, Store/ Prepare/Serve-Sanitary The Facility will make every effort to ensure food is prepared and served under sanitary conditions. Affected Residents This affected 9 Residents (Residents 1-9). It had the potential to affect all Residents. Corrective Action Dietary Staff were educated on 05/27/2015 regarding sanitation requirements. All staff were educated 06/10/2015. Signs were placed on the entrance of the kitchen doors alerting anyone entering the kitchen that they need to wear appropriate hair restraints. A hair restraint dispenser was placed next to the kitchen entrance. Systematic Changes The Dietary Manager or Administrator will conduct audits weeklyx4, q2 weeks x4, then monthly x3 to ensure Dietary staff are following this sanitation rule. Audits will begin 6/24/2015. Monitoring The QAPI Committee will review audits on a monthly basis. The Dietary Manager or Administrator will be responsible for	6/24/15
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F 371	Continued From page 9 far staff or visitors could come into the kitchen without a hair restraint and she stated, "Not at all." On 5/20/15 at 11:33 AM, the AMDS was asked where his beard restraint was and he stated, "I don't have one." He said he usually had a beard restraint on, but did not have one with him. He immediately went out of the kitchen and returned with a hair restraint to cover his beard. The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 5/20/15 at 4:40 PM, the Administrator, DNS and Systems Consultant were informed of the issue. No further information was provided by the facility.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 Drug Records, Label/Store Drugs and Biologicals. The Facility will make every effort to meet and comply with the Idaho and Federal Statues regarding the removal of expired medications. Affected Residents All Residents receiving a Tuberculin test or Pneumovax potentially could be affected by this citation.	6/24/15	

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F 431	<p>Continued From page 10</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>Corrective Action</p> <p>The two vials of medication identified in the survey were disposed of according to Facility policy and procedure. The DNS completed an audit of all medications in the Facility to ensure no other medications were expired.</p> <p>Systematic Changes</p> <p>The DNS and/or her Designee will place a label to clearly identify the expiration date on vials of Tuberculin and pneumovax. The DNS educated all Licensed Nurses about the importance of checking all medication expiration dates prior to administering the medication. The DNS and/or Designee will complete audits of medications located in the medication refrigerator to ensure compliance with this citation.</p> <p>Monitoring</p> <p>Audits will be conducted by the DNS or Designee weekly x4, q2 weeks x 4 and then monthly x 3. The audits will be reviewed at the QAPI Committee meeting monthly to ensure compliance with this citation. The DNS is responsible for compliance. These audits will begin on 06/24/2015.</p>	
	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure the following expired medications were removed from 1 of 1 medication refrigerator; one multidose bottle (50 tests) of Aplisol (tuberculin test) and four multidose bottles of Pneumovax. This failed practice created the potential for decreased efficacy for any resident who received the Pneumovax vaccine and any resident who required a Tuberculin test. Findings include:</p>			

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F 431	Continued From page 11 On 5/19/15 at 9:00 AM, during the inspection of the facility's medication refrigerator, with the DNS the following expired medications were identified: * Aplisol/Tubersol, multidose bottle, had two opened dates; 3/30/15, and 4/7/15. The manufacturers specifications documented, "A vial of Tubersol which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency." * Pneumovax 23, four multidose vials with the lot #K009809 expired on 5/16/15, per the manufacturer. The DNS acknowledged the identified medications had expired and should have been discarded.	F 431		
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F 441 SS=F	On 5/15/15 at 3:15 PM, the Administrator was notified about the expired medications. No additional information was provided. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441 Infection Control, Prevent Spread, Linens Affected Residents DNS in-serviced Infection Control Nurse on infection control practices, including identifying the root cause, and preventing the	6/24/15
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	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		development and transmission of infections. All Residents have the potential to be affected by this citation. Corrective Action Staff were educated on 5/21/2015 and 06/10/2015 on the Facilities Policy and Procedure for Preventing the spread of infection including hand hygiene and sanitizing vital sign equipment that is reusable.	
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F 441	<p>Continued From page 12</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>Systematic Changes New Orientation program has been updated to include current infection control Policies and Procedures, including hand washing and sanitizing equipment that is reusable. New mobile vital sign equipment caddy has been implemented to avoid cross contamination. Infection Control Nurse or Designee will review infection control log with Medical Director or Designee during weekly rounds to establish the root cause of current infections if indicated. The Infection Control Nurse or her Designee will conduct weekly audits x4 weeks, q2 weeks x4 and then monthly x3 to ensure compliance with this citation and that staff are</p>	
	<p>Based on observation, staff interview, policies and procedures and review of infection control records, it was determined: *The facility did not maintain an infection control program to help identify the root cause of and prevent the development and transmission of infections; and *The facility did not ensure adequate hand hygiene as cares were provided. The deficient practice could impact any resident residing in the facility, and created the potential for harm should residents develop infections. Findings included:</p>		<p>following Facility policy and procedures. Monitoring The Facility QAPI Committee will review the monthly audits to ensure compliance. The Infection Control Nurse or her Designee will be responsible for compliance. The audits will begin 06/24/2015.</p>	
	1. The facility's infection control log for 1/2015 documented:			

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F 441	<p>Continued From page 13</p> <p>- 3 different residents in rooms 201B, 204B and 203B were infected with E-Coli bacteria and the related diagnosis was UTI. Each infection was nosocomial (acquired in the facility) and all were resolved by 1/19/15.</p> <p>The infection control log for 2/2015 documented: - 1 resident in room 204B was re-infected with E-Coli bacteria and the related diagnosis was UTI. The infection was nosocomial and was resolved by 3/5/15.</p> <p>The same infection control log documented: - 6 different residents in room 304B, 305A, 305B, 312A, 303B and 205B, had nausea and vomiting between the dates of 2/6/15 and 2/27/15, and all were resolved by 3/3/15.</p> <p>2. On 5/18/15, from 2:30 PM to 2:50 PM, CNA #3 was observed taking vital signs on 3 different residents in rooms, 302B, 316A and 210B. The CNA was observed to touch the residents skin with her hands, touch the equipment to the residents skin and place the vital sign equipment basket on each residents bed. The CNA did not wash her hands between each resident, did not use hand sanitizer and did not clean the blood pressure cuff, temple thermometer or finger O2 oxygen monitor between each resident. The CNA asked the surveyor if she was supposed to wash her hands between residents when taking vital signs.</p> <p>On 5/21/15, at 10:05 AM, LN #2 (Infection Control Nurse) was informed of the concerns. LN #2 was asked what the root cause of the infections were and what interventions were put in place in, around, and during the identification of the nosocomial infections. LN #2 stated she thought the previous DNS contacted the health</p>	F 441		
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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
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June 1, 2015

Jerrilynn R. Herrera, Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Ms. Herrera:

On May 22, 2015, an on-site revisit of your facility was conducted to verify correction of deficiencies noted during the survey of February 18, 2015. Oak Creek Rehabilitation Center of Kimberly was found to be in substantial compliance with health care requirements as of **March 16, 2015**.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B listing the deficiencies that have been corrected is enclosed.

Thank you for the courtesies extended to us during our follow-up revisit. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj
Enclosures

cc: Lori Peel, Investigative Unit Manager, Bureau of Occupational Licenses