



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

PH. COPY

March 2, 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 **February 18, 2015**, a Complaint Investigation survey was conducted at Oak Creek Rehabilitation Center of Kimberly by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance 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 in your facility to be **WIDESPREAD PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situations in writing on **February 13, 2015**.

On **February 13, 2015**, the facility submitted a credible allegation that the immediate jeopardy was corrected. An on-site revisit was conducted on February 19, 2015, and it was determined that the immediate jeopardy to the residents had been removed effective February 14, 2015. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of

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Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 16, 2015**. Failure to submit an acceptable PoC by **March 16, 2015**, may result in the imposition of additional civil monetary penalties by **April 6, 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.
- 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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Based on the immediate jeopardy cited during this survey;

**F225 -- S/S: L -- 42 CFR §483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/Report Allegations/Individuals**

**F226 -- S/S: L -- 42 CFR §483.13(c) -- Develop/Implement Abuse/Neglect, Etc Policies**

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We are recommending to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the following remedies be imposed:

**Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

**Civil money penalty, a per instance of \$10,000 effective February 18, 2015.**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 18, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

**F225 -- S/S: L -- 42 CFR §483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/Report Allegations/Individuals**

**F226 -- S/S: L -- 42 CFR §483.13(c) -- Develop/Implement Abuse/Neglect, Etc Policies**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **1, 2, 5, 6, 7, 8, & 10** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the 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

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Street, Post Office Box 83720, Boise, Idaho, 83720-0036; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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 **March 16, 2015**. If your request for informal dispute resolution is received after **March 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/dj  
Enclosures

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

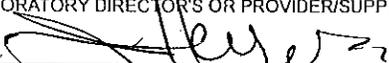
PRINTED: 03/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135084 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/18/2015 |
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|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>OAK CREEK REHABILITATION CENTER OF KIMBERLY | STREET ADDRESS, CITY, STATE, ZIP CODE<br>500 POLK STREET EAST<br>KIMBERLY, ID 83341 |
|---|---|

|                    |  |               |   |                      |
|--------------------|--|---------------|---|----------------------|
| (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 |
|--------------------|--|---------------|---|----------------------|

|  |   |
|--|---|
| <p>F 000 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were:<br/>Amy Barkley RN, BSN, Team Coordinator<br/>Jim Troutfetter, QIDP</p> <p>The survey team entered the facility on February 9, 2015 and exited on February 18, 2015.</p> <p>F 225 SS=L 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the</p> | <p>F 000</p> <p style="text-align: right;">RECEIVED<br/>APR 15 2015<br/>FACILITY STANDARDS</p> <p>F 225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse including misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with State Law through established procedures (including to State survey and certification agency).</p> <p>1. Root cause analysis on what the deficient practice is and how will it be fixed?</p> <p>Facility Administrator failed to investigate allegations of abuse. Administration staffs lack of protective response and investigation of the reported allegations.</p> <p style="text-align: right;">3/16/15</p> |
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|  |              |                      |
|--|--------------|----------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br>NHA | (X6) DATE<br>4/15/15 |
|--|--------------|----------------------|

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 225   | <p>Continued From page 1<br/>Investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on a complaint from the general public received by the Bureau of Facility Standards (BFS) on 2/5/15; review of the facility's abuse and incident/accident policy and procedures; staff, resident, and family interviews; review of Certified Nursing Aide (CNA) schedules; the facility's abuse investigations and incident/accident forms; and employee files, it was determined the facility failed to investigate six allegations of abuse involving 1 of 4 sampled residents (#1), 5 of 5 Random Resident (RR) (#s 5, 6, 7, 8, &amp; 10); and failed to completely investigate one allegation of abuse for sampled Resident #2. These allegations of abuse were reported to the Staff Development Coordinator/ Human Resource Coordinator (SDC/HRC), the Administrator/Abuse Coordinator, and attempts were made to notify the Director of Nursing Services (DNS). CNA #1 was reported in all seven allegations of abuse.</p> <p>The Administrative staff's lack of protective response and investigation of the reported allegations placed six residents on both halls and the remaining twenty-six residents at the facility at risk for potential abuse and/or harm. This failed</p> | F 225   | <p>Hired a new Director of Nursing Services that is very experienced and very knowledgeable with abuse regulations, investigations and reporting process. Due to the Administrator not reporting, All abuse allegations are now assigned and delegated to the DNS for investigation. The DNS will be the main contact for all staff in reporting abuse and DNS will immediately notify Administrator. All abuse investigations will be initiated by the DNS and will be reviewed and signed by the Administrator, DNS and Resident Services Director.</p> |

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| F 225   | <p>Continued From page 2<br/>practice constituted Immediate Jeopardy.</p> <p>The facility was notified of the Immediate Jeopardy in writing on 2/11/15 at 6:20 PM. The facility's abatement plan was accepted on 2/13/15 at 2:46 PM. The abatement included:<br/>re-education to the facility administrator, DNS, and other management staff on policies and procedures for recognizing abuse, reporting requirements, and investigation procedures; employ an interim consultant who will review clinical and administrative systems with a focus on abuse and hiring practices; and provide a written test to all scheduled staff and facility management related to recognizing abuse, zero-tolerance policy, chain-of-command reporting procedures, company-wide compliance hotlines and grievance procedures. Findings included:</p> <p>The facility's Abuse Policy and Procedure, revised on 6/7/13, documented:<br/>When an incident or suspected incident occurs, the Administrator, Director of Nursing, or designee investigates the allegation to include:<br/>- Interviews with any witnesses; the resident; employee accused; resident's roommate; family members; other residents for whom the accused employee provides care or services; and staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.<br/>Witness statements are documented in writing by the investigator and are signed and dated by both the interviewer and witness. In the event an employee is accused of abuse and/or neglect, the interview must be documented and the facility must attempt to get a signed, written statement from the accused. If the accused refuses to give</p> | F 225   | <p>2. What tool will the staff have if reports of abuse and neglect are not investigated by administration?<br/><br/>BRP Abuse hotline and advocacy listings are posted throughout the facility. As per grievance and Complaint reporting procedure. If the individual reporting a complaint is not satisfied with the outcome or result. They are to call the numbers listed which include BRP Abuse Hotline, State Licensing Agency, Office of Aging and Adult Protection.</p> <p>3. Once root cause analysis is found, how will that be monitored to ensure on-going compliance with the regulations?</p> |   |

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| F 225   | <p>Continued From page 3</p> <p>a signed written statement, the facility must document that refusal along with the interview. Review the personnel records of the suspected or accused employee(s). Accused employees are immediately removed from resident contact and suspended from duty. The accused employee will not be taken off suspension until the conclusions of the investigation have been reached. All allegations must be immediately reported to the State Agency's hotline. "Immediately means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident."</p> <p>On 1/21/15, the BFS received a "completed" abuse investigation report from the facility's Administrator which included the following allegations against CNA #1:<br/>Kissed an identified resident on the neck and/or lips four to five times while providing cares;<br/>Tickled residents to wake them up;<br/>Rough while providing cares to the residents; and<br/>Uses profanity towards staff and/or while providing cares to residents.<br/>The investigation documented CNA #1 had denied all allegations of abuse, except CNA #1 stated that she, "may have used profanity."</p> <p>Six additional allegations of abuse were reported, however these allegations were not investigated and included:<br/>Resident #1's wheelchair was allegedly pushed by CNA #1 into CNA #2 possibly causing Resident #1 to become upset.<br/>Resident #5 had been placed in a Hoyer lift and CNA #1 allegedly stated "Maybe we'll let you hang there awhile."<br/>Resident #6 was allegedly bounced up and down in a Hoyer lift, had his socks and pants pulled up</p> | F 225   | <p>Monday - Friday department head morning meeting will include reviews on all I &amp; As and abuse reports. Weekend allegations will be called in to DNS. In the event that the DNS is unavailable, All Weekend allegations will be called in to the Resident Services Director and BRP Hotline to ensure that all allegations are called in to State Agency - Bureau of Facility Standards within 24 hours of the incident. DNS or designee will immediately start investigation on all allegations of abuse. Random weekly compliance audit weekly X 4 and then every two weeks X 4 and then monthly X 3 and as needed to stay in compliance will be done by the system consultant or corporate officer and an audit form will be filled out. (Please see attached).</p> <p>All Abuse reports and audits will be reviewed in the Monthly CQI meeting.</p> |

F 225

A Systems Consultant was hired to educate facility administrator on appropriate abuse investigation, reporting process per State and Federal Regulations.

Facility Administrator or Designee will ensure to call in any abuse allegation within 24 hours to the State Abuse Hotline. Also Report all allegations of abuse to Systems Consultant or Corporate COO. Within 24 hours to ensure monitoring.

Facility Administrator or Designee will submit a comprehensive investigations to appropriate officials in accordance with State Law including State Survey and certification agency within 5 Working Days of the incident and will ensure the alleged violation is verified and the appropriate corrective action has been taken.

CNA # 1 was terminated on 02/10/2015 per Facility Policy guidelines.

Staff Development coordinator/Human Resources Coordinator was in service on abuse Policy and Procedures and Abuse reporting process on 03/09/2015.

F 225

Staffs were also in service on Abuse Policy, Abuse Reporting, Abuse Prevention, Recognizing signs and symptoms of abuse 02/12/2015, 02/13/2015, 02/19/2015, 02/20/2015, 03/06/2015 and 03/10/2015.

Resident #1, #5, #6, #7, #8 and #10 were interviewed, observed and reviewed by the Resident Services Director and Licensed Nurse to determine if the deficient practice has caused negative affects to their physical and psychological well-being.

Resident # 1

On 02/12/2015 Residents Skin records were reviewed for January and beginning of February. No new issues noted. Family notified of allegation. Resident interviewed. No S/S of psychosocial harm as evidenced by participation in activity program. Behaviors remain baseline with no fluctuation. Resident has shown no indicators that abuse occurred. IE: pulling away from staff or decrease in appetite.

F 225

Resident # 5

On 02/12/2015 Residents skin checks for January and beginning of February were reviewed with no new issue noted. No S/S of psychosocial harm was evidenced by no fluctuation in Residents activity level, behaviors remained at base line, no decrease in appetite and no pulling away from staff. Family notified of allegation and investigation.

Resident # 6

On 02/12/2015 skin checks for January and beginning of February were reviewed with no new skin issues noted. No S/S symptoms of psychosocial harm as evidenced by no change in behaviors, no decrease in appetite or activity level and no pulling away from staff. Family notified of allegation and investigation.

Resident # 7

02/12/2015 skin checks for January and beginning of February were reviewed with no new skin issues. No S/S of psychosocial harm evidenced by review of participation records in activity program, no decrease in appetite and behaviors have remained baseline. Family notified of allegation and investigation.

F 225

Resident # 8

On 02/12/2015 Skin checks for January and beginning of February were reviewed and no new skin issues noted. Resident has shown no S/S of psychosocial harm as evidenced by no decrease in activity level, decrease in appetite and behaviors have remained at baseline. Resident is not pulling away from staff. Family notified of allegation and investigation.

Resident # 10

On 02/12/2015 Skin checks were reviewed for January and beginning of February and no new skin issues were noted. Resident has shown no S/S of psychosocial harm as evidenced by decrease in appetite, activity level and behaviors have remained baseline. Resident is not pulling away from staff. Family was notified of allegation and investigation.

From observation and by the answer the residents have given upon interview, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice.

All residents have the potential to be affected by this practice.

F 225

All resident that were interview able were interviewed on 02/17/2015 and 03/06/2015. Questions about abuse have been asked for all interview able residents.

All residents that have low cognitive function were observed and assessed for any behavioral changes or any behavior and activities that are out of the normal routine on 02/17/2015 and 03/06/2015.

From observation and behavioral assessment done, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice

Staffs were in serviced on Federal tag and deficient practice on 03/10/2015.

Systems Consultant or Corporate COO, or Corporate Designee assigned will complete an audit weekly on all allegations of abuse, incidents of altercation involving residents, incident and accident report of unknown causes X 4 weeks and then every two weeks X 4 and then monthly X 3 to ensure all abuse policy and procedures are followed and implemented.

All audits will be reviewed at monthly CQI meeting.

Please See Exhibit A

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| F 225   | <p>Continued From page 4</p> <p>too hard, was tickled and CNA#1 was rough with him during cares.</p> <p>Resident #7 was allegedly rolled back and forth in a rough manner by CNA #1, causing tears to well up in the resident's eyes.</p> <p>Resident #8 allegedly had CNA #1 blowing "raspberries" on her face/neck to wake her up and did not stop when Resident #8 asked her to stop.</p> <p>Resident #10 was referred to in derogatory terms in front of another resident by CNA #1.</p> <p>When asked on 2/11/15 at 1:05 PM, the Administrator stated she did not know why the above allegations had not been investigated, but that they should have been investigated.</p> <p>The facility failed to ensure all allegations of abuse were thoroughly investigated. This failure directly impacted six residents and had the potential to place the remaining twenty-six residents at the facility at risk for potential abuse and/or harm. This failed practice created an Immediate Jeopardy situation.</p> | F 225   |  |   |
| F 226<br>SS=L   | <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on a complaint from the general public received by the Bureau of Facility Standards</p>   | F 226   | <p>DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES.</p> <p>The facility will ensure that residents are protected from abuse. The facility will operationalize its policies and procedures for screening employees; protecting residents from accused employee and reporting all allegations to State Agency (BFS).</p> | 03/16/2015  |

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F 226 Continued From page 5 (BFS) on 2/5/15; review of the facility's abuse and incident/accident policy and procedures; staff interviews; the facility's abuse investigations and incident/accident forms; and employee files, it was determined the facility failed to ensure residents were protected from abuse. The facility failed to operationalize its policies and procedures for screening employees; protecting residents from an accused employee; and reporting all allegations to the State Agency (BFS). This was true for 2 of 4 sampled residents (#s 1 & 2), 5 of 5 Random Residents (RR) (#s 5, 6, 7, 8, & 10), and had the potential to affect all residents residing in the facility. Seven allegations of abuse involving CNA #1 were reported to the Staff Development Coordinator/ Human Resource Coordinator (SDC/HRC), the Administrator/Abuse Coordinator, and attempts were made to notify the Director of Nursing Services (DNS). This failed practice placed seven residents on both halls and the remaining twenty-six residents in the facility in immediate jeopardy and at risk for abuse and/or serious harm.

On 2/11/15 at 6:20 PM, the administrator and DNS were notified in writing of the immediate jeopardy situation.

The facility submitted an acceptable abatement plan to the BFS on 2/13/15 at 2:46 PM, which included: Re-education to the facility administrator, DNS, and other management staff on policies and procedures for recognizing abuse, reporting requirements, and investigation procedures; employ an interim consultant who will review clinical and administrative systems with a focus on abuse and hiring practices; and provide a written test to all scheduled staff and facility management related to recognizing abuse,

F 226 1. Root cause analysis on what the deficient practice is and how will it be fixed?

Facility administration failed to operationalize its policies and procedure for screening and protecting resident from the accused staff. And facility Administrator failed to report all allegations to state agency - Bureau of Facility Standards.

A new HR/SDC was hired on fulltime basis starting 3/16/15 to ensure proper employee screening.

Hired a new Director of Nursing Services that is very experienced and very knowledgeable with abuse regulations, investigations and reporting process. Due to Administrator not reporting, All abuse allegations are now assigned and delegated to the DNS for investigation. The DNS will be the main contact for all staff in reporting abuse and DNS will immediately notify Administrator.

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| F 226   | <p>Continued From page 6</p> <p>zero-tolerance policy, chain-of-command reporting procedures, company-wide compliance hotlines, and grievance procedures. Findings included:</p> <p>On 1/29/15, the BFS received an investigation report from the facility which documented CNA #2 had verbalized concerns that CNA #1 "tickled residents to wake them up; kissed Resident #2 on the mouth; was rough with residents while providing cares; and used profanity." The facility documented CNA #1 was disciplined per policy for using profanity in the work place and was removed from the 300 hall where Resident #2 resided.</p> <p>On 2/5/15 the Bureau of Facility Standards received the following complaint from the general public: The complainant alleged that an abuse investigation was not conducted related to an incident in which CNA #1 was observed to be "too friendly and had said inappropriate things" to Resident #2 while providing personal cares. The Administrator and DON were told about the incident, however the complainant stated no statements were obtained from the witnesses. The complainant stated CNA #1 had been rehired by the facility about two months prior and was placed on "strict probation," for being rough with resident(s) in the past.</p> <p>On 2/10/15 at 8:35 AM, the administrator provided the survey team with CNA #2's written statement dated 1/21/15. The written statement included the allegation of abuse by CNA #1 towards Resident #2 and identified six additional allegations of abuse by CNA #1 towards six unidentified residents. When asked if the facility had identified the above residents and</p> | F 226   | <p>All abuse investigations will be initiated by the DNS and will be reviewed, signed by the Administrator, DNS and Resident Services Director.</p> <p>2. What system will be put in place for deficient practice regarding operationalizing policy, screening employees, DNS ignoring staff trying to report allegations of abuse and neglect to the state agency?</p> <p>All administration staff were re educated regarding abuse policies and procedures. Random weekly compliance audit will be done weekly X 4 and then every two weeks X 4 and then monthly X 3 and as needed to stay in compliance by the systems consultant or corporate officer and an audit form will be filled out. (Please see attached).</p> |   |

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investigated the additional allegations, the Administrator stated the facility had not.

On 2/10/15 at 11:45 AM, CNA #2 provided the name and allegation for each of the six unidentified residents. The following residents were identified as #s 1, 5, 6, 7, 8 & 10 and the allegations were as follows:

\* CNA #1 pushed Resident #1 in her wheel chair to the dining room and ran the wheel chair into CNA #2's leg, causing Resident #1 to become upset. CNA #1 told CNA #2 she was going to "punch her face and kick her a\*\* [profanity]."

\* Resident #5 had been placed in a Hoyer lift and CNA #1 stated, "Maybe we'll let you hang there awhile. What do you think about that?"

\* Resident #6 was bounced up and down in a Hoyer lift and CNA #1 stated, "How do you like that?" Additionally, CNA #1 would pull the resident's socks and pants up in an aggressive manner causing the resident to yell, "OUCH, STOP IT!" Finally, CNA #1 would tickle or shake the resident to wake him up and the resident would become combative.

\* Resident #7 was unable to verbalize pain/discomfort, however CNA #1 was observed to roll the resident back and forth in such an aggressive manner the resident had tears well up in his eyes.

\* CNA #1 was observed to "blow raspberries" on Resident #8's face/neck to wake her up for breakfast. The resident yelled, "STOP IT! STOP IT," however, CNA #1 did not cease when Resident #8 asked her to stop.

F 226

A new HR/SDC was hired on fulltime basis starting 3/16/15 to ensure proper screening per facilities new procedures. A new pre orientation checklist was initiated (Please see attached) to ensure that all abuse prevention requirement are being followed before new staff can begin orientation.

A new orientation checklist and guidelines is being initiated (please see attached) to ensure all new staff are properly oriented with abuse regulations, investigation and reporting process.

Hired a new Director of Nursing Services that is very experienced and very knowledgeable with abuse regulations, investigations and reporting process.

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\*While CNA #1 and CNA #2 were providing cares for two other residents in another room, CNA #1 referred to Resident #10 as a "B\*\*ch [profanity]" and a "piece of s\*\*t [profanity]."

On 2/9/15 at 11:05 AM, CNA #3 stated while she was not an eyewitness to any of the alleged incidents, she had heard about them from CNA #2. CNA #3 said CNA #2 approached her with concerns related to CNA #1 inappropriately kissing Resident #2, using profanity around/towards residents, and the rough handling of residents. CNA #3 said she told CNA #2 to report the concerns to the SDC. When asked if the SDC was the abuse coordinator, CNA #3 said she did not know and was never educated to whom allegations of abuse were to be reported.

On 2/9/15, at 11:45 AM, CNA #2 stated she went to the DNS's office on 1/19/15 to report her concerns and was told the DNS was in a meeting. The CNA stated she went home and called the facility and left a message for the DNS to call her, but received no return call. The CNA called the DNS back at approximately 7:00 PM and was told he was eating dinner and would call her back. The CNA waited until 10:00 PM for a call back and did not receive a call from the DNS. CNA #2 stated that on 1/20/15 she saw the DNS during her shift, but he did not approach her to discuss her concerns. The CNA said she felt like the DNS ignored her and she did not attempt to report her concerns to anyone else. CNA #2 stated, "I just couldn't take [CNA #1's] mouth anymore," and reported her concerns to the SDC on 1/21/15. CNA #2 stated she had never been educated regarding to whom allegations of abuse should be reported.

F 226

A Systems Consultant hired to educate, monitor and review clinical and administrative systems with a focus on abuse, abuse investigation, reporting process and hiring practices.

Orientation Program and hiring practice was reviewed and revised accordingly by the systems consultant and facility Administrator.

CNA # 2 was terminated on 02/10/2015 per facility policy.

All Current Employee have been reviewed for background check by Staff Development coordinator/Human Resources Coordinator on 02/23/2015.

Staff Development coordinator/Human Resources Coordinator and other office staff was in serviced on abuse prevention policies and procedures for screening potential employees and hiring practices on 02/13/2015 and 03/09/2015 with emphasis on abuse prevention screening and using a new before orientation checklist and requirements by the Administrator and Systems Consultant.

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On 2/10/15 at 6:00 AM, CNA #4 confirmed she was aware of the incident which occurred between CNA #1 and Resident #2 in mid-January 2015. When asked if she was interviewed by the facility's administrative staff about the incident, CNA #4 stated she and another CNA were sitting at a table when the DNS told them CNA #1 was under investigation and asked the CNAs if they had "ever noticed anything." CNA #4 stated she did not remember the date and/or time the DNS asked the questions about CNA #1. CNA #4 stated she heard CNA #1 use profanity towards staff and residents prior to the investigation and after the investigation. When asked if she reported her concerns to the DNS or administrator, CNA #4 stated, "No, when I have brought concerns up in the past, they have not been addressed."

CNA #1's employee file documented the CNA had at least two separate employment periods with the facility over a two year period. The employee's file included 3 disciplinary actions. The disciplinary action forms documented the following under supervisor comments:

\*"On 12/30/13 you failed to replace a tabs alarm on a resident. Shortly after that the resident self-transferred out of his wheelchair and fell, resulting in a minor injury. If you fail to follow a care plan again in the future, your employment at the facility will be terminated."

\*\*"On 3/10/14, you were observed walking out of a resident's room that you were assigned as 1:1. You walked down the hallway, talked to another CNA and walked back to the room. This violates the 1:1 job description and this resident's care

F 226 Administrator, DNS and other management staff were re educated on policies and procedures for recognizing abuse, reporting requirements and investigative procedures by the Systems Consultant.

Staffs were also in serviced on Abuse Policy, Abuse Reporting, and Abuse Prevention, Recognizing signs and symptoms of abuse on 02/12/2015, 02/13/2015, 02/19/2015, 02/20/2015, 03/06/2015 and 03/10/2015.

Residents #2, #1, #5, #6, #7, #8 and #10 were interviewed, observed and reviewed by the Resident Services Director and Licensed Nurse to determined if the deficient practice has caused negative affects to their physical and psychological well-being.

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| F 226   | <p>Continued From page 10<br/>plan. Effective today 3/10/14 your employment at the facility is terminated."</p> <p>NOTE: The CNA was re-hired in December 2014 and placed on "strict probation" by the facility related to identified "behavioral and attitude problems" observed and identified during her previous employment.</p> <p>**On 1/23/15, [the] use of profanity and Inappropriate [sic] interactions with residents. [CNA #1] will not use profanity at [the] work place. [CNA #1] will work only [on] the 200 hall. Any violations will result in discharge."</p> <p>The facility's Abuse Policy and Procedure, dated 6/7/13, documented:<br/>When an incident or suspected incident occurs, the Administrator, Director of Nursing, or designee investigates the allegation to include:</p> <p>*Interviews with any witnesses; the resident; employee accused; resident's roommate; family members; other residents for whom the accused employee provides care or services; and staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.</p> <p>* Witness statements are documented in writing by the investigator and are signed and dated by both the interviewer and witness. In the event an employee is accused of abuse and/or neglect, the interview must be documented and the facility must attempt to get a signed, written statement from the accused. If the accused refuses to give a signed written statement, the facility must document that refusal along with the interview.</p> | F 226   | <p>Resident # 2</p> <p>On 02/17/2015 Residents skin records were reviewed for January and beginning of February to ensure there were no new skin issues. None were noted. No S/S of psychosocial harm evidenced by no change in behaviors, appetite of activity level. Resident has shown no signs that abuse occurred. Family notified of allegation and investigation.</p> <p>Resident # 1</p> <p>On 02/12/2015 Residents skin records were reviewed for January and Beginning of February. No new skin issues noted. Family notified of allegation. Resident interviewed. No S/S of psychosocial harm as evidenced by no change in participation in activity program, behaviors remains baseline with no fluctuation. Resident has shown no indicators that abuse occurred. IE: pulling away from staff or decrease in appetite.</p> |   |

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| F 226   | <p>Continued From page 11</p> <ul style="list-style-type: none"> <li>* Review the personnel records of the suspected or accused employee.</li> <li>* Accused employees are immediately removed from resident contact and suspended from duty. The accused employee will not be taken off suspension until the conclusions of the investigation have been reached.</li> <li>* All allegations must be immediately reported to the State Agency's hotline. "Immediately means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident." This is also a requirement per Health and Welfare Informational Letter #2014-04.</li> <li>On 2/11/15 at 1:05 PM, the administrator stated the facility did not follow its policy and procedure for abuse in the following manner:</li> <li>* The facility did not notify the BFS within 24 hours of the reported allegation. (See BSF Informational Letter 2014-14)</li> <li>*The six additional allegations of abuse by CNA #1 reported by CNA #2 were not investigated. The Administrator stated she did not attempt to identify who the additional residents were or when the alleged events took place.</li> <li>* The SDC did not complete an Incident Report upon notification of the reported allegation.</li> <li>* CNA #1 was moved to the 200 hall and continued to work with Resident #1 and Resident #8.</li> <li>* The facility did not attempt to get a signed, written statement from the accused employee</li> </ul> | F 226   | <p>Resident # 5</p> <p>On 02/12/2015 Residents skin checks were reviewed for January and beginning of February. No new issues were noted. No S/S of psychosocial harm was evidenced by no fluctuation in Residents activity level, behaviors remain baseline, no decrease in appetite and no pulling away from staff. Family notified of allegation and investigation.</p> <p>Resident # 6</p> <p>On 02/12/2015 skin checks for January and beginning of February were reviewed with no new skin issues noted. No S/S of psychosocial harm evidenced by no change in behaviors, decrease in appetite, or activity participation level and no pulling away from staff. Family notified of allegation and investigation.</p> |   |

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| F 226   | <p>Continued From page 12</p> <p>and/or document the accused employee's refusal to provide a signed written statement.</p> <ul style="list-style-type: none"> <li>* The facility did not interview family members or other residents for whom the accused provided care and services.</li> <li>* The facility did not interview staff members on all shifts who had contact with the identified residents during the period of the alleged incidents.</li> <li>* The facility did not review the identified residents' clinical record and personnel record of the accused employee.</li> <li>* The facility did not document in writing the staff witnesses' statements, or include the date and signature of the interviewer and witness.</li> <li>* Resident # 2's Power of Attorney was not notified until 19 days after the allegations were reported. Family members and or representatives of Residents 1, 5, 6, 7, 8, &amp; 10 were not notified of the allegations of abuse.</li> </ul> <p>*Due to the lack of a complete investigation for Resident #2 and the lack of any investigation for the six additional identified residents, the accused employee continued to work with Resident #s 1 and 8, as well as all other residents residing on the 200 hall. The facility did not suspend CNA #1 pending the need for ongoing investigations to rule out abuse related to all the allegations.</p> <p>The administrator stated CNA #2 was terminated from the facility on 2/10/15 for excessive absenteeism.</p> | F 226   | <p>Resident # 7</p> <p>On 02/12/2015 Residents skin checks for January and beginning of February were reviewed with no new skin issues noted. No S/S of psychosocial harm evidenced by review of participation records in activity program, no decrease in appetite and behaviors have remained at baseline. Family notified of allegation and investigation.</p> <p>Resident # 8</p> <p>On 02/12/2015 Skin checks for January and beginning of February were reviewed and no new skin issues were noted. Resident has shown no S/S of psychosocial harm as evidenced by no decrease in activity level, decrease in appetite and behaviors have remained at baseline. Resident is not pulling away from staff. Family notified of allegation and investigation.</p> |   |

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| F 226   | <p>Continued From page 13</p> <p>On 2/11/15 at 1:30 PM, the DNS confirmed CNA #2 had made several attempts on 1/19/15 to talk with him. When the DNS was asked why he did not follow-up with CNA #2 on 1/19/15, he stated, "I did not feel it was an urgent critical need. I assumed she would come and talk to me about it [on 1/20/15] if it was a critical issue." When asked if the employee file for CNA #1 had been reviewed prior to her rehire in December 2014, the administrator and DNS stated it had not, however the DNS stated when CNA #1 was rehired she was placed on "strict probation" for three months related to concerns about her behavior, attitude, and absences. When asked why an employee would be rehired when concerns related to behavior and attitude were identified, the DNS stated, "Everyone makes mistakes and I felt like giving her another chance." The DNS did not identify what "strict probation" was or how it was to be implemented.</p> <p>No additional information was provided by the facility to resolve this concern. On 2/13/15 at 2:46 PM, the facility submitted an acceptable abatement plan to the BFS. On 2/12/15 the additional 6 allegations of abuse were reported to the BFS State Hotline.</p> <p>The facility failed to follow its own policy and procedures for investigating abuse; failed to immediately notify the BFS when an allegation of abuse was reported; failed to investigate six allegations of abuse involving sampled Resident #1, and Random Resident (RR) #s 5, 6, 7, 8, &amp; 10; and failed to completely investigate one allegation of abuse for sampled Resident #2. This failed practice placed 7 residents on both halls and the remaining twenty-six residents in the facility in immediate jeopardy and at risk for</p> | F 226   | <p>Resident # 10</p> <p>On 02/12/2015 Residents skin checks for January and beginning of February were reviewed with no new skin issues noted. Resident has shown no S/S of psychosocial harm as evidenced by no decrease in appetite, activity level and behaviors have remained at baseline. Resident is not pulling away from staff. Family was notified of allegation and investigation.</p> <p><i>continue on additional page.</i></p> |   |

F 226

From observation and by the answer the residents have given upon interview, the facility feels that there were no negative affects of resident's physical and psychological well being on this deficient practice.

All residents have the potential to be affected by this practice.

All resident that were interview able were interviewed on 02/12/2015 and 03/06/2015. Questions about abuse have been asked for all interview able residents.

All residents that have low cognitive function were assessed and observed for any behavioral changes or any behavior and activities that are out of the normal routine on 02/12/2015 and 03/06/2015.

From observation and behavioral assessment done, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice.

Staffs were in serviced on Federal tag and deficient practice on 03/10/1015.

Facility Administrator will review pre orientation checklist to ensure that Staff Development coordinator/Human Resources Coordinator have followed or implemented accordingly the facility potential employee screening process and hiring practices for every applicant.

F 226

Systems Consultant or Corporate HR or Designee assigned will complete an audit weekly to ensure that the facility hiring practices has been followed or implemented accordingly per facility policy and procedure. Audits will be done weekly X 4 and then every two weeks X 4 and then monthly X 3.

All audits will be reviewed at monthly CQI meeting.

Please See Exhibit B.

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>135084  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/18/2015  |
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| NAME OF PROVIDER OR SUPPLIER<br><br>OAK CREEK REHABILITATION CENTER OF KIMBERLY |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>500 POLK STREET EAST<br>KIMBERLY, ID 83341 |  |
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| F 226<br><br>F 329<br>SS=D  | <p>Continued From page 14<br/>abuse and/or serious harm.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and staff interview, it was determined the facility failed to ensure a resident receiving a medication with the potential to cause tardive dyskinesia received regular monitoring. This was true for 1 of 4 (Resident #2) sampled residents. This placed the resident at</p> | F 329<br><br>F 226<br><br>F 329   | <p>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>03/16/2015</p> <p>The facility will ensure that the residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat specific condition as diagnosed and documented in clinical record.</p> <p>Resident #2 's medication was reviewed for unnecessary drug to ensure all medication are not given on excessive dose, excessive duration and is necessary to treat specific condition as diagnosed and documented in clinical record.</p> <p>Resident # 2's tardive dyskinesia evaluation was done on 02/11/2015 by MDS staff and is now care planned to be done quarterly.</p> <p>All resident have the potential to be affected by this deficient practice.</p> <p>All residents receiving medication with the potential to cause tardive dyskinesia were reviewed on 03/09/2015 by Medical Records Staff and MDS staff to ensure that all resident that require tardive dyskinesia assessment are done and monitored.</p> |

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| F 329   | <p>Continued From page 15</p> <p>risk for adverse drug side effects. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 11/1/10 with multiple diagnoses which included dyspepsia (difficulty digesting food).</p> <p>Resident #2's record contained a physician's order, dated 3/18/14, documenting the resident was to receive Reglan 5 mg four times daily.</p> <p>The resident's record also contained a tardive dyskinesia evaluation, dated 4/23/14, which documented the evaluation was to be completed on a quarterly basis. However, no other tardive dyskinesia evaluations could be found in the resident's record.</p> <p>When asked on 2/11/15 at 4:30 PM., the DNS stated the 4/23/14 tardive dyskinesia evaluation was the most current and the evaluations had not been completed quarterly.</p> <p>During an additional interview on 2/12/15 at 9:47 AM., the facility's physician stated a tardive dyskinesia evaluation should have been completed quarterly for Resident #2.</p> <p>The facility failed to ensure Resident #2 was adequately monitored for signs and symptoms related to tardive dyskinesia.</p> | F 329   | <p>F 329</p> <p>MDS and Medical Record staff was in-serviced regarding tardive dyskinesia assessments and monitoring requirements on 03/09/2015 by the Administrator and Director of Nursing Services.</p> <p>On 03/11/2015 Pharmacist reviewed all current residents receiving medication with potential to cause tardive dyskinesia and coordinated a list to MDS staff and Medical Record's staff to ensure that all appropriate resident are reviewed and assess accordingly for AIMS.</p> <p>DNS will audit to ensure that appropriate tardive dyskinesia assessment is done and completed by the MDS staff per schedule.</p> <p>IDT will review and audit tardive dyskinesia assessment or AIMS weekly X 4 and then every two weeks X 4 and then monthly X 3 to ensure proper monitoring.</p> |   |
| F 490<br>SS=F   | <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial</p>   | F 490   | <p>All audits will be reviewed at monthly CQI meeting.</p> <p>Please see exhibit C.</p>   | 03/16/2015  |

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| F 490   | <p>Continued From page 16<br/>well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on a complaint from the general public received by the Bureau of Facility Standards (BFS) on 2/5/15; review of the facility's abuse and incident/accident policy and procedures; staff, resident, and family interviews; review of Certified Nursing Aide (CNA) schedules; the facility's abuse investigations and incident/accident forms; and employee files, it was determined the Administrator and management team failed to completely investigate an allegation of abuse and to identify and investigate six additional allegations of abuse. This affected 2 of 4 (#s 1 &amp; 2) sampled residents, 5 of 5 Random Residents (RR) (#s 5, 6, 7, 8, &amp; 10), and the remaining twenty-six residents in the facility. This failed practice placed 32 residents at increased risk for abuse and/or serious harm.</p> <p>On 1/21/15, the BFS received a "completed" abuse investigation report from the facility which included the following allegations against CNA #1:<br/>Kissed an identified resident on the neck and/or lips four to five times while providing cares;<br/>Tickled residents to wake them up;<br/>Rough while providing cares to the residents; and<br/>Uses profanity towards staff and/or while providing cares to residents.<br/>The investigation documented CNA #1 had denied all allegations of abuse, except CNA #1 stated that she, "may have used profanity."</p> <p>Six additional allegations of abuse were reported, however these allegations were not investigated and included:</p> | F 490   | <p>F 490<br/>EFFECTIVE<br/>ADMINISTRATION/RESIDENT WELL - BEING<br/>The facility will ensure to completely investigate an allegation of abuse and identify and investigate allegations of abuse.<br/>1. The systemic change to in-service staff is not sufficient. This tag speaks specifically to the Administration and their responsibilities.<br/>Administrator and management team failed to completely investigate an allegation of abuse and identify and investigate six allegation of abuse.<br/>2. How will the system be changes to ensure Administration will investigate and report allegations of abuse and neglect?<br/>Hired a new Director of Nursing Services that is very experienced and very knowledgeable with abuse regulations, investigations and reporting process. Due to Administrator not reporting, All abuse allegations are now assigned and delegated to the DNS for investigation. The DNS will be the main contact for all staff in reporting abuse and DNS will immediately notify Administrator. All abuse investigations will be initiated by the DNS and will be reviewed and signed by the Administrator, DNS and Resident Services Director.</p> |   |

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| F 490   | <p>Continued From page 17</p> <p>Resident #1's wheelchair was allegedly pushed by CNA #1 into CNA #2 possibly causing Resident #1 to become upset.</p> <p>Resident #5 had been placed in a Hoyer lift and CNA #1 allegedly stated "Maybe we'll let you hang there awhile."</p> <p>Resident #6 was allegedly bounced up and down in a Hoyer lift, had his socks and pants pulled up too hard, was tickled and CNA#1 was rough with him during cares.</p> <p>Resident #7 was allegedly rolled back and forth in a rough manner by CNA #1 causing him to have tears.</p> <p>Resident #8 allegedly had CNA #1 blowing "raspberries" on her face/neck to wake her up and did not stop when Resident #8 asked her to stop.</p> <p>Resident #10 was referred to in derogatory terms in front of another resident by CNA #1.</p> <p>On 2/11/15 at 1:05 PM, when asked about the above allegations, the administrator confirmed the allegations had not been investigated, they should have been, and "in hind-sight she recognized that."</p> <p>F 520 483.75(o)(1) QAA<br/>SS=F COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify</p> | F 490   | <p>F 490</p> <p>Random weekly compliance audit will be done weekly X 4 and then every two weeks X 4 and then monthly X 3 and as needed to stay in compliance by the System Consultant or corporate officer and an audit form will be filled out. (Please see attached).</p> <p>Monday - Friday department head morning meeting will include reviews on all I &amp; As and abuse reports. Weekend allegations will be called in to DNS. In the event that the DNS is unavailable, All Weekend allegation will be called in to the Resident Services Director and BRP Hotline to ensure that all allegation are called in to State Agency - Bureau of Facility Standards within 24 hours of the incident. DNS or designee will immediately start investigation.</p> <p>3. How will this be monitored to ensure compliance after consultant is no longer monitoring facility audits.</p> <p>The System Consultant will continue to monitor facility audits weekly X 4 and then every two weeks X 4 and then monthly X 3 and as needed to stay in compliance. In the absence or the event that the consultant is no longer available, a corporate officer with qualified experience and knowledge in abuse investigation and reporting will continue to monitor facility audits.</p> <p><i>continue on additional page.</i></p> |   |

F 490

A Systems Consultant was hired to educate facility administrator on appropriate investigation, reporting process per State and Federal Regulations.

Facility Administrator or Designee will ensure to call in any abuse allegation within 24 hours to the State Abuse Hotline. Also Report all allegations of abuse to Systems Consultant or Corporate COO. Within 24 hours to ensure monitoring.

Facility Administrator or Designee will ensure to report all investigation to appropriate officials in accordance with State Law including State Survey and certification agency within 5 Working Days of the incident and if the alleged violation is verified and the appropriate corrective action taken.

CNA # 1 was terminated on 02/10/2015 per Facility Policy guidelines.

Staff Development coordinator/Human Resources Coordinator was in serviced on abuse Policy and reporting process on 03/09/2015.

Staffs were also in service on Abuse Policy, Abuse Reporting, Abuse

Prevention, Recognizing signs and symptoms of abuse 02/12/2015, 02/13/2015, 02/19/2015, 02/20/2015, 03/06/2015 and 03/10/2015.

F 490

Resident #1, #2, #5, #6, #7, #8 and #10 were interviewed, observed and reviewed by the Resident Services Director and Licensed Nurse to determine if the deficient practice has caused negative effects to their physical and psychological well-being.

Resident # 1

On 02/12/2015 Residents Skin records were reviewed for January and beginning of February. No new issues noted. Family notified of allegation. Resident interviewed. No S/S of psychosocial harm as evidenced by participation in activity program. Behaviors remain baseline with no fluctuation. Resident has shown no indicators that abuse occurred. IE: pulling away from staff or decrease in appetite.

Resident # 5

On 02/12/2015 Residents skin checks for January and beginning of February were reviewed with no new issue noted. No S/S of psychosocial harm was evidenced by no fluctuation in Residents activity level, behaviors remained at base line, no decrease in appetite and no pulling away from staff. Family notified of allegation and investigation.

F 490

Resident # 6

On 02/12/2015 skin checks for January and beginning of February were reviewed with no new skin issues noted. No S/S symptoms of psychosocial harm as evidenced by no change in behaviors, no decrease in appetite or activity level and no pulling away from staff. Family notified of allegation and investigation.

Resident # 7

02/12/2015 skin checks for January and beginning of February were reviewed with no new skin issues. No S/S of psychosocial harm evidenced by review of participation records in activity program, no decrease in appetite and behaviors have remained baseline. Family notified of allegation and investigation.

Resident # 8

On 02/12/2015 Skin checks for January and beginning of February were reviewed and no new skin issues noted. Resident has shown no S/S of psychosocial harm as evidenced by no decrease in activity level, decrease in appetite and behaviors have remained at baseline. Resident is not pulling away from staff. Family notified of allegation and investigation.

F 490

Resident # 10

On 02/12/2015 Skin checks were reviewed for January and beginning of February and no new skin issues were noted. Resident has shown no S/S of psychosocial harm as evidenced by decrease in appetite, activity level and behaviors have remained baseline. Resident is not pulling away from staff. Family was notified of allegation and investigation.

From observation and by the answer the residents have given upon interview, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice.

All residents have the potential to be affected by this practice.

All resident that were interview able were interviewed on 02/17/2015 and 03/06/2015. Questions about abuse have been asked for all interview able residents.

All residents that have low cognitive function were observed and assessed for any behavioral changes or any behavior and activities that are out of the normal routine on 02/17/2015 and 03/06/2015.

F 490

From observation and behavioral assessment done, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice

Staffs were in serviced on Federal tag and deficient practice on 03/10/2015.

Systems Consultant or Corporate COO or Corporate Designee assigned will complete an audit weekly on all allegations of abuse, Incidents of altercation involving residents, incident and accident report of unknown causes X 4 weeks and then every two weeks X 4 and then monthly X 3 to ensure all abuse policy and procedures are followed and implemented.

All audits will be reviewed at monthly CQI meeting.

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| F 520   | <p>Continued From page 18</p> <p>issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on staff interview and record review, it was determined the facility failed to implement the facility's Quality Assessment and Assurance (QAA) process for identifying and investigating allegations of abuse for 7 of 7 Residents (Residents # 1 &amp; 2 and #s 5 - 10) and had the potential to affect all residents in the facility. Findings included:</p> <p>Intent language for F520 documented the QAA committee is responsible for identifying quality deficiencies and developing and implementing plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans.</p> <p>On 1/21/15, the facility received a written statement from CNA #2 documenting seven allegations of abuse involving seven residents. However, the facility could provide evidence of</p> | F 520   | <p>F 520</p> <p>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>The facility will ensure that to maintain a quality assessment and assurance committee and implement the facility's Quality Assessment and Assurance (QAA) process for identifying and investigating allegations of abuse.</p> <p>1. What systematic process will the QAA utilize to guide the facility to ensure F225, F226 and F490 are kept in compliance?</p> <p>A CQI reporting form was initiated to be utilized to guide the facility staff to ensure F225, F226 and F490 are kept in compliance. This form includes the description of the problem, the actions that were taken to address the problem, measurable outcomes that is expected to stay in compliance and the progress status to know and track measurable outcome and to know if the action taken is working or not working.</p> <p>Please see attached for sample CQI.</p> | 03/16/2015  |

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F 520 Continued From page 19  
only one investigation being completed. Please refer to F225 and F226 for details.

The facility's investigation included a report which did not include a date the investigation was completed. The report documented an allegation of staff sexual abuse toward Resident #2. The investigation stated the allegation of sexual misconduct was unsubstantiated. However, the investigation report documented an additional six allegations of abuse which were reported to the Administrator in a statement dated 1-21-15. The investigation did not address the additional allegations of abuse, which include the following:

- Resident #1's wheelchair was allegedly pushed by CNA #1 into CNA #2 possibly causing Resident #1 to become upset.
- Resident #5 had been placed in a Hoyer lift and CNA #1 allegedly stated "Maybe we'll let you hang there awhile."
- Resident #6 was allegedly bounced up and down in a Hoyer lift, had his socks and pants pulled up too hard, was tickled and treated roughly during cares. Each allegation involved CNA #1.
- Resident #7 was allegedly rolled back and forth in a rough manner by CNA #1, causing him to have tears.
- Resident #8 allegedly had CNA #1 blowing "raspberries" on her face/neck to wake her up and did not stop when Resident #8 asked her to stop.
- Resident #10 was referred to in derogatory

F 520  
CNA # 2 was terminated on 02/10/2015 per facility policy.

Residents #2, #1, #5, #6, #7, #8 and #10 were interviewed, observed and reviewed by the Resident Services Director and Licensed Nurse to determine if the deficient practice has caused negative affects to their physical and psychological well-being.

Resident # 2

On 02/17/2015 Residents skin records were reviewed for January and beginning of February to ensure there were no new skin issues. None were noted. No S/S of psychosocial harm evidenced by no change in behaviors, appetite of activity level. Resident has shown no signs that abuse occurred. Family notified of allegation and investigation.

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| F 520   | <p>Continued From page 20</p> <p>terms in front of another resident by CNA #1.</p> <p>When asked on 2/11/15 at 1:05 PM., the Administrator stated she did not know why the above allegations had not been investigated and stated they should have been investigated.</p> <p>During an additional interview on 2/18/15 at 8:30 AM., the Administrator stated the facility's QAA meets on a monthly basis, but the topics of thorough investigation and identifying abuse had not been discussed. She further stated she was not sure why the topics had not been addressed.</p> <p>The facility's QAA failed to identify allegations of abuse.</p> | F 520   | <p>Resident # 1</p> <p>On 02/12/2015 Residents skin records were reviewed for January and Beginning of February. No new skin issues noted. Family notified of allegation. Resident interviewed. No S/S of psychosocial harm as evidenced by no change in participation in activity program, behaviors remains baseline with no fluctuation. Resident has shown no indicators that abuse occurred. IE: pulling away from staff or decrease in appetite.</p> <p>Resident # 5</p> <p>On 02/12/2015 Residents skin checks were reviewed for January and beginning of February. No new Issues were noted. No S/S of psychosocial harm was evidenced by no fluctuation in Residents activity level, behaviors remain baseline, no decrease in appetite and no pulling away from staff. Family notified of allegation and investigation.</p> <p><i>continue on additional page</i></p> |   |

F 520

Resident # 6

On 02/12/2015 skin checks for January and beginning of February were reviewed with no new skin issues noted. No S/S of psychosocial harm evidenced by no change in behaviors, decrease in appetite, or activity participation level and no pulling away from staff. Family notified of allegation and investigation.

Resident # 7

On 02/12/2015 Residents skin checks for January and beginning of February were reviewed with no new skin issues noted. No S/S of psychosocial harm evidenced by review of participation records in activity program, no decrease in appetite and behaviors have remained at baseline. Family notified of allegation and investigation.

Resident # 8

On 02/12/2015 Skin checks for January and beginning of February were reviewed and no new skin issues were noted. Resident has shown no S/S of psychosocial harm as evidenced by no decrease in activity level, decrease in appetite and behaviors have remained at baseline. Resident is not pulling away from staff. Family notified of allegation and investigation.

F 520

Resident # 10

On 02/12/2015 Residents skin checks for January and beginning of February were reviewed with no new skin issues noted. Resident has shown no S/S of psychosocial harm as evidenced by no decrease in appetite, activity level and behaviors have remained at baseline. Resident is not pulling away from staff. Family was notified of allegation and investigation.

From observation and by the answer the residents have given upon interview, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice.

All residents have the potential to be affected by this practice.

All resident that were interview able were interviewed on 02/12/2015 and 03/06/2015. Questions about abuse have been asked for all interview able residents.

All residents that have low cognitive function were assessed and observed for any behavioral changes or any behavior and activities that are out of the normal routine on 02/12/2015 and 03/06/2015.

**F 520**

From observation and behavioral assessment done, the facility feels that there were no negative affect of resident's physical and psychological well being on this deficient practice

Staffs were in serviced on Federal tag and deficient practice on 03/10/1015.

Staffs were also in serviced on Abuse Policy, Abuse Reporting, and Abuse Prevention, Recognizing signs and symptoms of abuse on 02/12/2015, 02/13/2015, 02/19/2015, 02/20/2015, 03/06/2015 and 03/10/2015.

A Quality Assessment and Assurance (QAA) process for identifying and investigating allegations of abuse was started on 03/10/2015.

Systems Consultant or Corporate Designee assigned will review and audit monthly to ensure that the facility Quality Assessment and Assurance (QAA) process includes Identifying and Investigating allegations of abuse monthly X 12.

Please See Exhibit E.

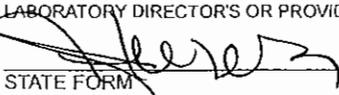
Bureau of Facility Standards

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MDS001530 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/18/2015 |
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|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>OAK CREEK REHABILITATION CENTER OF KII | STREET ADDRESS, CITY, STATE, ZIP CODE<br>500 POLK STREET EAST<br>KIMBERLY, ID 83341 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
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|       |  |       |                              |   |
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| C 000 | 16.03.02 INITIAL COMMENTS<br><br>The following deficiencies were cited during the followup compliant investigation survey of your facility.<br><br>The surveyors conducting the survey were:<br>Amy Barkley RN, BSN, Team Coordinator<br>Jim Troutfetter, QIDP<br><br>The survey team entered the facility on February 9, 2015 and exited on February 18, 2015.  | C 000 |                              |   |
| C 105 | 02.100.02 ADMINISTRATOR<br><br>02. Administrator. The governing body, owner or partnership shall appoint a licensed nursing home administrator for each facility who shall be responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided he is currently licensed as a nursing home administrator. This Rule is not met as evidenced by: Please refer to F 490 as it relates to Administration. | C 105 | Please refer to #490 3/16/15 | RECEIVED<br>APR 15 2015<br>FACILITY STANDARDS |
| C 107 | 02.100.02,b Written Policies/Procedures<br><br>b. The administrator shall be responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility, or through arrangements with an outside service and of the operation of its   | C 107 | Please refer to #490 3/16/15 |   |

|  |              |                      |
|--|--------------|----------------------|
| Bureau of Facility Standards<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br>NHA | (X6) DATE<br>4/15/15 |
|--|--------------|----------------------|

STATE FORM

Bureau of Facility Standards

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>MDS001530 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/18/2015 |
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|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>OAK CREEK REHABILITATION CENTER OF KII | STREET ADDRESS, CITY, STATE, ZIP CODE<br>500 POLK STREET EAST<br>KIMBERLY, ID 83341 |
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|--------------------|--|---------------|---|--------------------|
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|-------|--|-------|--|------------|
| C 107 | Continued From page 1<br><br>physical plant. The policies and procedures shall further clearly set out any instructions or conditions imposed as a result of religious beliefs of the owner or administrator. The administrator shall see that these policies and procedures are adhered to and shall make them available to authorized representatives of the Department. If a service is provided through arrangements with an outside agency or consultant, a written contract or agreement shall be established outlining the expectations of both parties.<br>This Rule is not met as evidenced by:<br>Refer to F490. | C 107 |  |            |
| C 123 | 02.100,03,c,vii Free from Abuse or Restraints<br><br>vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others;<br><br>This Rule is not met as evidenced by:<br>Refer to F225 and F226.   | C 123 | Please refer to F 225<br><br>Please refer to F 226 | 03/16/2015 |
| C 175 | 02.100,12,f Immediate Investigation of Incident/Injury<br><br>f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility  | C 175 | Please refer to F225<br><br>Please refer to F226   | 03/16/2015 |





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

March 10, 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 **February 18, 2015**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly. The complaint was investigated during a complaint investigation conducted from February 9 through February 12, 2015.

The following documents were reviewed:

- The medical records of ten residents;
- The facility's policy and procedure for Abuse and Incident/Accidents;
- The facility's staff in-services and training related to abuse prohibition;
- The Certified Nurse Aide schedules from September 2014 to February 2015;
- The facility's Abuse Investigations from September 2014 to February 2015;
- Residents' grievances from September 2014 to February 2015;
- The facility's Incident and Accident reports from September 2014 to February 2015; and
- The facility's personnel files.

The following interviews were completed:

- The Staff Development Coordinator, Director of Nursing Services (DNS), Administrator, Social Service Designee and the Medical Director were interviewed related to Residents' Behaviors and/or Facility Practices;
- Twenty-five Certified Nurse Aides and/or Licensed Nurses were interviewed related to the facility's policies and procedures for identifying and reporting suspected abuse; and

Jerrilynn R. Herrera, Administrator  
March 10, 2015  
Page 2 of 2

- Five family members were interviewed related to care and services provided by the nursing staff to the residents.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6857**

**ALLEGATION:**

The complainant stated a Certified Nurse Aide (CNA) was observed to be providing cares in a sexually inappropriate way.

**FINDINGS:**

Based on review of the facility's abuse and incident/accident policy and procedures; staff, resident and family interviews; review of the Certified Nurse Aide schedules; the facility's abuse investigations and incident/accident reports and employee files, it was determined the facility failed to operationalize their policies and procedures for screening employees; identification and investigation of abuse allegations; protection of residents from an accused employee and report all abuse allegations to the State Agency. These allegations were substantiated and cited at F225 and F226.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



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

NS/dmj