



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

July 16, 2015

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

Provider #: 135084

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Ms. Herrera:

On **July 6, 2015**, a Facility Fire Safety and Construction 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 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 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. 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to

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Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 29, 2015**. Failure to submit an acceptable PoC by **July 29, 2015**, may result in the imposition of civil monetary penalties by **August 18, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- 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.

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 **August 10, 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 **August 10, 2015**. A change in the seriousness of the deficiencies on **August 10, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 10, 2015**, includes the following:

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Denial of payment for new admissions effective **October 6, 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 noncompliance, 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 **January 6, 2016**, 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, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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 **July 6, 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:

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

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Go to the middle of the page to Information Letters section and click on State and select the following:

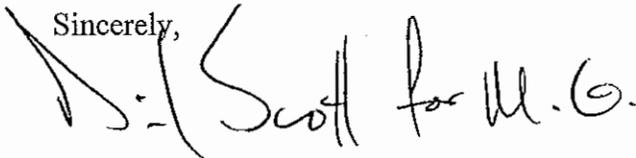
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **July 29, 2015**. If your request for informal dispute resolution is received after **July 29, 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, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Mark P. Grimes for M.G.". The signature is written in a cursive style with a large initial "M" and "G".

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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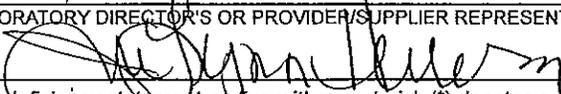
Printed: 07/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/06/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>OAK CREEK REHABILITATION CENTER OF KI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single story, Type V (III) construction, with multiple exits to grade. It was originally constructed in 1963, is fully sprinklered with smoke detection throughout. Currently the facility is licensed for 57 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on July 6, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing	K 029	Affected Residents  This deficient practice affected  25 Residents, staff and visitors.	8/5/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



NHA

7/27/15

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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K 029	<p>Continued From page 1</p> <p>doors. Failure to provide self-closing doors to hazardous areas would allow smoke and dangerous gases to pass into corridors affecting egress. This deficient practice affected 25 residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 31 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour on July 6, 2015 from 11:00 AM to 3:00 PM, observation and operational testing of the double doors to the storage in the main dining hall found the hinge side of the primary door was delaminating. When activated, the doors would not self-close. This storage measured approximately ten feet by five feet (50 square feet) and further found to house adult diapers and paper products up to eight feet in height. When asked about this condition, the Maintenance Supervisor stated he was aware the door was required to self-close and the facility recently discovered the door was delaminating at the hinge side.</p> <p>2) During the facility tour on July 6, 2015 from 11:00 AM to 3:00 PM, observation of the Physical Therapy unit in the 300 hall found the primary access to a storage room inside. This room measured approximately eight feet by eight feet and housed boxed medical records stacked and palletized up to five feet in height. Operational testing of the door entering this storage and the main door from the unit into the corridor found neither were equipped to self-close. (Refer also to K-072).</p> <p>3) During the facility tour on July 6, 2015 from 11:00 AM to 3:00 PM, observation and</p>	K 029	<p><b>Corrective Action</b></p> <p>The double doors to the storage area in the main dining area have been repaired and a self closing mechanism installed.</p> <p>Self closing mechanisms were also installed on the Physical Therapy unit door, the storage room door in the Therapy room and the soiled linen room door located at the 100/200 wing intersection.</p> <p><b>Systemic Changes</b></p> <p>The Maintenance Supervisor has inspected all doors in the Facility that are located in areas that pose a degree of hazard greater than normal to ensure they are safeguarded with self closing mechanisms. Maintenance Supervisor will conduct audits to</p>	

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K 029	<p>Continued From page 2</p> <p>operational testing of the door into the Soiled Linen room located at the 100/200 wing intersection found it would not self-close. Interview of the Maintenance Supervisor found he was aware of this door being required to self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of</li> </ol>	K 029	<p>ensure that all doors with self closing mechanisms remain in working order. Audits will be conducted weekly x4, q2 weeks x2, then monthly x3 beginning on 08/05/2015.</p> <p><b>Monitoring</b></p> <p>The Facility will monitor these audits through Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis.</p> <p>Maintenance Supervisor will be responsible for compliance.</p>	

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K 029	Continued From page 3 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	<b>Affected Residents</b>  All Residents, Staff and visitors have the potential to be affected by this citation.  <b>Corrective Action</b>  A No Smoking sign was prominently placed at the front entrance.  Metal ashtray containers with self closing lids were placed in both designated smoking areas where they are readily available.	8/5/2015

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K 066	<p>Continued From page 4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide metal disposal containers with self-closing lids in designated smoking areas and allowed smoking to occur at the main entrance. Allowing smoking at the public entrance and failure to provide appropriate disposal containers could potentially increase health risks associated and exposure to fires in the presence of oxygen. This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 31 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 6, 2015 from 11:00 AM to 3:00 PM, observation of the main entrance found it used as a smoking area and was not equipped with a metal container with a self-closing lid. When asked, both the Administrator and the Maintenance Supervisor stated this area was not designated for smoking and they were aware of the requirement of the disposal container.</p> <p>2) During the facility tour conducted on July 6, 2015 from 11:00 AM to 3:00 PM, two areas were noted as designated smoking areas and neither had a metal disposal container with a self-closing lid present:</p> <p>Exit off the 300 wing Gazebo area located at the northeast section of the property</p> <p>Actual NFPA standard:</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall</p>	K 066	<p><b>Systematic Changes</b></p> <p>Staff were in-serviced on 07/17/2015 on where the designated smoking areas are located and proper disposal of cigarettes. The Maintenance Supervisor or Designee will inspect the designated smoking areas to ensure cigarettes are being disposed of in the metal containers with self closing mechanisms and there is no smoking in areas that are not designated smoking areas.</p> <p><b>Monitoring</b></p> <p>The Maintenance Supervisor or Designee will document weekly compliance checks x q 4 weeks, q weekly x2 and monthly x 3. Audits will begin on 08/05/2015. These audits will be reviewed monthly at the -QAPI Committee Meeting to ensure on-going compliance with this citation.</p>	

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K 066	Continued From page 5 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	<b>K 072</b>  Affected Residents All Residents and staff have the potential to be affected by this citation.  Corrective Action The door knob on the storage room in the Therapy Department and the door knob in the kitchen have both been replaced with single action door knobs.  Systematic Changes The Maintenance Supervisor or Designee will conduct audits on all doors requiring single action door knobs to ensure they remain in proper working order. Audits will be conducted weekly x4, q 2 weeks x 2 then monthly x3. Audits will begin 08/05/2015.  Monitoring The Maintenance Supervisor will be responsible for compliance. The audits will be forwarded to the QAPI Committee monthly to ensure on-going compliance with this citation.	8/5/2015
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means	K 072		

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K 072	<p>Continued From page 6</p> <p>exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were maintained free of all impediments and available for use in a fire or other emergency. Failure to provide instant use of doors from the egress side would hinder safe evacuation during a fire or other emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 31 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 6, 2015 from 11:00 AM to 3:00 PM, observation and operational testing of the following doors found they were not equipped with single operational locking mechanisms, which did not require a key or special knowledge to open from the egress side:</p> <p>The door leading into the storage area contained in the Physical Therapy unit was equipped with a hasp and padlock. One of two entry doors from the main Kitchen to the corridor was equipped with a keyed lock requiring more than one operation to open.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability.</p>	K 072			

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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		
(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	
K 072	Continued From page 7 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 072			