



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK-- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

August 1, 2016

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 18, 2016**, 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 Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator

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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 **August 15, 2016**. Failure to submit an acceptable PoC by **August 15, 2016**, may result in the imposition of civil monetary penalties by **August 31, 2016**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 22, 2016**, (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 22, 2016**. A change in the seriousness of the deficiencies on **August 22, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 22, 2016**, includes the following:

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Denial of payment for new admissions effective **October 18, 2016**.
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 18, 2017**, 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 18, 2016**, 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 August 15, 2016. If your request for informal dispute resolution is received after August 15, 2016, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

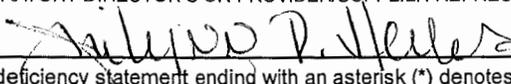
NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2016
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NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KI	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 18, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>The Facility will make every Effort to meet and comply With the Idaho Statutes Life Safety Codes.</p> <p style="text-align: right;"><i>RECEIVED AUG 10 2016 FACILITY STANDARDS</i></p>	
K 027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 10-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This Standard is not met as evidenced by: Based on operational testing, observation and interview, the facility failed to ensure smoke barrier doors would fully close and resist the passage of smoke. Failure to maintain smoke resistive properties of smoke barrier doors would allow smoke and dangerous gases to pass between compartments during a fire event. This</p>	K 027	<p>K 027</p> <p>AFFECTED RESIDENTS</p> <p>The deficient practice affected 13 residents, staff and visitors in 2 of 4 compartments.</p> <p>CORRECTIVE ACTION</p> <p>The smoke barrier doors separating the 100 hall from the main lobby was found to have plastic stripping on the door frame that prevented the door from fully closing when activated. The strip was removed and the door is closing properly.</p>	8/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 8/5/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2016
NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KI		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 027	Continued From page 1 deficient practice affected 13 residents, staff and visitors in 2 of 4 smoke compartments on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 34 on the day of the survey. Findings include: During the facility tour conducted on July 18, 2016 from approximately 1:30 PM to 4:30 PM, observation and operational testing of the smoke barrier doors separating the 100 hall from the main lobby and the 200 hall revealed the doors would not fully close when activated, leaving an approximately three (3) inch gap between the doors. When asked about the doors inability to fully close, the Maintenance Director stated he was not aware these doors were not fully closing. Actual NFPA standard: 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 027	SYSTEMIC CHANGES The Maintenance Supervisor has checked all the smoke barrier doors in the facility to ensure there is no stripping on them that can hinder proper closing of the doors. The Maintenance Supervisor or Designee will perform documented audits on all smoke barrier doors in the Facility to ensure they remain in proper working order. Audits will be done weekly x 4 weeks, q weekly x2 and monthly x3. Audits will begin 08/19/2016. MONITORING	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that doors equipped with delayed egress components were properly signed in accordance with NFPA 101. Failure to provide the appropriate signage for doors equipped with magnetic locking arrangements and a delayed	K 038	Audits will be reviewed monthly at the QAPI Committee meeting to ensure on-going compliance with this citation.	

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K 038	<p>Continued From page 2</p> <p>egress component could hinder the safe evacuation of the facility during a fire or other emergency. This deficient practice affected 34 residents, staff and visitors on the day of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 34 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 18, 2016 from approximately 2:00 PM to 4:00 PM, observation of exit doors revealed they were equipped with magnetic locks which would engage in the presence of a "Wandergaurd" pendant carried by residents. Interview of the Maintenance Director indicated that once activated, the magnetic locks would release under delayed egress feature when 15 lbf force was applied to the latching mechanism for 15 seconds. Further inspection revealed the exit doors equipped with these magnetic locks were not signed indicating the delayed egress operational feature.</p> <p>Actual NFPA standard:</p> <p>19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.</p> <p>7.2.1.6 Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected</p>	K 038	<p>AFFECTED RESIDENTS</p> <p>This deficient practice affected all Residents, visitors and staff.</p> <p>CORRECTIVE ACTION</p> <p>There were durable, readily visible signs posted next to all doors with a releasing device that says: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS".</p> <p>SYSTEMIC CHANGES</p> <p>Maintenance Supervisor will conduct audits on all doors that have a self releasing device to ensure the proper signage remains in place. Audits will be conducted weeklyX4, q 2 weeks x2 then monthly x 3 beginning on 8/19/2016.</p>	8/19/16

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

Printed: 07/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2016
NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KI			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341	
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K 038	Continued From page 3 throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	MONITORING Audits will be reviewed on a monthly basis at the QAPI Committee meeting to ensure on-going compliance.	08/19/2016
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected	K 050		

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

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K 050	<p>Continued From page 4</p> <p>times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire drills were conducted for each shift during each quarter. Failure to conduct fire drills on each shift during each quarter could hinder staff capabilities to respond during a fire event. This deficient practice affected 34 residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 34 on the day of the survey.</p> <p>Findings include:</p> <p>During review of provided facility fire drill records conducted on July 18, 2016 from approximately 1:30 PM to 2:00 PM, records revealed the following fire drills had not been conducted:</p> <p>Noc shift drill during the first quarter of 2016 PM shift drill during the second quarter of 2016 Day shift drill during the fourth quarter of 2015</p> <p>When asked about the missing drills, the Maintenance Director stated there was a change in Maintenance personnel and he thought that might have been during those instances when the drills were not conducted.</p> <p>Actual NFPA standard:</p>	K 050	<p>AFFECTED RESIDENTS</p> <p>All Residents, staff and visitors could potentially be affected by this citation.</p> <p>CORRECTIVE ACTION</p> <p>The Facility will be conduct quarterly fire drills on each shift to familiarize facility personnel with the emergency action required under varied conditions.</p> <p>SYSTEMIC CHANGES</p> <p>The maintenance Supervisor or Designee will conduct fire drills in accordance with the life safety code. Three drills each quarter will be conducted. A drill will be conducted on day, evening and night shift. The Maintenance Supervisor or designee will ensure that staff in the facility sign the drill sheet and keep</p>	8/10/16

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K 050	Continued From page 5 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	accurate records of the drill. Audits by the Administrator or Designee will be conducted each month to ensure compliance. MONITORING The Maintenance Supervisor, Administrator and/or Designee is responsible for compliance. The fire drill reports will be forwarded to the QAPI Committee to ensure that drills are being conducted on a monthly basis.	