



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
JAMIE SIMPSON – PROGRAM SUPERVISOR  
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: 208-334-6626  
FAX: 208-364-1888

December 18, 2012

Erika Schreiber, Administrator  
Creekside Inn Assisted Living Alzheimer's Community  
240 East Kathleen Avenue  
Coeur D'Alene, ID 83814

License RC-954

Dear Ms. Schreiber:

On October 16, 2012, a Complaint Investigation survey was conducted at Creekside Inn Assisted Living Alzheimer's Community. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Rae Jean McPhillips, RN, BSN  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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October 26, 2012

Erika Schreiber, Administrator  
Creekside Inn Assisted Living Alzheimer's Community  
240 East Kathleen Avenue  
Coeur D'Alene, ID 83814

Dear Ms. Schreiber:

An unannounced, on-site complaint investigation was conducted at Creekside Inn Assisted Living Alzheimer's Community on 10/16/12. During that time, interviews and record reviews were conducted with the following results:

**Complaint # ID00005462**

**Allegation #1:** The facility did not provide appropriate supervision to an hourly adult care resident.

**Findings #2:** Substantiated. The facility was issued two deficiencies at IDAPA 16.03.22.345.03.f and 720.01 for not providing adequate supervision to prevent falls and for not maintaining pertinent health information relevant to the supervision of an hourly adult care resident.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on . The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Rae Jean McPhillips, RN, BSN  
Health Facility Surveyor  
Residential Assisted Living Facility Program



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October 26, 2012

Erika Schreiber, Administrator  
Creekside Inn Assisted Living Alzheimer's Community  
240 East Kathleen Avenue  
Coeur D'Alene, ID 83814

Dear Ms. Schreiber:

An unannounced, on-site complaint investigation survey was conducted at Creekside Inn Assisted Living Alzheimer's Community from October 16, 2012, to October 16, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

**Complaint # ID00005521**

**Allegation #1:** Kitchen staff touched ready-to-eat foods with their bare hands.

**Findings #1:** An unannounced kitchen inspection was conducted on 10/16/12. Observations of the kitchen cleanliness, along with food preparation and storage areas were conducted. The kitchen's food temperature logs were reviewed. Additionally, the dietary manager and the administrator's designee were interviewed.

No staff were observed to touch ready-to-eat foods with bare hands during the kitchen inspection. The dietary manager was observed to wear gloves when she had contact with ready-to-eat foods. Additionally, the dietary manager was observed to wash her hands prior to putting on gloves and again when she took them off.

On 10/16/12 at 9:15 AM, the dietary manager stated kitchen staff were instructed to use "tongs," or put on clean gloves prior to touching ready-to-eat foods. She stated that she had worked in the kitchen since shortly after the facility opened and had never observed any kitchen staff touch ready-to-eat foods with their bare hands.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: Foods were not reheated to a safe temperature.

Findings #2: The food temperature logs from March through September 2012 were reviewed. The food temperature logs documented the temperatures of foods served at all three meals. All food temperatures were documented at, or above, the temperatures required for food safety.

On 10/16/12 at 9:15 AM, the dietary manager stated she checked the temperatures of all foods prior to serving. She stated that when food was reheated it had to reach 165 degrees Fahrenheit prior to being served to residents. She stated that she had worked in the kitchen since shortly after the facility opened and food was always reheated to at least 165 degrees Fahrenheit prior to serving.

On 10/16/12 at 10:09 AM, the administrator's designee stated it was the facility's policy for staff to monitor the temperature of food prior to serving residents to ensure safety. She stated that to her knowledge, food was always reheated to at least 165 degrees.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: Meats were not cooked to the correct temperature.

Findings #3: The food temperature logs from March through September 2012 were reviewed. The food temperature logs documented the temperatures of foods served at all three meals. All food temperatures were documented at, or above, the temperatures required for food safety.

On 10/16/12 at 9:15 AM, the dietary manager stated she checked the temperatures of all foods prior to serving. She stated that she had worked in the kitchen since shortly after the facility opened and meats were always cooked to, or greater than, the temperature required by the Idaho Food Code.

On 10/16/12 at 10:09 AM, the administrator's designee stated it was the facility's policy for staff to monitor the temperature of food prior to serving residents to ensure safety. She stated to her knowledge undercooked meat had never been served to residents.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #4: Raw meats were stored above ready-to-eat foods.

Findings #4: A large "meat rack" was observed in the facility's walk-in cooler. The top tray of the rack was labeled "pre-cooked," the second tray was labeled "pork," the third tray was labeled "beef," and the last tray was labeled "chicken." The only meat observed in the walk-in cooler was on the "meat rack." Vegetables and other ready-to-eat foods were observed to be stored well away from the meat rack.

On 10/16/12 at 9:15 AM, the dietary manager stated meat was always thawed and stored on the "meat rack" in the walk-in cooler. She stated that she had worked in the kitchen since shortly after the facility opened and had never observed raw meat stored above ready to eat foods.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #5: The facility did not use sanitizers to wipe down kitchen surfaces.

Findings #5: On 10/16/12 at 9:15 AM, the dietary manager stated the facility used quaternary ammonium for sanitizing kitchen surfaces. She stated the bucket was cleaned and refilled with the sanitizing solution every 2 hours. She stated previous dietary manager also used quaternary ammonium for sanitizing kitchen surfaces.

The content of the sanitizing bucket was tested on 10/16/12 and was found to contain quaternary ammonium at an adequate level to sanitize the kitchen surfaces.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

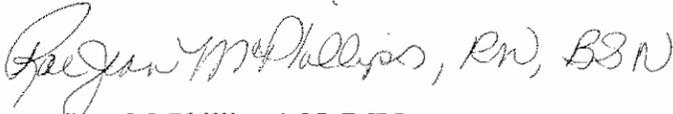
Erika Schreiber, Administrator

October 26, 2012

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As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Rae Jean McPhillips, RN, BSN

Health Facility Surveyor

Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



Facility Name <i>Creekside Inn A.L.</i>	Physical Address <i>240 E. Kathleen Ave.</i>	Phone Number <i>208-665-2444</i>
Administrator <i>Erika Schreiber</i>	City <i>Coeur d'Alene</i>	ZIP Code <i>83814</i>
Survey Team Leader <i>Rae Jean McPhillips</i>	Survey Type <i>Complaint Investigation</i>	Survey Date <i>10/16/12</i>

**NON-CORE ISSUES**

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L & C USE
1	345.03.F	The facility did not provide adequate supervision to an hourly adult care resident.	12/6/12 <sup>pm</sup>	
2	730.01.b	The facility did not maintain pertinent health information relevant to the supervision of an hourly adult care resident.	12/6/12 <sup>pm</sup>	

Response Required Date <i>11/15/12</i>	Signature of Facility Representative <i>Eva Schreiber</i>	Date Signed <i>10.16.12</i>
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