



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 26, 2012

Diane Holley, Administrator
Creekside Care Center
222 6th Avenue West
Jerome, ID 83338

Dear Mrs. Holley:

An unannounced, on-site complaint investigation survey was conducted at Creekside Care Center on October 23, 2012. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005725

Allegation #1: The facility did not respond appropriately when there was a scabies outbreak.

Findings #1: The "Control of Communicable Diseases Manual, 19th edition" documented that scabies was transmitted by "prolonged direct contact with infested skin." The manual also documented that the mites and eggs are usually destroyed after one treatment; however, occasionally 2 courses of treatment, a week apart from each other, may need to be completed. The manual also documented methods to control the spread of scabies from one individual to another. They included: 1) laundering underwear, clothing and bedsheets worn or used by the patient in the 48 to 72 hours prior to treatment in hot cycles of both washer and dryer to kill mites and eggs. 2) Specific treatment to the affected individual. 3) providing treatment and education to infested individual and others at risk. None of the control methods recommendations included isolation or quarantine for those individuals who were affected by scabies.

The "Centers for Disease Control and Prevention" guidelines regarding scabies documented that anyone who was diagnosed with scabies and any other individuals who had prolonged skin-to-skin contact with the affected person should receive treatment. The guidelines documented retreatment may be necessary if itching continued more than 2-4 weeks after treatment or if new burrows or a rash developed. The guidelines also recommend that bedding, clothing and towels used by a person with scabies should be cleaned in the

washing machine and dryer on hot cycles. The guidelines also recommended that a nurse or caretaker working in an institutional setting should be treated prophylactically to reduce the risk of further scabies transmission in the facility. There were no guidelines or recommendations to isolate or quarantine a resident who was diagnosed with scabies.

On 10/23/12 at 10:30 AM, residents were observed in the facility. All of the residents appeared well groomed and none of the residents were observed scratching themselves or appeared uncomfortable and itchy.

Three residents', who were treated for scabies, records were reviewed on 10/23/12. All three residents were seen by their physicians and immediately started on treatment for scabies. They all received a second treatment and one resident received a third treatment.

On 10/23/12 between 10:30 AM and 1:00 PM, the facility administrator, assistant administrator and two caregivers were interviewed. They stated as soon as the residents complained of itching or had a rash, they were seen by their physicians. One resident was diagnosed as having scabies on 9/7/12. Treatment was given to that resident and to the other residents who had itching and/or rashes. The staff stated, they had called the local public health office and were instructed to follow the CDC guidelines, such as:

- * Bagging all of the linens and clothing for all the residents
- * Washing and drying the clothing and bedding in hot temperatures
- * Ensuring all residents and staff at the facility received an initial treatment (either cream or oral medication) for scabies during the first part of September.
- * Ensuring all of the residents and staff received a second treatment for scabies a week after their first treatments.
- * Vacuuming and cleaning the facility
- * Putting sheets/covers over all of the furniture in the building and changing them daily

Additionally, all of the staff stated they did not believe there were any residents who currently had scabies, but they would continue to monitor and treat as needed.

A Review of the facility's memos to staff dated between 9/11/12 and 10/8/12, documented staff were instructed to change the sheets on the chairs in the living room and to wash all of the residents' bedding and clothing in hot water and dry them at hot temperatures. The memos also documented that all residents and staff needed to be treated for scabies. Additionally, the memos documented all staff and residents had received a second treatment for scabies.

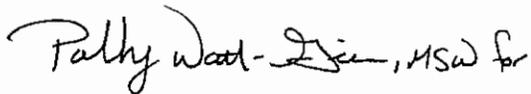
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On 10/23/12 at 12:18 PM, a home health nurse stated from what she had seen, she felt the facility had responded appropriately in addressing the scabies issue.

Unsubstantiated.

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,

A handwritten signature in cursive script that reads "Rae Jean McPhillips, RN, BSN".

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

RM/pwg

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