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
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CERTIFIED MAIL: 7012 1010 0002 0836 1895

February 12, 2014

Charles D. Lloyd Jr., Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Lloyd:

On **January 31, 2014**, a Recertification, Complaint Investigation and State Licensure 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual 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, 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. **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 3). **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 CORRECTION. After each deficiency has been answered and dated, the administrator should sign both 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 **February 25, 2014**. Failure to submit an acceptable PoC by **February 25, 2014**, may result in the imposition of civil monetary penalties by **March 17, 2014**.

The components of a Plan of Correction, as required by CMS include:

- 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 in place or what systemic change will you 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. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:

  a. Specify by job title, who will do the monitoring. It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.

  b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for "random" audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.

  c. Start date of the audits;

- Include dates when corrective action will be completed in column 5.

  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*.

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 **March 7, 2014 (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 **March 7, 2014**. A change in the seriousness of the deficiencies on **March 7, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 7, 2014** includes the following:

Denial of payment for new admissions effective **May 1, 2014**. [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 **July 31, 2014**, 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 Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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. 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 **January 31, 2014** 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 noncompliance 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

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 **February 25, 2014**. If your request for informal dispute resolution is received after **February 25, 2014**, 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,

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135064		C 01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KIMBERLY	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
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual Federal recertification and complaint investigation survey of your facility. The surveyors conducting the survey were: Linda Kelly, RN; Bradley Perry, LSW; and, Jana Duncan, RN. The survey team entered the facility on Monday, January 27, 2014, and exited the facility on Friday, January 31, 2014. Survey Definitions: ADLs = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director Nursing Services LN = Licensed Nurse MDS = Minimum Data Set assessment MAR = Medication Administration Record UTI = Urinary Tract Infection	F 000	The following represents the actions taken by the facility to correct and bring to complete compliance the practices in the facility, and in response to the findings as a result of the Idaho Department of Health and Welfare, Bureau of Facility Standards Annual Health Recertification Survey. The signing of this plan of correction is not an admission or agreement by facility of the truth of the facts alleged in this statement of deficiency and plan of correction. This plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the facilities credible allegation of compliance.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 246	F246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES The facility will make every effort to meet and comply with the Idaho and Federal Statutes to ensure that a resident receives services in the facility to accommodate individual needs.	3/7/14

RECEIVED MAR 12 2014 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: MBA/HCM | TITLE: Administrator | (X6) DATE: 2/25/14

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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	135084		C 01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KIMBERLY	500 POLK STREET EAST KIMBERLY, ID 83341

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F 246	Continued From page 1 interview, it was determined the facility failed to ensure a call light was accessible for 1 of 9 sample residents (#3). Failure to ensure the call light was accessible placed the resident at risk for her needs to be unmet and for a negative effect on her psychosocial well-being. Findings included: The resident was readmitted to the facility in 2011 with multiple diagnoses which included multiple sclerosis (MS) and unspecified debility. The resident's most recent quarterly MDS assessment, dated 1/4/14, coded, in part: * Intact cognition, with a BIMS score of 14; * Total dependence for bed mobility/transfers/dressing/toileting/hygiene/bathing; * Functional limitation in range of motion in both upper and lower extremities; and, * Always incontinent of bowel and bladder. On 1/27/14 at 2:25 p.m., the resident was observed awake on her back with 2 pillows under her head and the head of the bed elevated approximately 10 degrees. The resident's hands were positioned on her chest. The call light was clipped onto the covers over the resident and about 6 inches away from the resident's hands. When asked how she let staff know when she needed or wanted something, the resident stated in a whispered voice, "I use the button." Then she stated, "I'm just hot." When asked if she could activate the "button" the resident looked down at the call light and stated, "I can't. I can't reach it." At 2:35 p.m., LN #2 was asked about the resident's ability to use her call light. The LN stated, "She has MS. She's pretty dependent but	F 246	**Affected Residents** Staff in-serviced on 2/3/14 about ensuring Resident #3's call light is always within reach. All residents could be affected by this citation. **Corrective Action** The facility staff was in-serviced on 2/3/14 about ensuring that all residents' call lights are within reach at all times. **Systematic Changes** The Administrator, Director of Nurses or their designee will conduct resident room audits to ensure compliance with this citation. The audits will be conducted weekly x4, q2 weeks x4, then monthly x 3. **Monitoring** The facility will monitor these audits through Quality Assurance Performance Improvement Committee (Q.A.P.I.) on a monthly basis. The Director of Nursing or her designee is responsible for compliance. Audits will begin 3/7/14.	

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F 246	Continued From page 2 she can make her needs know." When asked what if the resident could not reach the call light, the LN stated, "Usually it's in her hand and she can squeeze it." The LN accompanied the surveyor to the resident's room and acknowledged that the call light was not in the resident's hand or within reach of her hands. The LN moved the call light, placed it in the resident's left hand, then told the resident the call light was in her hand. The resident whispered, "Thank you." On 1/30/14 at 4:00 p.m., the Administrator and DON were informed of the call light issue. No other information was received from the facility which resolved the issue.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a sanitary and comfortable environment was provided in a facility shower room, a resident's bathroom and a resident's bedroom. This was true for 1 of 2 shower rooms and 1 of 23 resident rooms examined (room #204). There was potential for harm for residents who use the shower room who could become chilled during their shower if cold air came in through the crack. 1. On 1/27/14 at 2:45 PM the shower room next	F 253	F253 Housekeeping and Maintenance Services The facility will make every effort to meet and comply with the Idaho and Federal Statutes regarding housekeeping and maintenance services necessary to maintain sanitary, orderly, and a comfortable interior. Affected Residents All residents could be affected by this citation Corrective Action The window in the shower room was repaired by the afternoon of 1/27/14. Room 204 was painted so there was no exposed dry wall in the room between the heater and the window. The scuff marks were also painted in the bathroom of Room 204.	3/7/14

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F 253	Continued From page 3 to resident room 202 was observed to have a window with 25 inch diagonal crack in it. On 1/28/14 at 9:30 AM, the maintenance supervisor observed the window crack and said, "Oh, that's new. I did not know that. That must have happened recently. I check the building every week for stuff like that." On 1/28/14 at 3:55 PM, the Administrator notified the surveyor the window in the shower room had been replaced. 2. On 1/28/14 at 8:25 AM resident room 204 was found to have paint missing with exposed dry wall approximately 7 feet in length and 3 inches wide, between the window and space heater. On 1/28/14 at 8:55 AM in the bathroom of resident room number 204 was found to have three scuff marks approximately 2-3 inches in length and 1/2 inch wide, to the lower left wall below the toilet. On 1/28/14 at approximately 9:30 AM, the maintenance supervisor was notified of the paint findings and said, "I've seen this problem so I've been going around to fix the paint in other areas. It's been 4 months since I've been able to look at room touch ups." On 1/28/14 at 6:00 PM, the Administrator and Director of Nursing notified of the issues. No further information was provided.	F 253	**Systematic Changes** The facility Administrator, Maintenance Director, and/or the Housekeeping Supervisor will conduct audits weekly x4, q2 weeks x4, then monthly x3 to identify any other issues with walls needing to be painted, scuff marks, or cracked windows that would need to be replaced. **Monitoring** The Q.A.P.I. committee will review audits on a monthly basis. Administrator, Maintenance Director, and Housekeeping Supervisor are responsible for compliance. The audits for this citation will begin on 3/7/14.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272	**F272 Comprehensive Assessments** The facility will make every effort to meet and comply with the Idaho and Federal Statutes regarding comprehensive assessments.	3/7/14

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	135094		C 01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KIMBERLY	500 POLK STREET EAST KIMBERLY, ID 83341

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F 272	Continued From page 4 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to care plan	F 272	**Affected Residents** Resident #6 had a care plan placed in their respective chart addressing incontinence. All residents that trigger for incontinence could be affected by this citation **Corrective Action** Resident #6 had a care plan placed in the record surrounding urinary incontinence. All residents that triggered on the MDS CAA for urinary incontinence were reviewed to ensure they had appropriate care plans. **Systematic Changes** The Director of Nursing or her designee will conduct audits on MDS CAA's that trigger for Urinary Incontinence to ensure they have care plans on a weekly basis x4, q2 weeks x4, then monthly x3. **Monitoring** The Q.A.P.I. Committee will review the audits on a monthly basis to ensure compliance. The Director of Nursing or her designee are responsible for compliance. Audits begin on 3/7/14.	

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F 272	Continued From page 5 incontinence care after an MDS CAA triggered for Urinary Incontinence. This was true for 1 of 9 (#6) sampled residents. This had the potential to harm the resident if the resident had a urinary decline or developed UTI's due to insufficient incontinence care. Findings include: Resident #6 was readmitted to the facility on 11/12/12 with multiple diagnoses including cerebral vascular disease, osteoporosis, and anxiety. The resident's annual MDS assessment dated 11/14/13, documented the resident: - was cognitively intact with a BIMS of 13; - required extensive assistance with transfers, dressing, personal hygiene and bathing; - was occasionally incontinent of bladder. Section V CAA Summary of the annual MDS assessment, dated 11/14/13, contained an 'X' mark in the Urinary Incontinence and Indwelling Catheter section titled Care Planning Decision, which indicated the area would be care planned. In the Care Plan Consideration area the MDS Coordinator documented on 11/15/13, "Will continue to plan of care to minimize the risk of skin breakdown or other problems associated with incontinence." Note: The resident's entire care plan was reviewed but it did not address incontinence issues. Refer to F315 for further information related to incontinence care. On 1/29/14 at 2:10 PM, the MDS Coordinator was interviewed regarding the CAA issue. When informed an incontinence care plan was not found in the chart, the MDS Coordinator looked in the chart and stated, "I can't see it either."	F 272		

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F 272	Continued From page 6 On 1/29/14 at 5:00 PM, the Administrator and DON were notified of the issue. No further information was provided by the facility.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to revise a care plan for 1 of 9 sampled residents (#4). The care plan did not contain sufficient information for staff regarding the resident's Baclofen pump. This had the potential to result in harm if the resident did not receive appropriate care due to lack of	F 280	F280 Right to Participate Planning Care-Revise CP The facility will make every effort to meet and comply with the Idaho and Federal Statutes regarding care plans. Affected Residents Resident #4's care plan was updated surrounding the Baclofen Pump. All residents that have Baclofen pumps could be affected by this citation. Corrective Action Resident #4's care plan was updated to ensure that the physician name, medication dosage, and where the pump was located on the resident. The manual for the Baclofen Pump was placed with the Medication Sheets of the resident to ensure Licensed Nursing Staff could locate it.	3/7/14

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F 280	Continued From page 7 direction in the care plan. Findings include: 1. Resident #4 was readmitted to the facility on 11/1/10 with multiple diagnoses including open head wound, paraplegia, and chronic pain. The resident's neurology clinic physician documented on 12/17/13 the resident's intrathecal Baclofen pump was drained and refilled with new medication. The resident's care plan included a focus area dated 11/6/11 and titled "[Resident Name] has frequent c/o [complaint of] headaches, abdominal discomfort. Family states that he has a sensitivity to touch and has feeling of prickling." Two of the interventions were: -10/28/13, "For information on Baclofen pump use and the alarm system and sounds see the manual. -1/3/12, [Resident Name] has a Baclofen pump and sees a specialist for its' care." Note: These were the only references to the Baclofen pump in the care plan. On 1/29/14 at 10:30 AM, LN #6 was interviewed about what she would do if the pump alarm sounded and she stated she would, "Notify the doctor immediately." When asked if she knew where the manual was located which was referenced on the care plan, she said it was in the chart room. When asked to produce the manual for the surveyor, she could not find it. After she could not locate it for several minutes, the DON, MDS Coordinator, and LN #1 assisted in the search.	F 280	The nursing staff was in-serviced on 2/5/14 about the updated care plan, location of the manual, and who to call if there are issues with the pump. **Systematic Changes** The facility will change Resident #4's care plan after each doctors visit to ensure the correct dosage is listed on the care plan. The Director of Nursing or her designee will audit for the manual, care plan accuracy, and correct dosage weekly x4, q2 weeks x4, then monthly x3. **Monitoring** The Director of Nursing, MDS Coordinator, or designee are responsible for compliance. The QAPI Committee will review the monthly audits to ensure compliance with this citation. Audits for this citation will begin on 3/7/14.	

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OAK CREEK REHABILITATION CENTER OF KIMBERLY	500 POLK STREET EAST KIMBERLY, ID 83341

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F 280	Continued From page 8 On 1/29/14 at 11:00 AM, the MDS Coordinator brought a copy of the Baclofen manual to the surveyor. The MDS Coordinator said the manual was found in the resident's over flow chart in the medical records storage area in a building next to the main facility and was not readily accessible to nursing staff. On 1/29/14 at 11:10 AM, the MDS Coordinator and DON were interviewed regarding the care plan. When asked how staff would know which doctor to call if the alarm went off or if there were any issues with the pump, the DON said the doctor's contact information was on the face sheet in the chart. When the surveyor indicated the face sheet contained four care providers and asked how staff would know which provider to contact, the MDS Coordinator stated, "I can add that to the care plan." On 1/29/14 at 1:25 PM, the MDS Coordinator was interviewed again, after the surveyor reviewed the Baclofen pump manual provided. When asked if the pump medication dosage was found on the care plan or the MAR, she stated, "It's not." She also acknowledged the care plan did not address where the pump was located on the resident's body. On 1/29/14 at 5:00 PM, the Administrator and DON were informed of the care plan issue. No further information was provided by the facility.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281 Services Provided Meet Professional Standards The facility will make every effort to meet and comply with the Idaho and Federal Statutes regarding professional standards	3/7/14

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F 281	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility's Finger Stick Glucose policy and procedure (P&P), it was determined the facility failed to ensure LNs consistently followed blood glucose (BG) check procedures. This was true for 2 of 3 LNs (#s 2 and 3) and affected 2 of 3 residents (#s 5 and 13) observed during BG checks. Failure to allow alcohol to dry before puncturing residents' fingers and/or to wipe away the first drop of blood with a dry cotton ball and use the next drop of blood for the BG check placed the residents at risk for inaccurate BG results and could result in them getting too much of too little insulin to meet their needs. Findings included: Note: Clinical Nursing Skills, 7 7th edition, 2010, by Potter and Perry, pages 1155 and 1156, stated, "... 9 Choose puncture site. Puncture site should be vascular... 11 Clean site with antiseptic swab, and allow it to dry completely ... Alcohol can cause blood to hemolyze. ... 14 Wipe away first droplet of blood with cotton ball... First drop of blood may contain more serous fluid than blood cells. ... 15 Lightly squeeze puncture site (without touching) until large droplet of blood has formed... 16 Obtain test results. ... " 1. Resident #5's Active Order from 1/1/14 to 1/31/14 included orders for NovoLog insulin by subcutaneous injection 4 times a day per sliding scale (SS) for uncontrolled diabetes. On 1/28/14 at 10:0 a.m., LN #2 was observed as she performed a BG check for Resident #5. The	F 281	**Affected Residents** All residents that need blood sugar checks could be affected by this citation. Resident #5 and #13 were specifically reviewed with the licensed nursing staff discussing the proper method of completing blood sugar checks. **Corrective Action** The facility re-inserviced all nurses on Resident #5 and #13's deficient practice in regards to professional standards and facility policy on blood glucose checks and the impact on other residents who may have blood sugar checks. **Systematic Changes** The Director of Nursing or her designee will complete a skills check off all on all nurses to ensure	

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F 281	Continued From page 10 LN cleansed the resident's left pointer finger with an alcohol swab, waited 2 seconds then punctured the finger with a lancet. The LN wiped away the first droplet of blood with an alcohol wipe, waited 4-5 seconds then applied the second droplet of blood onto the test strip. The glucose meter gave an error reading. The LN repeated the same steps using the resident's right pointer finger. The glucose meter gave another error reading. The LN left the room and returned a few minutes later with a different glucose meter. The LN performed a third BG check using the resident's right 2nd finger and the same steps as noted above. The BG was 223. The LN stated, "I'm going to call [Nurse Practitioner's name] and let him know before I give any insulin." 2. a) On 1/28/14 at 11:20 a.m., LN #2 was observed as she performed a BG check for Resident #13. The LN cleansed the resident's right pointer finger with an alcohol swab, made a fanning motion with her hand one and a half times (it took about 2 seconds) over the finger, then punctured the finger with a lancet. The LN wiped away the first droplet of blood with an alcohol wipe, waited 5 seconds, then applied the second droplet of blood onto the test strip. The BG was 239. On the way to the medication cart, the LN was asked if 2 seconds was enough time for the alcohol to dry before she punctured the resident's finger. The LN stated, "Yes, and I did this (she made the fanning motion again)." When asked what she used to wipe away the first droplet of blood, the LN stated, "I used an alcohol pad. I should have used a cotton ball." At 11:25 a.m., the LN was observed as she drew	F 281	compliance with this citation. All new nurses hired by the facility will have a competency check off to ensure compliance with this citation as well. The Director of Nursing or designee will conduct audits on nurses to ensure they meet professional standards and facility policy on a weekly basis x4, q2 weeks x4, then monthly x3. **Monitoring** The facilities Q.A.P.I. committee will review monthly audits, skills check-off sheets, and/or competency check-offs for newly hired nurses. The Director of Nursing or her designee will be responsible for compliance. Audits will begin on 3/7/14.	

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F 281	Continued From page 11 up 15 units of NovoLog insulin (12 units were scheduled to be given before lunch plus 3 units according to the resident's sliding scale insulin orders) then administered the insulin per subcutaneous injection into the right side of the resident's abdomen. At 11:30 a.m., the DON was asked to provide the facility's P&P regarding BG checks. At about 1:30 p.m., the DON provided a Finger Stick Glucose P&P, revised 6/1/13, which documented, in part, "... 3. Choose puncture site... 4. Clean site with antiseptic swab and allow site to dry completely before puncturing. (Alcohol can cause blood to hemolyze resulting in a false low or high glucose). 5. Wipe first drop of blood away with a cotton ball. 6. Lightly squeeze finger...Wait for large droplet of blood to form. 7. Obtain results..." b) On 1/29/14 at 11:15 a.m., LN #3 was observed as she performed a BG check for Resident #13. The LN cleansed the resident's left pointer finger with an alcohol swab, waited about 8 seconds, then applied the first droplet of blood onto the test strip. The BG was 178. At 11:20 a.m., the LN was observed as she drew up 13 units of NovoLog insulin (12 units were scheduled to be given before lunch plus 1 unit according to the resident's sliding scale insulin orders) then administered the insulin per subcutaneous injection into the left side of resident's abdomen. On 1/30/14 at 4:00 p.m., the Administrator and DON were informed of the BG check technique issues.	F 281		

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F 281	Continued From page 12 No other information or documentation was received from the facility which resolved the BG technique issues.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, review of clinical records and Incident Reports, and staff interviews, it was determined the facility failed to ensure 1 of 2 residents (#3) reviewed for pressure ulcers (PU) did not develop avoidable recurrent PU. Resident #3, who had a history of stage 4 pressure ulcer to the coccyx, was harmed when an avoidable stage 2 PU recurred on the resident's coccyx related to the use of "soaker pads." Findings included: The resident was readmitted to the facility in 2011 with multiple diagnoses which included multiple sclerosis and unspecified debility. The resident's 4/6/13 annual MDS and 7/5/13 quarterly MDS assessments coded, in part: * Total dependence for bed mobility/transfers/dressing/toileting/hygiene/bathin	F 314	F314 Treatment/Svcs to Prevent/Heal Pressure Sores The facility will make every effort to meet and comply with the Idaho and Federal Statutes to ensure residents do not develop pressure sores. Affected Residents Staff was in-serviced about the importance of not placing a under pad between the low air loss bladders and the cover of the mattress for Resident #3. All residents who are on air-beds could be affected by this citation. Corrective Action The Administrator, DON, or their designee will conduct an in-service with the Housekeeping staff and nursing staff to discuss the appropriate placement of underpads and that they are never to go between the low air loss bladders and the cover of the mattress. Systematic Changes The Administrator, DON, or their designee will conduct audits of residents on air beds on a weekly basis x 4, q2 weeks x4 and then	3/7/14

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F 314	Continued From page 13 g; * Always incontinent of bowel and bladder; * At risk for PU; and, * One unhealed stage 2 PU, dated 3/24/13. The resident's PU CAA Analysis of Findings, dated 4/9/13, documented, "CAA triggered for multiple reasons. Bed mobility is dependent, she is always incontinent of bowel and bladder, she has a past hx [history] of having a stage IV pressure area which took a very long time to resolve and she has developed a new stage II area...in the coccyx area..." The resident's 10/4/13 and 1/4/14 quarterly MDS assessments, differed from the 2 aforementioned MDSs, in part, as follows: * No unhealed PU; and, * PU present on the prior assessment. The resident's care plan identified the following focus areas: * "At risk of pressure areas due to scarring of coccyx area from previous events of pressure areas. Risk factors include; refusal to take supplements hight [sic] in protein, refusal to lay off her buttocks when in bed, incontinence of B/B [bowel and bladder], impaired mobility and "picky" with dietary intake." It was initiated 1/10/12 and revised 1/16/14. Interventions included alternating air cushion in wheelchair (w/c) and air mattress on bed, draw sheet between the resident's skin and a Hoyer (mechanical lift) sling during transfers, pillows for positioning, and weekly skin checks by the LN. * ADL functioning, initiated 1/10/12. Interventions included, "Peri-care after each episode of incontinence... [and] Use of hoyer [sic] lift for all transfers."	F 314	monthly x3 to ensure compliance with this citation that underpads are not being placed between the low air loss bladders and the cover of the mattress. Monitoring The Q.A.P.I. committee will review the audits on a monthly basis. The Director of Nursing or her designee will be responsible for compliance for this citation. Audits will begin on 3/7/14.	

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F 314	Continued From page 14 Review of the resident's clinical record revealed the 3/24/13 stage 2 PU was unavoidable. However, an Incident Report (IR), dated 10/29/13, contained documentation that a recurrent stage 2 PU to the resident's coccyx was avoidable. The 10/29/13 IR documented the following, in part, "Brief narrative of what happened... Upon skin assessment it was noted that there is an open area to coccyx 1 cm [centimeter] x [by] 1 cm." The undated Accident Team Recommendations included, "[Resident's name] has poor nutritional status overall and thin skin. Hx [history] of pressure ulcer and has scar tissue to coccyx that has lost it's [sic] elasticity which puts her at risk for breakdown to the same place. Upon investigation it was found that Housekeeping staff was placing soaker pads between mattress [and] cover when sanitizing beds. Pads removed [and] Housekeeping Supervisor notified to educate her staff...Protective dressing placed to res[ident's] coccyx..." On 1/28/14 at 5:00 p.m., during incontinence care by CNAs #4 and #5, a reddened but intact and blanchable area was noted on the resident's coccyx. A draw sheet was the only bed linen between the resident and the cover on the low air loss mattress. On 1/29/14 at 3:55 p.m., the DON was asked about the 10/29/13 IR regarding the resident's stage 2 coccyx PU. The DON said she would get back with the surveyor. On 1/30/14 at 8:40 a.m., the DON and MDS	F 314		

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F 314	Continued From page 15 nurse were interviewed together. The DON stated, "We discovered housekeeping was putting draw soaker pads between the low air loss bladders and the cover over the mattress." The DON said the Housekeeping Supervisor in-serviced her staff. When asked to provide documentation of the in-service, the DON stated, "She may have just talked to her staff." The DON said she would check to see if it was documented or not. When asked if the resident had refused cares, the MDS nurse, who was reviewing the resident's clinical record at the time, said there was no documented evidence the resident had refused care, except once on 10/16/13. At that time, the DON was asked to provide documentation regarding the resident's PU risk assessments, the 3/24/13 and 10/29/13 PU tracking forms and nurses' notes (NN). Note: Regarding the use of absorbent pads, Potter and Perry's The Fundamentals of Nursing, 7th edition, page 1304, stated, in part,"...Use underpads with caution because some of these pads do not wick the drainage away from the client's skin and will cause skin damage." On 1/30/13 at about 10:30 a.m., the DON stated the Housekeeping Supervisor was the only housekeeping staff when the PU was found 10/29/13. The DON said she talked to the Housekeeping Supervisor about the soaker pad issue herself but did not document the conversation. The DON provided the requested information and a 10/31/13 progress note by a Wound Ostomy Certified Nurse (WOCN). The WOCN's progress note documented, in part, "New open area coccyx. Pt [patient] has scar tissue from previous area of breakdown...is on	F 314		

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F 314	Continued From page 16 low air loss bed, on turn schedule, [with] limited time sitting... It measures 0.5 x 0.1 cm today...has old scar tissue in wound. This area could be a skin tear vs [versus] stage II pressure area..." The resident's Skin Impairment records dated 10/29/13, 11/5/13, 11/11/13, and 11/19/13, the open area on the resident' coccyx was consistently documented as pressure related. On 1/30/14 at about 3:00 p.m., when asked for evidence the 10/29/13 open area on the resident's coccyx was not pressure related, the DON did not provide any documentation to that effect. The DON was informed of the concern the resident was harmed related to the 10/29/13 avoidable recurrent stage 2 coccyx PU. On 1/30/14 at about 11:15 a.m., the Administrator was also informed of harm related to the PU issue. No other information or documentation was received from the facility which resolved the issue in which Resident #3, who had a history of stage 4 PU to the coccyx, was harmed when the facility failed to ensure an avoidable 2 PU did not reoccur on the resident's coccyx.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315		

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F 315	Continued From page 17 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review, it was determined the facility failed to ensure 1 of 6 (#6) sampled residents who were reviewed for incontinence care, received adequate incontinence care due to the lack of a care plan. This had the potential to harm the resident if the resident had a urinary decline or developed UTI's due to insufficient incontinence care. Findings include: Resident #6 was readmitted to the facility on 11/12/12 with multiple diagnoses including cerebral vascular disease, osteoporosis, and anxiety. The resident's annual MDS assessment dated 11/14/13, documented the resident: - was cognitively intact with a BIMS of 13; - required extensive assistance with transfers, dressing, personal hygiene and bathing; - was occasionally incontinent of bladder. Note: The resident's entire care plan was reviewed but it did not address incontinence issues. Refer to F272 for further information about the MDS CAA related to incontinence care. The resident's Care Plan Assignment Report for December 2013 documented the resident was incontinent of urine 10 times for the month. The resident's Progress notes documented the	F 315	F315 No Catheter, Prevent UTI, Restore Bladder The facility will make every effort to meet and comply with the Idaho and Federal Statutes to ensure prevention of UTI's, catheter insertion, and restoring bladder function. Affected Residents Resident #6's care plan was updated to include an incontinence care plan. All residents with incontinence could be affected by this citation. Corrective Action Resident #6's care plan surrounding incontinence was completed and placed in the residents' record. Resident's identified by the MDS as incontinent were reassessed and reviewed to ensure proper care plans had been developed. Systematic Changes The DON or her designee will conduct audits weekly x 4, q2 weeks x4 and then monthly x3 to ensure compliance with this citation. The audits will review	3/7/14

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F 315	Continued From page 18 following: -"12/21/13 3:02 AM, Resident needing to use bathroom more frequently. Stated that has the urge but doesn't 'go'; -12/23/13 2:40 PM, Resident this shift has had loud vocals with excessive worries regarding be [sic] incontinent...; -12/24/13 2:45 AM, Demanded toileting immediately d/t [due to] 'needing to go'. Staff reports some urge incontinence with resident during evening shift." On 1/29/14 at 9:15 AM, the resident was interviewed regarding her toileting needs. She said she would use her call light when she needed to use the commode and said she was not on a scheduled toileting plan. She also said since she required a mechanical lift it sometimes took longer to be toileted and would sometimes become incontinent of urine while she waited. On 1/29/14 at 1:50 PM, CNA #7 was interviewed regarding the resident's toileting needs. CNA #7 stated the resident was, "Very rarely," incontinent of urine. When asked how the staff knew of the resident's toileting needs, she said the resident would use her call light to inform them. She also said the resident was not on a scheduled toileting program. On 1/29/14 at 2:10 PM, the MDS Coordinator was interviewed regarding the incontinence issue. When informed an incontinence care plan was not found in the chart, the MDS Coordinator looked in the chart and stated, "I can't see it either." On 1/29/14 at 5:00 PM, the Administrator and	F 315	residents that triggered for incontinence ensuring they have proper care plans in their resident record. Monitoring The Q.A.P.I. Committee will review these audits on a monthly basis to ensure compliance with this citation. The Director of Nursing or designee is responsible for compliance of this citation. Audits will begin on 3/7/14.	

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F 315	Continued From page 19 DON were notified of the issue. No further information was provided by the facility.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and resident record review, it was determined the facility failed to maintain a medication error rate of less than 5% when the wrong dose of a stool softener laxative was given and a pain medication was given with an enteral feeding formula without a water flush between the two. This was true for 2 of 27 medications (7.4%) and it affected 2 of 9 residents (#s 5 and 8) during medication pass observations. These failures created the potential for residents to receive less than optimum benefit from their prescribed medications. Findings include: 1. On 1/29/14 at 10:15 a.m., LN #3 was observed as she poured, then administered, 8 medications to Resident #5 via the resident's enteral feeding tube. The medications included 10 milliliters of Docusate Sodium 50 mg/5 ml (50 milligrams per 5 milliliters). At about 10:45 a.m., reconciliation of the aforementioned medications with the resident's Active Orders from 1/1/14 to 1/31/14 revealed the order, "Docusate Sodium 60 mg/15 ml give 10 ml liquid Enteral Tube..."	F 332	<u>F332 Free of Medication Error of Rates of 5% or more</u> The facility will make every effort to meet and comply with the Idaho and Federal Statutes to ensure medication errors are 5% or less. Affected Residents The facility obtained the correct Docusate liquid bottle for Resident #3. L.N. #3 was educated on 1/29/14 and 2/3/14 about the facility policy and proper way to administer medications via peg tube and ensure that water is flushed between the pain medication and the Jevity feeding per facility policy. All residents who have a tube feeding could be affected by this citation	3/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135084		C 01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KIMBERLY	600 POLK STREET EAST KIMBERLY, ID 83341

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F 332	Continued From page 20 Note: The LN had administered 10 ml of the 50 mg/5 ml concentration (100 mg) rather than 10 ml of the 60 mg/15 ml concentration (40 mg). The resident received 60 mg more of the Docusate Sodium than was ordered. At about 11:00 a.m., LN #3 was asked about the resident's Docusate Sodium. The LN compared the concentration on the Docusate Sodium bottle in the medication cart to the resident's physician orders and MAR then acknowledged that she had given the wrong dosage of Docusate Sodium to the resident. On 1/31/14 at 4:00 p.m., the Administrator and DON were informed of the issue. No other information/documentation was received from the facility which resolved the issue. 2. Note: Regarding the administration of medications via a feeding tube, CMS Letter 13-02-NH, dated November 2, 2012, stated "Surveyors have identified problems regarding safe administration of medications via a feeding tube...not flushing the tube before, in between and after administration of a medication...The procedures must reflect current standards of practice, including but not limited to...flushing the feeding tube before...and after drug administration. Note: The facility's Enteral Feeding/Tube Feeding Policy/Procedure documentation on page 2 included, "Medications...C. Flush with 5-10cc [cubic centimeters] of water after the administration of each medication. D. Once all medication is administered, flush tube with 60cc of water."	F 332	Corrective Action The Colace order for Resident #3 was fixed to ensure that the order and the medication label matched. On 2/3/14 the Director of Nursing in-serviced the Licensed Nursing Staff about the standards surrounding administration of medications for residents that have tube feedings. The Director of Nursing also in-serviced Licensed Nursing Staff about the importance of checking the Physician Order against the medication label sent by the Pharmacy to ensure accuracy. Systematic Changes The Director of Nursing or her designee will conduct skills check offs on all nurses surrounding the administration of medication for residents that have tube feedings. Competency check-offs will be completed on all new nurses hired by the facility to ensure compliance with this citation.	

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F 332	Continued From page 21 On 1/29/14 at 2:25 p.m., LN #3 was observed as she crushed a hydrocodone/APAP 10/325 tablet and mixed it with 10 milliliters of water, administered the pain medication (med) to Resident #8 via the resident's enteral feeding tube, then administered a bolus feeding of Jevity 1.5 via the feeding tube. However, the LN did not flush the resident's feeding tube with water in between the pain medication and the enteral feeding. As the LN began the enteral feeding the surveyor asked her about a water flush between the medication and the enteral feeding. The LN stated, "We flush before and after each feeding." At 3:00 p.m., upon completion of the resident's bolus tube feeding, the LN was asked again about the lack of a water flush between the pain medication and the enteral feeding. The LN stated, "I flushed before the med then I gave the med with about 10 ml of water then I gave the feeding and I flushed after that." On 1/31/14 at 4:00 p.m., the Administrator and DON were informed of the issue. No other information/documentation was received from the facility which resolved the issue.	F 332	Audits will be conducted on medication pass and tube feedings by the DON or her designee on a weekly basis x 4, q2 weeks x4 and then monthly x3 to ensure compliance with this citation. The DON or her designee will also conduct quarterly competency and skills check-offs for residents who have medications administered per peg tube. Monitoring The facilities Q.A.P.I. committee will review audits, skills check-off sheets on a monthly basis. The Director of Nursing or her designee will be responsible for compliance. The audits will begin on 3/7/14.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	F431 Drug Records, Label/Store Drugs & Biologicals The facility will make every effort to meet and comply with the Idaho and Federal Statutes to ensure medications are labeled correctly.	3/7/14

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F 431	Continued From page 22 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and clinical record reviews, the facility failed to ensure a second LN consistently witnessed and documented the disposal of used fentanyl (long acting pain medication) patches; and, that medications labels matched physician orders. This was true for 3 of 9 residents (#s 2, 5, and 12) during medication pass observations. Not having 2 LNs witness the disposal of Resident #2	F 431	Affected Residents Resident #2 and #5's MAR was changed to ensure that two nurses would witness the destruction of the fentanyl path. Resident #5 and #12's mislabeled medications were corrected to ensure that the correct route was listed. Resident #5's Nasal Spray was re-order to ensure the label matched the Physician Order. All residents could be affected by this citation Corrective Action The medication pass times were changed to ensure that two nurses were available for the destruction of Duragesic Patches. The label for the Miacalcin was corrected to ensure that it matched the physician orders. All residents with tube feeding were reviewed to ensure the proper route was listed on their medication cards.	

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F 431	Continued From page 23 and #5's used fentanyl patches created the potential for diversion of the long acting opioid medication. Mislabeled medications created the potential for Residents #5 and #12 to receive the medications by the wrong route (by mouth rather than via enteral feeding tube) and for Resident #5's daily Miacalcin nasal spray to be administered in the same nostril, rather than alternating the nostrils as ordered. Findings included: 1. Resident #2 was admitted to the facility in 2011 with multiple diagnoses which included Alzheimer's dementia with behavioral changes and chronic pain. The resident's Active Orders from 1/1/14 to 1/31/14 included 2 Duragesic (brand name for fentanyl) patch orders as follows: * Duragesic 12 micrograms (mcg)/hour patch every 3 days, "2nd LN to witness old patch removal and disposal in toilet;" and, * Duragesic 75 mcg/hour patch every 3 days, "2nd LN to witness cut up [of] old patch and dispose in toilet." Note: Both orders were started 9/26/13. The resident's November and December 2013 and January 2014 MARS included the 2 fentanyl orders with the instructions for 2 LNs to witness the disposal of the used patches. Both of the fentanyl patches were on the same schedule to be changed every 3 day at 9:00 p.m. The aforementioned MARs contained documentation, however, that a second LN did not witness the cut up and disposal of the used fentanyl 75 mcg patches as follows: * November: 11/10 and 11/13;	F 431	The Director of Nursing in-serviced Licensed Nursing staff on 2/3/14 surrounding the destruction of Duragesic Patches needing a second Licensed Nurse as a witness and the importance of checking the Physician Order against the Medication label to ensure accuracy. If the label is incorrect the nurses will re-order the medication to ensure accuracy. **Systematic Changes** The DON or her designee will conduct audits on random resident medications and residents who have Duragesic Patches on a weekly basis x 4, q2 weeks x4 and then monthly x3 to ensure compliance with this citation surrounding the destruction of Duragesic Patch and to ensure labels on medications match the Physician Orders. **Monitoring** The facilities Q.A.P.I. Committee will review all audits on a monthly basis to ensure compliance with this citation. The Director of Nursing or her designee is responsible for compliance. Audits will begin on 3/7/14.	

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F 431	Continued From page 24 * December: 12/13, 12/19, 12/28, and 12/31; * January: 1/24. Note: A second LN did sign as a witness for the removal and disposal of the fentanyl 12 mcg patches on the same dates. On 1/29/14 at 3:50 p.m., the DON was asked about the resident's used fentanyl patches. The DON said she would look into it and get back with the surveyor. On 1/30/14 at 8:25 a.m., the DON confirmed that the disposal of the resident's used fentanyl patches was not consistently documented as witnessed by a second LN. 2. Resident #5 was admitted to the facility with multiple diagnoses which included dementia and personal history of malignant neoplasm (cancer) of the large intestine and rectosigmoid junction. Note: On 12/20/13, an enteral feeding tube was surgically placed in the resident's abdomen. The resident's Active Orders from 1/1/14 to 1/31/14 included: * Duragesic 12 micrograms/hour transdermal patch every 3 days, "2nd LN to witness old patch removal and dispose in toilet." It was started 12/17/13; * Miacalcin (brand name for calcitonin-salmon, for osteoporosis) 200 unit/activation, 1 spray everyday in one nostril, "alternating nostrils each day." It was started 12/17/13. A Physician's Telephone Order, dated 1/4/14, increased the resident's Thorazine (generic name chlorpromazine, an antipsychotic medication) 25 mg from 2 times/day to 3 times/day via the enteral feeding tube.	F 431		

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F 431	Continued From page 25 a) The December 2013 MAR documented the resident's Duragesic patch was changed every 3 days at 9:00 p.m. However, it also contained documentation that the disposal of the used patches was not witnessed by a second LN on 12/23 and 12/28. On 1/29/14 at 4:00 p.m., the DON was asked about the resident's Duragesic patches. The DON confirmed that a second LN did not consistently document as a witness to the disposal of the used patches. The facility's policy regarding used fentanyl patch disposal was requested. A Disposal of Fentanyl Transdermal Patches policy, dated 1/18/13, was received on 1/30/14. It documented, in part, "Procedure: 1. The facility should have the disposal of a fentanyl transdermal patch witnessed by another nurse to prevent diversion and document the removal and disposal down the toilet. ... 3...Do not cut patches with scissors... 5. Used patches will be removed from the resident and flushed down the toilet with two nurses present." b) On 1/29/14 at 10:00 a.m., LN #3 was observed as she administered Miacalcin 1 spray into the resident's right nostril then documented it on the resident's MAR. The pharmacy label read, "Calcitonin-Salmon 200 unit dose 1 spray nasally every day." At about 11:15 a.m., reconciliation of the Miacalcin with the resident's physician orders revealed that the instructions to alternate the nostrils was not included on the pharmacy label for the calcitonin-salmon.	F 431		

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F 431	Continued From page 26 At 11:35 a.m., LN #3 was asked about the discrepancy between the physician's order and the pharmacy label for the resident's Miacalcin. The LN stated, "It [pharmacy label] should say to alternate nares [nostrils]." c) On 1/28/14 at 9:00 a.m., LN #2 was observed as she poured 3 medications (meds), which included Thorazine 25 milligrams (mg) 1 tablet, for Resident #5. The pharmacy label on the Thorazine read, "Thorazine 25 mg 1 by mouth three times daily." The LN attempted to administer the medications via the resident's enteral feeding tube, but was not successful, as the tube was plugged. At 9:30 a.m., reconciliation of the medications with the resident's physician orders, revealed the Thorazine was ordered via the enteral feeding tube on 1/4/14. On 1/28/13 at about 10:15 a.m., LN #2 stated a pharmacist was in the building and had changed the label on the resident's Thorazine. Note: The order for Thorazine via the resident's enteral tube route was given on 1/4/14. The pharmacy did not provide a label with the correct route of administration for Thorazine for 24 days. On 1/30/14 at 4:00 p.m., the Administrator and DON were informed of the issues regarding the resident's used fentanyl patches and pharmacy labels. No other information was received from the facility which resolved any of these issues. 3. On 1/27/14 at 2:00 p.m., LN #1 was observed as she poured then administered 4 medications and 1 can of Promote to Resident #12 via the	F 431		

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F 431	Continued From page 27 resident's enteral feeding tube. The meds included 1 tablet of lorazepam (brand name Ativan, for anxiety) 0.5 milligrams (mg) and 1 tablet of chlorpromazine (brand name Thorazine, an antipsychotic) 100 mg. However, the pharmacy label for lorazepam read, "Take 1 tab by mouth three times daily;" and, the pharmacy label for chlorpromazine read, "Take 1 tab by mouth four times daily." At 2:05 p.m., reconciliation of the medications with the resident's Active Orders from 1/1/14 to 1/31/14 revealed both of the medications were ordered to be given via the enteral feeding tube. The Ativan order was dated 6/26/12 and the Thorazine order was dated 12/13/12. At 2:10 p.m., LN #1 was asked about the resident's pharmacy label instruction for Ativan and Thorazine by mouth rather than via the enteral tube. The LN stated, "Yeah, pharmacy is here every evening except Monday." The LN confirmed that the pharmacy labels had not been changed, "Yet." The LN indicated she would contact the pharmacy about the incorrect labels. On 1/30/14 at 4:00 p.m., the Administrator and DON were informed of the issue. No other information was received from the facility which resolved the issue.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	<u>F441 Infection Control, Prevent Spread, Linens</u> The facility will make every effort to meet and comply with the Idaho and Federal Statutes surrounding Infection Control.	3/7/14

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F 441	Continued From page 28 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed hand hygiene after administration of a medication by subcutaneous injection. This affected 2 random residents (#s 13	F 441	Affected Residents LN in-serviced by DON discussing infection control practices surrounding the surveyor observation for Resident #13 and 14. All residents could be affected by this citation Corrective Action The Administrator, DON, or their designee will in-service all staff on 2/27/14 about the necessity of hand hygiene either with soap, warm water, and friction for 20-30 seconds after a resident contact or alcohol-based waterless hand rubs between resident contacts. Systematic Changes The infection control nurse or her designee will conduct weekly audits x 4, q2 weeks x4 and then	

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F 441	Continued From page 29 and 14). Failure to follow standard infection control measures placed the residents at risk for infections. Findings included: On 1/29/14 at 11:20 a.m., LN #3 was observed as she administered an insulin medication into Resident #13 abdomen via subcutaneous injection then, removed her gloves. However, the LN did not perform any type of hand hygiene before she left the resident's room and returned to the medication cart parked in the hallway by the main dining room. Within seconds, another staff asked the LN to help move a chair into Resident #14's room and the LN did so bare handed. At 11:35 a.m., LN #3 was informed of the above observation. The LN indicated yes when she nodded her head up and down. She stated, "Okay. Thank you." The facility's Hand Hygiene policy included, "Cleaning hands with soap, warm water, and friction for 20-30 seconds or alcohol-based waterless hand rubs as promptly and thoroughly as possible between resident contacts... Times to perform hand hygiene: ... After removing gloves..." On 1/31/14 at 4:00 p.m., the Administrator and DON were informed of the infection control issue. No other information was received from the facility regarding the issue.	F 441	monthly x3 to ensure compliance with this citation. The audits will ensure that all staff are following proper infection control procedures after or before a patient contact. **Monitoring** The facility Q.A.P.I. Committee will review the monthly audits to ensure compliance. The Director of Nursing, Infection Control Nurse, or their designee are responsible for compliance. The audits will begin 3/7/14.	

Bureau of Facility Standards

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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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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the State licensure survey and complaint investigation of your facility. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator; Bradley Perry, LSW; and, Jana Duncan, RN, MSN. Survey Definitions: DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse	C 000	RECEIVED MAR 12 2014 FACILITY STANDARDS	
C 361	02.108.07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F253 regarding a cracked window and missing paint.	C 361	C361- See P.O.C F253	3/7/14
C 393	02.120.04.b Staff Calling System at Each Bed/Room b. A staff calling system shall be installed at each patient/resident bed	C 393	C393- See P.O.C. F246	3/7/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: MBA/HCM | TITLE: Administrator | (X6) DATE: 3/7/14

Bureau of Facility Standards

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	MDS001530		01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREEK REHABILITATION CENTER OF KI	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) COMPLETE DATE
C 393	Continued From page 1 and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F 246 as it related to call light accessibility.	C 393		
C 411	02.120.05,k All Resident Rooms Numbered k. All patient/resident rooms shall be numbered. All other rooms shall be numbered or identified as to purpose. This Rule is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure five rooms in the facility were labeled. This had the potential to effect the residents or visitors who resided or came to the facility. Findings include: On 1/27/14 at 11:25 AM a tour of the facility was completed. The following rooms did not have any identification: *Television room *Medication room *300 Hall dining room *Pyxis nurse room [hallway entrance] *Pyxis nurse room [dining room entrance] On 1/27/14 at 2:20 PM, the Administrator was	C 411	**C411 All Resident Rooms Numbered** The facility will make every effort to meet and comply with the Idaho Statutes to ensure all resident rooms are labeled. **Affected Residents** All residents could be affected by this citation. **Corrective Action** The rooms that were identified in the survey were labeled within an hour of notification from the survey team. **Systematic Changes** The Administrator or his designee will conduct weekly audits x 4, q2 weeks x4 and then monthly x3 to ensure that all rooms in the facility are labeled to ensure compliance with this citation. **Monitoring** The Q.A.P.I. Committee will review the monthly audits surrounding this citation. The Administrator is responsible for compliance for this citation. Audits will begin on 3/7/14.	3/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001530		01/31/2014

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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C 411	Continued From page 2 shown unlabeled rooms and he stated, "Very true, I'll take care of that." On 1/27/14 at 2:45 PM, the Administrator was observed in hallway 300 placing temporary signs to label doors.	C 411		
C 644	02.150.01.a.i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Refer to F 441 as it related to hand hygiene.	C 644	C644- See P.O.C. F 441 C664 Required Members of Committee The facility will make every effort to meet and comply with the Idaho Statutes surrounding an Infection Control Committee. Affected Residents All residents could be affected by this citation	3/7/14 3/7/14
C 664	02.150.02.a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, the facility failed to ensure the pharmacist, food services supervisor, a representative from the housekeeping department, and a representative from the maintenance department attended/participated in ICC meetings at least quarterly. This failure created the potential for a negative affect for all residents, staff, and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included:	C 664	Corrective Action The Administrator or DON will ensure that all members of the infection control committee listed in the State guidance are at the Infection Control Committee on a quarterly basis. Systematic Changes The Administrator or his designee will conduct an audit on a monthly basis to ensure all members of the Infection Committee were in attendance of the at least quarterly meeting to ensure compliance with this citation.	

Bureau of Facility Standards

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	MDS001530		01/31/2014

NAME OF PROVIDER OR SUPPLIER: OAK CREEK REHABILITATION CENTER OF KII

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C 664	Continued From page 3 On 1/30/14 at 10:00 a.m., the Infection Control Nurse (ICN) was interviewed. The ICN stated the ICC met monthly during Quality Assurance (QA) meetings. Attendance records were requested for the last 6 months of ICC meetings. The ICN provided the requested attendance records about 11:00 a.m. on 1/30/14. The attendance records, dated 8/27/13, 9/24/13, 10/15/13, 11/27/13, 12/31/13, and 1/21/14, documented the following ICC members did not attend/participate in ICC meetings at least quarterly: * Pharmacist: did not attend/participate in any of the meetings. * Food Services Supervisor: attended only the November and December meetings; * Maintenance representative: did not attend/participate in any of the meetings; and, * Housekeeping: did not attend/participate in any of the meetings. On 1/30/14 at 4:00 p.m., the Administrator and DON were informed of the issue. No other information was received from the facility which resolved the issue.	C 664	Monitoring The Q.A.P.I Committee will review the monthly and/or Quarterly Infection Control Committee report to ensure that all members were present. The Administrator is responsible for compliance. Audits will begin on 3/7/14 for this citation.	
C 745	02.200.01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F 281 as it related to blood glucose check techniques.	C 745	C745 See P.O.C. 281	3/7/14

Bureau of Facility Standards

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C 761	Continued From page 4	C 761		
C 761	02.200,02,c,i When Average Census of 59 or Less i. In SNFs with an average occupancy rate of fifty-nine (59) patients/residents or less a registered professional nurse shall be on duty eight (8) hours of each day and no less than a licensed practical nurse shall be on duty for each of the other two (2) shifts. This Rule is not met as evidenced by: Based on review of the Three-Week Nursing Schedule and staff interview, the facility failed to ensure an RN was on duty 8 hours on 1/15/14, 1/16/14, and 1/17/14. This failure created the potential for a negative effect for 9 of 9 sample residents (#s 1-9) and all other residents who lived in the facility. Findings included: On 1/28/14 at about 4:30 p.m., the Administrator provided the Three-Week Nursing Schedule for 1/5/14 through 1/25/14. It provided evidence that the facility did not have any RN coverage on 1/15, 1/16, and 1/17/14. On 1/29/14 at 9:00 a.m., when asked about RN coverage, the Administrator stated, "There was a week [DON's name] was sick and we didn't have RN coverage for 3 days." No other information was received from the facility which resolved the issue.	C 761	**C761 RN Staffing** The facility will make every effort to meet and comply with the Idaho Statutes to surrounding RN coverage. **Affected Residents** The facility will ensure there is 8 hours of RN coverage for the identified residents in the survey #1-9.All residents residing in the facility could be affected by this citation. **Corrective Action** The facility will ensure that there are at least 8 hrs of continuous RN coverage on a weekly basis. **Systematic Changes** The Administrator or his designee will conduct weekly audits x 4, q2 weeks x4 and then monthly x3 to ensure that there has been 8 hrs a day of continuous RN coverage ensuring compliance with this citation. **Monitoring** The facilities Q.A.P.I. Committee will review the monthly audits to ensure compliance with this citation. The Administrator is responsible for compliance. Audits will begin on 3/7/14.	3/7/14
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's	C 779		

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C 779	Continued From page 5 needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 regarding the lack of an incontinence care plan.	C 779	C 779- See P.O.C. F272	3/7/14
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 regarding Baclofen pump care plan not revised. Refer to F315 regarding lack of incontinence care plan.	C 782	C 782- See P.O.C. F 280 and F 315	3/7/14
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F 314 as it related to recurrent pressure ulcers.	C 789	C789- See P.O.C. F 314	3/7/14
C 798	02.200,04,a MEDICATION ADMINISTRATION Written Orders 04. Medication Administration. Medications shall be provided to patients/residents by licensed nursing staff in accordance with established written procedures which shall include at least the following:	C 798	C798- See P.O.C. F332	3/7/14

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C 798	Continued From page 6 a. Administered in accordance with physician's dentist's or nurse practitioner's written orders; This Rule is not met as evidenced by: Refer to F 332 as it related to medication errors.	C 798		
C 832	02.201.02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Refer to F 431 as it related to prescription labels.	C 832	C832- See P.O.C. F 431 C833 No Alteration of Original Legend The facility will make every effort to meet and comply with the Idaho Statutes surrounding labeling of medications. Affected Residents New medication cards were obtained by the facility for Resident #5 and #12 to ensure there was no alteration of the original pharmacy label. All residents could be affected by this citation Corrective Action The DON in-serviced the Licensed Nursing staff that labels stating "Directions changed refer to chart" are not allowed to be affixed to a medication card as that changes the original Physician Order.	3/7/14 3/7/14
C 833	02.201.02,g No Alteration of Original Legend g. No alteration or replacement of original prescription legend shall be allowed. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined that original prescription legends were altered on 3 of 27 medications during medication pass observations which involved 2 of 9 residents (#s 5 and 12). The failure created the potential for medication errors. Findings included: 1. On 1/27/14 at 2:00 p.m., LN #1 was observed as she poured 4 medications for Resident #12. The medications included 10 milliliters (ml) of Depakene (brand name for valproic acid) 250	C 833		

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C 833	Continued From page 7 milligrams (mg)/5 ml syrup. The prescription label on the Depakene read, "Give 10 ml (600 mg) daily." The label did not include the route of administration. However, a sticker on the prescription label read, "Directions changed refer to chart." At 2:10 p.m., LN #1 was asked about the sticker on the resident's original Depakene prescription label. The LN said a nurse must have added the sticker because of a change. She added, "Pharmacy is here every evening except Monday." The LN indicated the prescription label should have already been replaced. 2. On 1/28/14 at 9:55 a.m., LN #2 was observed as she poured 3 medications for Resident #5. The medications included Thorazine 25 milligrams (25) 1 tablet by mouth three times daily and Macrobid 100 mg 1 tablet by mouth two times daily for 7 days. A sticker, which read, "Directions changed refer to chart" was on the prescription label for both the Thorazine and Macrobid. At about 10:15 a.m., LN #2 stated a pharmacist was in the building and had already changed the prescription labels on the resident's medications. On 1/31/14 at 4:00 p.m., the Administrator and DON were informed of the issue. No other information was received from the facility which resolved the issue.	C 833	**Systematic Changes** The DON or her designee will conduct weekly audits x 4, q2 weeks x4 and then monthly x3 to ensure that no labels have been affixed to the medication cards which would change the original physician order or pharmacy label. **Monitoring** The facilities Q.A.P.I. Committee will review the monthly audits to ensure compliance with this citation. The Director of Nursing or her designee is responsible for compliance. Audits will begin on 3/7/14.	
C 852	02.201.03,f Disposition of Unused Schedule II Drugs f. All schedule II drugs which are discontinued or which are left over	C 852	C 852 See P.O.C. F431	3/7/14

Bureau of Facility Standards

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C 852	Continued From page 8 after the discharge or death of a patient/resident shall be handled or returned according to applicable regulations of the Idaho Board of Pharmacy. It shall be noted in the patient's/resident's medical record when schedule II drugs are returned. This Rule is not met as evidenced by: Refer to F 431 as it related to used fentanyl patch disposal.	C 852		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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February 12, 2014

Charles D. Lloyd Jr., Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Lloyd:

On **January 31, 2014**, a Complaint Investigation survey was conducted at Oak Creek Rehabilitation Center of Kimberly. Linda Kelly, R.N., Bradley Perry, L.S.W. and Jana Duncan, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on January 27 through 31, 2014.

The following documents were reviewed:

- The facility's grievance files;
- Resident Council meeting minutes October 2013 through January 2014;
- The identified resident's entire medical record;
- Nine other residents were reviewed for quality of care concerns;
- Four residents were interviewed individually regarding quality of care;
- Two other residents were reviewed for advance directives, code status and health decline physician and family notifications;
- An infection control report; and
- The identified resident's trust account.

The following interviews were completed:

- Five residents were interviewed at a group interview regarding quality of care and trust account issues;
- Two resident's family members were interviewed regarding the quality of care, code status,

timely health decline notification and management of trust accounts;

- The Director of Nursing (DoN) was interviewed regarding the quality of care, code status and timely health decline notification;
- The Infection Control Nurse (ICN) was interviewed regarding infection control procedures and precautions for the facility; and
- The Office Manager was interviewed regarding the management of residents' trust accounts.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005899

ALLEGATION #1:

The complainant stated the Durable Power of Attorney for Health Care (DPAHC) ordered a change in the resident's resuscitation code status on February 1, 2013, at 2:41 p.m., over the phone, but it was not immediately implemented, and the facility kept calling for clarification on the issue.

The complainant stated; however, the DPAHC ordered the change back to the original resuscitation code status after speaking with the resident's physician at 9:49 p.m., before the resident would have needed resuscitation.

FINDINGS:

The identified resident had expired prior to the complaint investigation.

The identified resident's advanced directives were reviewed and documented the resident was on comfort care with a do not resuscitate (DNR) order.

The identified resident's nursing progress notes were reviewed and indicated that the code status was not requested until 10:40 p.m. on February 1, 2013, and the nurse immediately called the Director of Nursing, the physician and the administrator regarding the change of status. After talking with the DPAHC, the physician called the facility back on behalf of the DPAHC at 11:30 p.m. to alert the facility to ignore the verbal code status change requested during the previous hour.

Review of the advanced directives in two other resident's records documented clear advance directive orders.

Two resident's family members were interviewed regarding advance directives and expressed no concerns.

The DoN was interviewed about the change of code status and said she and the physician were notified since it was a change of condition for the resident.

Although the incident may have occurred as described, based on records reviewed and residents, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated it is impossible for the identified resident to contract the flu and expire within only a few hours.

FINDINGS:

An infection control report was reviewed during the time of the alleged event, and it documented that only two residents contracted the flu in the facility, and the identified resident was not one of the two.

The identified resident's medical record documented in the nurses' progress notes, the physician's notes, the coroner's report and an infection control report that the resident did not have the flu or expire related to the flu. The documentation further indicated the resident had the Norovirus, which has a symptom of vomiting, which lead to the cause of death of aspiration pneumonia.

Nine residents were reviewed for quality of care concerns and no concerns regarding the flu were found.

Five residents were interviewed at a group interview regarding the quality of care and no one voiced concerns over their care.

Four individual resident's interviews were conducted regarding quality of care and none expressed concerns related to the flu.

Two resident's family members were interviewed regarding the quality of care, and neither of them voiced any concerns over the care.

The ICN was interviewed regarding the flu and she said that during the time in question only two residents contracted the flu; however, many residents acquired the Norovirus and were placed in contact isolation according to standards of practice and the facility's policy.

The DoN was interviewed regarding the flu concerns. She said a different resident had contracted the flu and all the residents were being treated with preventive precautions. She said that when the Norovirus was found in the facility they initiated proper infection control procedures. Residents were isolated, the facility was temporarily shut down to visitors and no new admissions were allowed into the facility.

Based on records reviewed and residents, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the physician and family notification of the resident's change of condition was not timely. The complainant stated the family was not notified until February 1, 2013, at 2:41 p.m. of the resident's illness, the resident expired nine hours later.

FINDINGS:

The identified resident nurses' progress notes, doctor's notes and doctor's orders were reviewed for timely physician and family notification. The notes and orders documented that the family and physician were informed of the resident's health decline on January 30, 2013. The notes further document that from January 30 through February 2, 2013, the family was contacted eight times regarding the identified resident's change of condition and the physician was notified at least seven times during the same period.

Two resident's family members were interviewed regarding timely notifications of health decline and no concerns were voiced.

The DoN was interviewed regarding the identified resident's notifications and she said that the family and physician were sufficiently informed of the resident's health decline. In addition, she said all resident's families are notified when there is a change of condition for a resident.

Based on records reviewed and residents, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident's remaining trust account balance may not have been handled correctly, and the DPAHC did not receive a January 2013 statement.

FINDINGS:

The identified resident's trust account was reviewed. Trust statements documented the January 2013 statements had been mailed to both the DPAHC and the resident's Successor Trustee. A copy of a processed check documented the resident's account balance was sent to a local funeral home one day after the resident expired, which zeroed out the account.

Five residents were interviewed at a group interview regarding trust accounts and no one expressed concerns on how the facility handles their accounts.

Two resident's family members were interviewed regarding the management of trust accounts and neither of them expressed any concerns.

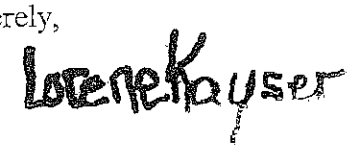
The Office Manager was interviewed regarding the management of trust accounts and how the funds are dispersed after a resident leaves the facility. She said monthly statements are sent out and she keeps copies of the statements. She also said that when a resident expires at the facility, depending upon which government insurance the resident has at the time, those funds would either be sent directly to the funeral home or sent to the appropriate agency for reimbursement.

Based on records reviewed and resident, family and staff interviews, the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 28, 2014

Charles D. Lloyd Jr., Administrator
Oak Creek Rehabilitation Center of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

FILE COPY

Provider #: 135084

Dear Mr. Lloyd:

On **January 31, 2014**, a Complaint Investigation survey was conducted at Oak Creek Rehabilitation Center of Kimberly. Linda Kelly, R.N., Bradley Perry, L.S.W. and Jana Duncan, R.N. conducted the complaint investigation. The complaint was investigated during the facility's annual Recertification and State Licensure survey.

The records of ten sample residents, including the records of the identified resident and two other residents with pressure ulcers, were reviewed. The following documentation was reviewed for the identified resident:

- Admission orders, "Active Order" and interim physician's orders;
- Physician visit notes and office telephone notes;
- Admission nursing assessment;
- Comprehensive care plans;
- Nurses' notes;
- Pressure sore risk assessment;
- Weekly Skin Impairment sheets;
- Treatment sheets;
- Wound Ostomy Certified Nurse (WOCN) evaluation;
- Weekly weights;
- Initial Nutritional Interview/Review and follow-up reviews by the Dietary Services Manager;
- Initial Nutritional Evaluation and follow-up reviews by a Registered Dietitian;

- Food Intake records;
- Input and Output records;
- Speech Therapy (ST) Evaluation and follow-up visit notes;
- Barium Swallow study report;
- Occupational Therapy Evaluation and follow-up visit notes;
- Physical Therapy Evaluation and follow-up visit notes;
- Activities of Daily Living (such as: bed mobility, transfers, eating) records; and
- Chest x-ray report.

Interviews were conducted with:

- The Director of Nursing (DoN);
- Minimum Data Set (MDS) Nurse;
- Three Certified Nursing Aides (CNAs); and
- Registered Dietitian (RD).

Observations of skin breakdown/pressure ulcers were made for two residents.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006082

ALLEGATION #1:

The complainant stated an identified resident developed a pressure ulcer on the resident's butt and was admitted to the hospital with diagnosis of pressure ulcer.

FINDINGS:

The identified resident's clinical record contained evidence the resident was admitted to the facility with excoriation and shearing to the buttocks, which persisted throughout the resident's stay in the facility. The resident's skin care plan interventions were appropriate and implemented in a timely manner. There was no documented evidence the identified resident developed a pressure ulcer while in the facility. However, another resident developed an avoidable pressure ulcer while in the facility and the facility was cited for the failure. Please refer to F314 regarding the failed practice.

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

ALLEGATION #2:

The complainant stated an identified resident lost over 40 pounds and was admitted to the hospital with a diagnosis of malnutrition. The complainant stated the resident weighed 269 pounds on May 3, 2013, 229 pounds on June 14, 2013, then up to 240 pounds with IV fluids.

FINDINGS:

Review of the clinical record revealed the identified resident was admitted to the facility with orders for a regular 2000-calorie diabetic diet and thin liquids. The record contained evidence that the resident's weight fluctuated between 267.5 and 260.3 pounds between May 14, 2013 and May 23, 2013. On May 24, 2013, the Registered Dietitian (RD) noted the resident had a high body mass index (BMI) and high blood sugar levels and that the resident would benefit from a 10 to 15 pound weight loss. By May 29, 2013, the resident's weight was 253.3 pounds. The resident was noted to have difficulty swallowing on June 3, 2013, and the physician was notified. Oral liquids were changed to nectar thick liquids and a Speech Therapy (ST) evaluation was ordered. The ST evaluation was completed the next day and the resident's diet was changed to dysphagia 2 with honey thick liquids. The ST noted "a structure displacement of (the resident's) larynx by 10-25% to the left of midline making safe positioning for PO (oral) intake difficult." The physician assessed the resident June 4, 2013, and ordered a modified barium swallow study per the ST's recommendation. By June 5, 2013, the resident's weight was 250 pounds. The barium study completed June 6, 2013, confirmed displacement of the larynx and the swallowing problems. On June 7, 2013, the RD offered nutritional supplements; however, the resident declined the supplements and expressed desire to lose more weight. The RD recommended a gradual weight loss instead and cautioned the resident against rapid weight loss. The RD and the physician reassessed the resident June 10, 2013. The RD recommended nothing by mouth (NPO) or if the resident wished to eat, a licensed nurse to feed the resident 1/2 teaspoon of pureed food at a time followed by multiple swallowing. On June 10, 2013, the physician noted "not able to swallow safely by mouth for nutrition and hydration... Alternating methods of feeding are recommended." However, the resident wanted to think about a feeding tube placement and the physician agreed that a licensed nurse would feed the resident tiny bites. By June 13, 2013, the resident's weight was down to 240.7 pounds. The physician reassessed the resident June 14, 2013, and noted "really unable to eat or drink anything at this time..." The resident agreed to expedite feeding tube placement that day and was admitted to a hospital for the tube placement.

The resident did have weight loss. However, deficient practice was not identified as the resident's facility clinical record contained documented evidence that the facility provided timely and appropriate care and interventions.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident was admitted back to the hospital June 14, 2013, with a diagnosis of aspiration pneumonia.

FINDINGS:

Review of the identified resident's clinical record revealed the first manifestation of respiratory issues; wheezing and crackle lung sounds and light yellow sputum, was noted May 29, 2013. The physician was notified that day and gave orders for an oral antibiotic and nebulizer treatments. The respiratory issues persisted but did not worsen, and the nebulizer treatments were continued. During this time, the resident resumed smoking cigarettes. On June 4, 2013, a Speech Therapy (ST) evaluation was completed and "a structure displacement of (the resident's) larynx by 10-25% to the left of midline making safe positioning for PO (oral) intake difficult." The physician assessed the resident June 4, 2013, and ordered a modified barium swallow study per the ST's recommendation. The barium study completed June 6, 2013, confirmed displacement of the larynx and the swallowing problems. The Registered Dietitian (RD) and the physician reassessed the resident June 10, 2013. The RD recommended nothing by mouth (NPO) or if the resident wished to eat, a licensed nurse to feed the resident 1/2 teaspoon of pureed food at a time followed by multiple swallowing. On June 10, 2013, the physician diagnosed "other respiratory complications - aspiration" and noted "not able to swallow safely by mouth for nutrition and hydration... Alternating methods of feeding are recommended." However, the resident wanted to think about a feeding tube placement and the physician agreed that a licensed nurse would feed the resident tiny bites. The physician reassessed the resident again on June 14, 2014, and noted "really unable to eat or drink anything at this time..." The resident agreed to expedite feeding tube placement that day and was admitted to a hospital for tube placement.

The resident was diagnosed with respiratory complications related to aspiration. However, deficient practice was not identified as the resident's facility clinical record contained documented evidence that the facility provided timely and appropriate care and interventions.

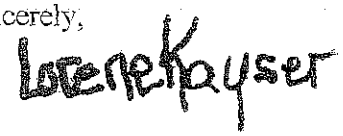
CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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 or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj