



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

June 15, 2017

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

Provider #: 135084

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

Dear Mr. Smith:

On **June 6, 2017**, a Facility Fire Safety and Construction survey was conducted at **Oak Creek Rehabilitation Center of Kimberly** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 28, 2017**. Failure to submit an acceptable PoC by **June 28, 2017**, may result in the imposition of civil monetary penalties by **July 18, 2017**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 11, 2017**, (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 **July 11, 2017**. A change in the seriousness of the deficiencies on **July 11, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **July 11, 2017**, includes the following:

Denial of payment for new admissions effective **September 6, 2017**.  
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 **December 6, 2017**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 6, 2017**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<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 **June 28, 2017**. If your request for informal dispute resolution is received after **June 28, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 06/15/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  06/06/2017
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NAME OF PROVIDER OR SUPPLIER  OAK CREEK REHABILITATION CENTER OF KIMBERLY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  The facility is a single story, Type V (III) construction, with multiple exits to grade. It was originally constructed in 1963, is fully sprinklered with smoke detection throughout. Currently the facility is licensed for 57 SNF/NF beds.  The following deficiencies were cited during the annual life safety code survey conducted on June 6, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		

RECEIVED  
JUN 30 2017  
FACILITY # 135084

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6/28/17
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 353	<p>Continued From page 1</p> <p>any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the required supply of spare sprinklers for the fire suppression system. Failure to ensure spare sprinklers are readily available for prompt replacement could slow or hinder the restoration of the system due to a damaged or operated sprinkler. This deficient practice affected 38 residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on June 6, 2017, from approximately 10:30 AM to 12:00 PM, observation of the cabinet which holds spare sprinklers for replacement on the premises, revealed the facility did not maintain a supply of spare sprinklers of each type and temperature rating. The facility had five (5) total replacement sprinklers, not the required six (6). During the facility tour, recessed sprinkler heads were observed in the facility, but there were no recessed spare sprinklers in the box. When asked, the Maintenance Supervisor stated the facility was unaware of the requirement for replacement sprinklers.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 (2011) 5.2.1.4 The supply of spare sprinklers shall be inspected annually for the following: (1) The correct number and type of sprinklers as</p>	K 353	<p>Delta fire provided facility with one (1) recessed sprinkler replacement, bringing facility reserve sprinklers to six of all type heads. Maintenance supervisor will conduct inventory not less than quarterly to ensure that required stock is maintained.</p>	6/22/2017	

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K 353	Continued From page 2 required by 5.4.1.4 and 5.4.1.5 (2) A sprinkler wrench for each type of sprinkler as required by 5.4.1.6 5.4.1.4* A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. 5.4.1.4.1 The sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property and ratings installed and shall be as follows: (1) For protected facilities having under 300 sprinklers-no fewer than 6 sprinklers (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers	K 353			
K 511 SS=F	NFPA 101 Utilities - Gas and Electric  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were installed and used in accordance with NFPA 70. Failure to ensure proper electrical installations and use could result in electrocution or fire. This deficient practice affected 38 residents, staff and	K 511			

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K 511	Continued From page 3 visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 38 on the day of the survey.  Findings include:  During the facility tour on June 6, 2017 from approximately 10:30 AM to 12:00 PM, observation of the facility revealed the following: 1.) The HR office had an RPT (Relocatable Power Tap) being used as permanent wiring for a small refrigerator and microwave. There was an additional RPT being used for power cords that were too short to allow the RPT to rest on the floor. This caused the RPT to "dangle" from the power cords, suspended, not resting on a solid surface. 2.) Resident room 201 had a medical bed plugged in to an RPT being used as permanent wiring. 3.) Resident room 310 had a multi-plug adapter in use. 4.) The Medical Records office had an RPT being used for power cords that were too short to allow the RPT to rest on the floor. This caused the RPT to "dangle" from the power cords, suspended, not resting on a solid surface. 5.) The Administration office had an RPT plugged in to an RPT creating a "daisy chain". 6.) At the ice machine in the dining room, there was a power cord plugged in to an outlet with the cord running through a hole in the wall and into an adjoining closet. Further observation revealed the cord continued up the wall of the closet where it was spliced to another wire that continued through the ceiling. It could not be determined where the cord went or what it was providing power for.	K 511	1.) Business Office removed refrigerator and microwave.  2.) Bed plug moved to wall receptacle.  3.) Multi-plug adapter removed and RPT put in place.  4.) Medical records RPT surface mounted to wall.  5.) RPT removed eliminating "Daisy Chain"  6.) Cord ran through wall removed, penetration filled with intumescent fire caulk	6/22/2017  6/06/2017  6/06/2017  6/22/2017  6/06/2017  6/22/2017

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K 511	Continued From page 4 When asked, the Maintenance Supervisor stated the facility was unaware of the inappropriate use of relocatable power taps and multi plug adapters in the facility. He also stated that the facility was unaware of the power cord going through the wall in the dining room.  Actual NFPA standard:  NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 511		
K 712 SS=F	NFPA 101 Fire Drills  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	K 712		

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K 712	<p>Continued From page 5</p> <p>routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on June 6, 2017 from approximately 8:30 AM to 10:30 AM, fire drill documentation revealed the facility failed to perform a fire drill on third shift during the first quarter of 2017 and on second shift during the fourth quarter 2016. When asked, the Maintenance Supervisor stated the facility was unaware of the missing fire drills.</p> <p>Actual NFPA standard:</p> <p>19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.</p>	K 712	<p>Facility has revised fire drill schedule so that two (2) drills are conducted each month for a total of 24 fire drills each year. Administrator will review drill logs every two (2) months to ensure compliance. This system will remain in effect not less than 12 months</p>	6/22/2017	

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K 916 SS=F	<p>NFPA 101 Electrical Systems - Essential Electric System</p> <p>Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 38 on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on June 6, 2017, from approximately 10:30 AM to 12:00 PM, observation of the facility revealed no alarm annunciator for the EES was present within the facility. When asked, the Maintenance Supervisor stated that the facility was aware that they were missing an alarm annunciator for the generator. He further stated the facility had purchased a diesel generator and would be installing the new generator with the annunciator panel soon.</p>	K 916	<p>Facility will install new generator unit and Annunciator panel no later than 30 November 2017</p>	11/30/2017	

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K 916	Continued From page 7 Actual NFPA standard:  NFPA 99 Chapter 6 Electrical Systems 6-4 Essential Electrical System Requirements - Type 1. 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: (a) When the emergency or auxiliary power source is operating to supply power to load (b) When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following: (a) Low lubricating oil pressure (b) Low water temperature (below that required in 6.4.1.1.11) (c) Excessive water temperature (d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply (e) Overcrank (failed to start) (f) Overspeed	K 916			