IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 4, 2017

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

Provider #: 135084

Dear Mr. Smith:

On **July 21, 2017**, a survey was conducted at Oak Creek Rehabilitation Center of Kimberly by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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 one that comprises a pattern that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) in writing on **July 20, 2017**.

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. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 14, 2017**. Failure to submit an acceptable PoC by **August 14, 2017**, may result in the imposition of additional civil monetary penalties by **September 8, 2017**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.

- Include dates when corrective action will be completed <u>in column (X5)</u>.

  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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Based on the immediate jeopardy cited during this survey:

- **F309 -- S/S: K -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being**

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Civil money penalty
- Denial of Payment for new admission on or before October 21, 2017

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 20, 2018**, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

- **F309 -- S/S: K -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

- Residents #s 5 and 7 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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.
In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **August 14, 2017**. If your request for informal dispute resolution is received after **August 14, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

c: Chairman, Board of Examiners - Nursing Home Administrators

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 **07/21/2017**

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 A Complaint Investigation survey was conducted at the facility on July 17, 2017 to July 21, 2017. Immediate Jeopardy was identified at 42 CFR 483.25 [F309]. Immediate Jeopardy at F309 was removed July 26, 2017 at 12:01 am. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Susan Costa, RN Definitions Include: ADL - Activities of Daily Living am - morning BG - Blood Glucose [sugar] cm - Centimeter CNA - Certified Nursing Assistant C/O - Complains of COPD - Chronic Obstructive Pulmonary disease CPAP - Continuous Positive Airway Pressure CRD - Clinical Regional Director DM - Diabetes Mellitus DNS - Director of Nursing Services FOF - Found on Floor g - Gram HI - High IDNS - Interim Director of Nursing Services LLE - Lower Left Extremity LN - Licensed Nurse LTC - Long Term Care MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set mg - Milligram	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135084		C **07/21/2017**

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	Continued From page 1 mg/dl - Milligram/deciliter mL - Milliliter OSA - Obstructive Sleep Apnea oz - Ounce P & P - Policy and Procedure SSI - Sliding Scale Insulin RCA -Root Cause Analysis ROM - Range of Motion RSD - Resident Services Director r/t - Related to w/c - Wheelchair	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 157		9/11/17

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 **07/21/2017**

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 157	Continued From page 2 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, it was determined the facility failed to ensure physicians were notified when the facility did not follow orders for oxygen therapy. This was true for 1 of 7 (#7) residents reviewed for oxygen management and had the potential for harm if orders were not followed as directed. Findings include: Resident #7 was admitted to the facility on 6/16/17 with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD) with oxygen dependence, Type II diabetes mellitus, and obstructive sleep apnea (OSA).	F 157	1. One resident was impacted by the deficient practice. Resident's C-PAP order was reviewed and resident's care plan and C.N.A. Kardex(the Kardex is verbatim from the resident's care plan as it appears in PCC and coded to the Kardex specific to what direct care givers need to know in order to provide comprehensive quality care) were updated to reflect use of C-PAP at night. CPAP was functional first day of complaint survey and remains functional with resident utilizing CPAP nightly.	

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 **07/21/2017**

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 157	Continued From page 3 Resident #7's Admission MDS (Minimum Data Set) assessment, dated 6/22/17, documented severe cognitive impairment, bowel/bladder incontinence, and extensive-to-total assistance by staff required for bed mobility, transfers, dressing and hygiene. A Physician Progress Note for Resident #7, dated 7/7/17, documented, "Recent sleep study received and indicates severe OSA. Extremely Severe OSA- initiate (resume) CPAP[Continuous Positive Airway Pressure]." A physician order, dated 7/7/17, documented staff were to provide Resident #7 with a CPAP each night at bedtime for diminishing blood-oxygen saturation rates and that the machine was to be dialed to the "B" setting. On 7/17/17 at 12:56 am, Resident #7's family member expressed concern that the facility did not assist the resident with his CPAP at night. She stated Resident #7 was sleepy during the day, which was consistent with his demeanor when not using the CPAP. The family member stated the facility informed her that a piece to the mask was either broken or missing and the CPAP was not used since his admission to the facility "over a month ago." A Nursing Progress Note, dated 7/13/17, documented a medical supply company was contacted regarding a missing piece of the CPAP device. Resident #7's record did not include documentation the physician was notified the	F 157	2. All residents with physician orders have the potential to be impacted by the deficient practice. The following are the corrective actions put into place. a. All residents' physician orders were reviewed to ensure administration/application was occurring as ordered. b. All care plans and C.N.A. Kardex's were reviewed and revised to ensure inclusion of physician orders, as appropriate. c. Licensed nurses and C.N.A.'s were in-serviced related to following the care plans and Kardex's and ensuring nurse/physician/facility management notifications if order cannot be carried out and/or refused. d. All facility staff were in-serviced to be aware of resident needs, communicate perceived changes in resident condition/equipment to facility management. 3. Measures/Systemic changes are: a. All physician orders from the previous timeframe (24-72 hrs) are reviewed in each Clinical Meeting and care plans/Kardex's updated at that time, as appropriate (refer to Clinical Meeting sheet) b. All eMars from previous timeframe (24-72 hrs) are reviewed in each Clinical Meeting to identify refusals/omissions/findings outside parameters, etc. and to ensure physician notification occurred and this notification is included in nurse progress notes. (refer	

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 **07/21/2017**

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 157	Continued From page 4 resident was unable to use the CPAP as ordered. On 7/19/17 at 5:00 am, Resident #7 was observed sleeping in his room with oxygen delivery via nasal cannula. The CPAP was not in use. On 7/19/17 at 5:10 am, LN #4 stated she did not know whether Resident #7's physician was notified the CPAP was not used as ordered.	F 157	to Clinical Meeting sheet) c. Room rounds are conducted by facility management staff prior to IDT Stand-up and Stand-down meetings that occur each business day to ensure resident's needs are being met and care plan items are present and being used as directed. These Room Round sheets are reviewed in the meeting, deficient items addressed as needed and sheets submitted to Administrator/ designee (refer to Room Round sheet). Facility management staff are also instructed to periodically throughout the day to check on their assigned residents to ensure their needs are being met. 4. Processes that monitor performance to ensure effectiveness and compliance: a. MDS Coordinator will conduct admit, quarterly, annual, and in the event of a change of condition audits to ensure inclusion of physician orders into care plans and ensure resident specific items/equipment/devices are care planned. (refer to MDS audit sheet.) b. QA tool developed to ensure resident specific items/equipment/ devices are present and care planned. (Refer to Resident-in-Room audit tool). These will be done weekly x4 and monthly x3 and included in the monthly QAPI meeting for review and action plans developed as appropriate. c. QA tool developed to ensure Care Plans are accurate and complete. (Refer to QA- Care Plan audit tool). These will be done weekly x4 and monthly x2 and included in the monthly QAPI meeting for	

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 07/21/2017

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 157	Continued From page 5	F 157	review and action plans developed as appropriate.	
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and review of facility policies, Incident Reports, and investigations, it was determined the facility failed to ensure 1 of 7 residents (#1 reviewed for quality of care concerns were not neglected by staff. Specifically: a) Resident #1 sustained harm when she fell from a wheelchair in the dining room as staff failed to offer repositioning, toileting, and physician-ordered interventions, or provide any other meaningful interaction, cares, or services for 7-hours. The resident sustained a fractured leg and hand requiring hospitalization, as well as an injury to her face. Findings include: The facility's Abuse policy, revised 5/31/17, defined neglect as "the failure of the facility, its	F 223	Failed to ensure residents were not neglected by staff. 1. One resident was affected by the deficient practice. This resident no longer resides at the facility. 2. All residents at the facility have the potential to be affected by the deficient practice of being neglected by staff. The following are the corrective actions put into place: a. All care plans were reviewed and updated to reflect the current needs of each of the residents, including any disease processes that would require interventions by licensed nurses, C.N.A.'s or other staff. b. All C.N.A Kardex's were reviewed and updated to reflect the current needs of	9/11/17

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 **07/21/2017**

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 223	Continued From page 6	F 223		

employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur, such as: the deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual resident's care needs."

1. Resident #1 was admitted to the facility on 6/15/11 with diagnoses that included dementia, muscle weakness, Type II diabetes mellitus, and chronic pain.

Resident #1's quarterly MDS (Minimum Data Set) assessment, dated 5/30/17, documented severely impaired cognition, delusions, bowel/bladder incontinence, and extensive-to-total assistance of 2 staff required for bed mobility, transfers, dressing and hygiene.

Resident #1's Care Plan directed staff to offer toileting, check for incontinence every 2 hours, turn and reposition every 2 hours, notify the Resident Services Director when mood/behavior changes took place, and provide assistance at meals as needed.

An Incident Report, dated 7/5/17 and revised 7/14/17, documented Resident #1 fell from a wheelchair to the dining room floor at 1:41 pm. The Report documented Resident #1's fall was due to "weakness/fainted. Res[ident] had sudden onset weakness, slumping to right side in chair and leaning forward in w/c [wheelchair] when

each of the residents.
c. Room audits/observations/interviews with staff, resident, and resident reps were conducted for all residents to ensure that what is occurring in the room with the resident is included in the resident's care plan.
d. Licensed Nurses and C.N.A.'s were in-served r/t need to following the plan of care and Kardex and need to notify Licensed Nurse when staff is unable to meet the needs of a resident, recognizing and responding to changes in resident condition, and notifying physician in event of a change in condition. Licensed Nurses also in-serviced on use of Staff Assignment sheet, the appropriate interventions in the event of an incident e.g. if diabetic obtain a BG level.
e. All facility staff were in serviced to be aware of resident needs, communicate perceived changes in resident condition/equipment to facility management.
3.Measures/Systemic Changes are:
a. Staff Assignment sheet is completed for each shift and the licensed nurse at the start of the shift reviews, makes/changes assignments as appropriate and signs off to ensure adequate staffing and that each resident has staff assigned to him/her. The sheet is submitted daily to the DNS for review.
b. Room Rounds are conducted by facility management staff prior to IDT Stand-up and Stand-down meetings to ensure resident's needs are being met and care plan items are present and being used as

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 **07/21/2017**

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 223	Continued From page 7 overbalanced and fell to floor. "Res[ident #1] was in dining room leaning in chair and fell forward hitting face/head on floor landing on left hip/side. Nursing was immediately notified and assessment started. Pressure held to stop nose bleed, skin tear cleansed and treated. Due to limited ROM [Range of Motion] in LLE [left lower extremity], order obtained, records copied and 911 was called to transport res[ident] to Emergency room. MD and family notifications complete." The 7/5/17 Incident Report documented LN (Licensed Nurse) #1, who was assigned to care for Resident #1 that day, completed the facility's I&A Report, however LN #1 stated on 7/18/17 at 9:48 am that she did not witness Resident #1's fall. A 7/5/17 Emergency Room Provider Note documented Resident #1 sustained a fracture of the right hand and lower left leg, and she presented with a hematoma to the right forehead and a skin tear with bruising to the right hand. On 7/17/17 at 1:33 pm, the Administrator stated his review of a closed circuit visual recording of the 7/5/17 incident documented Resident #1 was in the main dining room from 6:43 am until she fell at 1:41 pm. A written statement from a State Ombudsman, dated 7/13/17, documented s/he reviewed a facility video that documented "very brief" staff contact with Resident #1 and that the resident was not taken from the dining room or provided with cares or services. The Ombudsman documented the video showed Resident #1's	F 223	directed. These Room Round sheets are reviewed in the meeting, deficient items addressed as needed and sheets submitted to Administrator/designee (refer to Room Round sheet). c. At each Clinical Meeting the ADL flow sheets/ Bath sheets/ Meal ?monitors are reviewed from the previous day(s) to help ensure completeness/accuracy/ and consistency with each resident's care plan. d. At each Clinical Meeting the 24-hour report log, nurse progress notes and eMar are reviewed to identify any issues related to care, etc. 4. Processes that monitor performance to ensure effectiveness and compliance: a. QA audit tools Resident-in-Room and Resident-in- Facility will be done weekly x4 and monthly x3 and included in the monthly QAPI meeting for review and action plans developed as appropriate.	

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 **07/21/2017**

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 223	Continued From page 8 head dropping to the table and back to the chair, and the resident rocking side-to-side for about 10 minutes prior to the fall. The Ombudsman's written statement documented Resident #1 leaned to the left side of the wheelchair and in what appeared to be an attempt to reach something on the ground fell to the floor. The written statement documented Resident #1 did not move after the fall, and that nursing staff was "rather slow" and uncertain in their clinical response to the resident. On 7/19/17 at 4:30 pm, the Administrator provided an undated Root Cause Analysis (RCA) of the fall that documented a CNA unable to work as scheduled on 7/5/17 was replaced by another staff member who arrived late to the facility. The RCA documented CNA assignments were adjusted for the CNA's late arrival, but the CNA whose assignment was adjusted was not informed of the change, which created confusion related to staff-resident assignments. The facility's 7/5/17 schedule and time cards documented CNA #8, who was assigned to the 100 hall, arrived at the facility at 6:01 am; CNA #7, who was assigned to the 200 hall, arrived at the facility at 5:57 am; and CNA #6, who was also assigned to the 200 hall, arrived at the facility at 6:09 am. Resident #1's room was located in the 200 hall; facility staffing records documented there were 2 Licensed Practical Nurses, 2 Registered Nurses (Director of Nursing Services and Assistant DNS) and 6 CNAs on duty in the facility at the time of Resident #1's fall in the main dining room.	F 223		

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 **07/21/2017**

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 223	Continued From page 9 On 7/18/17 at 9:48 am, LN#1 stated she was assigned to care for residents on both the 100- and 200 halls, including Resident #1, who she stated was in the main dining room from before breakfast until after the fall that afternoon. She stated Resident #1 was usually incontinent of bowel and bladder, but was able to tell the CNA staff when she needed pericare. LN #1 stated Resident #1 did not receive any medications on her shift, nor assessed for pain and/or pain medications. LN #1 stated she did not know whether Resident #1 was provided incontinent care or offered a scheduled nutritional supplement that morning. On 7/19/17 at 10:52 am, CNA #8 stated she was on duty at the facility at the time Resident #1 fell, and remembered talking briefly that day with Resident #1, but was not in the dining room at the time of the fall. CNA #8 said she did not provide incontinent care or offer fluids or nutrition to Resident #1 on 7/5/17. On 7/19/17 at 2:40 pm, CNA #4 stated she observed Resident #1 leaning in her wheelchair at approximately 9:30 am to 10 am on 7/5/17 so she asked an Activities Assistant to help her reposition the resident. CNA #4 stated she walked by Resident #1 multiple times that day, but did not provide incontinent care, or offer fluids and/or nutrition. On 7/20/17 at 12:45 pm, CNA #6 stated she saw Resident #1 leaning over in her wheelchair at 1:30 pm and requested help from CNA #8 to reposition and provide incontinent care for Resident #1. CNA #6 stated she heard a "thud" about 15 minutes later and saw Resident #1 on	F 223		

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 **07/21/2017**

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 223	Continued From page 10 the floor. CNA #6 stated she did not provide incontinent care, or offer fluids/nutrition to Resident #1 on 7/5/17. On 7/20/17 at 5:30 pm, LN #3 stated she saw Resident #1 during an activity in the morning, and that she was leaning forward in her chair. LN #3 stated she told both LN #1 and the Director of Nursing Services (DNS) that Resident #1 was leaning in the wheelchair and that she thought a CNA had returned Resident #1 to her room after lunch. LN #3 stated she was surprised when she heard and then realized Resident #1 had fallen to the floor. LN #3 stated Resident #1 was lying on her left side in a pool of blood from injuries to the face and right hand. LN #3 said she was not familiar with Resident #1 and left the area for assistance from LN #1. She stated 2 CNAs were with Resident #1 at the time and the DNS was providing care to the resident upon her return. LN #3 stated she did not know what contributed to the fall. LN #3 stated she saw Resident #1 leaning in her wheelchair that morning, but the resident appeared "fine" when she last observed her in the wheelchair. Resident #1 was in a wheelchair in the main dining room from before 7:00 am until her fall at 1:41 pm. There were 4 nurses and 6 CNAs on duty in the facility at the time of the fall. During that time, Resident #1 was not offered toileting, incontinent care, physician-ordered nutritional supplements, pain assessments, analgesic medication, supervision, or any type of meaningful interaction with staff. Resident #1 fell and sustained a fractured left leg and right hand, as well as wounds to her face and right hand.	F 223		
F 279	483.20(d);483.21(b)(1) DEVELOP	F 279		9/11/17

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 07/21/2017

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 279 SS=E	Continued From page 11 COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 279		

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 **07/21/2017**

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 279	Continued From page 12 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure care plans based on residents' comprehensive assessments were developed and implemented. This was true for 4 of 7 residents (#2, #3, #5, and #7) reviewed for initial care plans and created the potential for harm if residents received inappropriate or inadequate care. Findings include: 1a. Resident #7 was admitted to the facility on 6/16/17 with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD) with oxygen dependence, Type II diabetes mellitus, and obstructive sleep apnea (OSA).	F 279	Failed to ensure care plans based on resident's comprehensive assessments were developed and implemented. 1. The residents that were affected by the deficient practice had their care plans completely revised and updated to reflect their current medical, nursing, and mental and psychosocial needs including the services that are to be furnished to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being any services the facility cannot provide or that the resident refuses, any specialized services or specialized rehab services the facility will	

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 **07/21/2017**

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 279	Continued From page 13 Resident #7's Admission MDS (Minimum Data Set) assessment, dated 6/22/17, documented severe cognitive impairment, bowel/bladder incontinence, and staff assistance required for bed mobility, transfers, dressing and hygiene. A Physician Progress Note, dated 7/7/17, documented, "Recent sleep study received [by Resident #7] and indicates severe OSA. Extremely Severe OSA initiate (resume) CPAP." A 7/7/17 physician order documented staff were to provide Resident #7 with a Continuous Positive Air Pressure (CPAP) machine at night and on the "B" setting. Resident #7's Medication Administration Record (MAR) documented staff was to provide the CPAP nightly at the "B" setting each shift "for dropping oxygen level." Nursing Progress Notes from 7/7/17 through 7/18/17 documented: * 7/7/17 - 7:00 pm: "Res[ident] has been exhibiting moist productive cough throughout shift. Res[ident] [family member] reported it was because he has not been using his CPAP machine." * 7/13/17: The facility contacted a medical supply company regarding a missing piece of equipment for Resident #7's CPAP. On 7/17/17 at 12:56 am, Resident #7's [family member] stated the CPAP had not been used since the resident's admission to the facility "over	F 279	proved as a result of PASARR recommendations, the resident's goals for admission and desired outcomes, resident's preferences and potential for future discharge and the residents desire to return to the community, and discharge plans, as appropriate. These residents' care plans were reviewed and revised, as appropriate, in a IDT Care Plan Meeting and the results of this meeting were documented in the individual resident's progress notes. 2. All residents residing at the facility have the potential to be affected by the deficient practice. a. Facility managers (IDT team) were in serviced r/t comprehensive care plan development and PCC system. b. All resident care plans were reviewed and revised according to the above (#1)criteria. c. All resident care plans were reviewed and revised, as appropriate, in an IDT Care Plan Meeting and the results of this meeting were documented in the individual resident's progress notes. 3. Measures/Systemic Changes are: a. A MDS Resident/ Resident Room form was developed for use in gathering information related to in conjunction with the MDS assessment, communication with staff, and observations to develop a comprehensive, resident-focused care plan. b. IDT were inserviced related to requirements/process/methods for development of comprehensive care plans.	

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 **07/21/2017**

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 279	Continued From page 14 a month ago." As of 7/18/17, the facility had not developed a care plan for Resident #7's physician-ordered CPAP. On 7/19/17 at 5:00 am, Resident #7 was observed sleeping in his room and receiving oxygen via nasal cannula. The CPAP was not in use. On 7/19/17 at 5:10 am, LN #4 stated the CPAP was missing a part of the facemask apparatus and Resident #7 could not use the CPAP until the missing piece was replaced. b. Resident #7's clinical record did not include a care plan addressing the resident's Type II diabetes mellitus despite physician's orders directing staff to assess blood glucose levels before meals as administer Novolog insulin per sliding scale as needed. On 7/19/17 at 5:10 am, LN #4 stated a diabetic management care plan had not been developed for Resident #7. 2. Resident #5 was admitted to the facility on 6/12/17 with diagnoses that included Type II diabetes mellitus with use of insulin and repeated falls. Resident #5's clinical record did not include an individualized diabetic management care plan; an Altered Diet Care Plan, dated 6/16/17, did not include the following:	F 279	c. The MDS Coordinator will develop and communicate a schedule for the IDT notifying them of MDS/ Care Plan schedule. d. Care Plan Meetings will be scheduled following admit, quarterly, annual and in the event of a significant change. These meetings will include the resident, resident rep(s), attending physician, LN responsible for the resident, a nurse aide, restorative aide (if applicable), dietary staff, activities, social services, and other parties as identified. This meeting will precede the resident's Care Conference. e. At the Clinical Meeting (held every business day) the following items will be reviewed and care plans updated as appropriate/applicable: Incident Reports, Alert Charting Log, Physician Orders, Progress Notes, ADL Flow Sheets, Bath Sheets, Meal Monitors, BG's, Behavior document, and the 24-hour report. Participants include the DNS, MDS Coordinator, Social Services, Activities, Dietary (when available). 4. Processes that monitor performance to ensure effectiveness and compliance: a. QA audit tools- QA/QI Care Plans and QA/QI MDS/CAA's will be done weekly x4 and monthly x3 and included in the monthly QAPI meeting for review and action plans developed as appropriate.	

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 **07/21/2017**

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 279	Continued From page 15 * When staff was to check BG levels; * Established BG level parameters; * Direction for when staff was to notify the physician if blood glucose (BG) levels fell outside physician-established parameters; * When to administer or withhold insulin; and * When to follow hyper/hypoglycemic facility protocols. On 7/18/17 at 2:56 pm, the Director of Nursing Services stated the care plan should have been more specific in regards to diabetic management. 3. Resident #3 was admitted to the facility on 3/24/17 with diagnoses that included muscle spasms and fibromyalgia. A quarterly MDS assessment, dated 7/4/17, documented Resident #3 was cognitively intact and required extensive assistance or was totally dependent on staff for all Activities of Daily Living (ADL), including eating, bathing, transfers, and bed mobility. Resident #3's Admission Nursing Assessment, dated 3/29/17, documented range-of-motion (ROM) impairments which affected both hands and ankles. The assessment documented the resident was "bedfast" and had "very limited" ability to change his own body position. An Admission Skin Risk Predictor Assessment, dated 3/29/17, documented Resident #3 was at "high risk" for developing skin related issues. "High risk" was defined as the need for frequent repositioning, pressure reducing devices, foam wedges for lateral positioning, floating of heels, nutrition, and moisture management.	F 279		

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 07/21/2017

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 279	Continued From page 16 An ADL Care Plan, dated 3/29/17, documented Resident #3 required the assistance of 2 staff for positioning, but did not address frequency of positioning, floating of heels, bathing frequency, toileting, or level of assistance required for eating. On 7/19/17 at 4:39 pm, the DNS stated the care plan should have been more specific in regards to Resident #3's ADL needs. She stated she could not determine from the care plan how often Resident #3 required repositioning, incontinence care, or bathing. 4. Resident #2 was admitted to the facility on 1/24/17 with diagnoses that included Down syndrome, severe intellectual disability, and obesity. Resident #2's quarterly MDS assessment, dated 5/1/17, documented severe cognitive impairment, bowel/bladder incontinence, and total dependence on staff for personal hygiene. Resident #2's ADL Care Plan, dated 1/24/17, did not identify how often staff were to determine whether the resident required incontinent care. On 7/19/17 at 4:39 pm, the DNS stated the care plan should have been more specific in regards to Resident #2's ADL needs, but that staff should perform a "check and change" a minimum of every two hours. She stated she could not determine how often staff were to provide Resident #2 with toileting/incontinent care based on the current care plan.	F 279		
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280		9/11/17

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 **07/21/2017**

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 280 SS=D	Continued From page 17 PARTICIPATE PLANNING CARE-REVISE CP	F 280		

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and

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 **07/21/2017**

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 280	Continued From page 18 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280		

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 07/21/2017

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 280	Continued From page 19 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to reflect current fall prevention interventions. This was true for 1 of 4 residents (#5) reviewed for care plan revision and had the potential to cause harm if residents did not receive appropriate care and interventions due to outdated and/or incomplete care plan information. Findings include: Resident #5 was admitted to the facility on 6/12/17 with diagnoses that included Type II diabetes mellitus, pseudo seizures, and repeated falls. Resident #5's admission Minimum Data Set (MDS) assessment, dated 6/19/17, documented moderate cognitive impairment and falls prior to admission. A Convulsions and History of Falls Care Plan, dated 7/14/17, documented staff was to monitor Resident #5 for convulsions, ensure her safety, record the length of time during any convulsions, complete neuro checks for suspected head injury, and report convulsions to the physician. The care plan did not include interventions to prevent falls or specific safety measures to protect the resident from injury related to seizures. A 6/18/17 Incident and Accident Report (I&A) documented Resident #5 lost her balance, fell, and bumped her head ambulating to the	F 280	Facility failed to ensure resident's care plans were revised to reflect current fall prevention interventions. 1.The care plan for the resident impacted by the deficient practice was revised to reflect current fall prevention interventions. 2. All residents have the potential to be impacted by the deficient practice. a. All resident's care plans were reviewed and revised to reflect their current status/needs. b. Assessments (e.g. as applicable, fall, skin, bladder. bowel. elopement, smoking, pain, self-med) were completed on all residents so that care plans are reflective of current status and risk. 3. Measures/Systemic Changes are: a. IDT Fall Committee Meeting scheduled for q week, notation to resident's progress note. b. Incident/accidents are reviewed at each Clinical Meeting to ensure completeness of investigation and to ensure appropriate fall interventions are put into place x72 hours. c. A resident who experiences an incident/accident will be put on Alert Charting for no less than 72 hours following the occurrence to ensure stable condition and appropriateness of interventions. d. Licensed staff inserviced related to instructions for completion of	

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 07/21/2017

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 280	Continued From page 20 bathroom. Resident #5's care plan was not updated following the 6/18/17 fall. A Nurse's Note, dated 6/24/17, at 3:47 am documented, "Resident had a seizure after supper ... Resident had to be lowered to the floor as she began to have a seizure lasting 2-3 minutes ... Resident c/o (complained of) black out periods ... spots before her eyes ... headaches ... Resident had two seizures during the day shift." Resident #5's care plan was not updated following the three seizures on 6/23/17. A Nurse's Note, dated 6/25/17 at 3:47 pm, documented Resident #5 was "FOF (Found on Floor) with seizure like activity." Resident #5's care plan was not updated following the 6/25/17 seizure. A 7/2/17 I&A documented Resident #5 fell in her room while attempting to transfer from a wheelchair to her bed. Resident #5's care plan was not updated following the 7/2/17 fall. A Nurse's Note, dated 7/11/17 at 10:07 pm, documented Resident #5 experienced a seizure at 11:00 am and was assisted to the floor as she slid out of a wheelchair. Resident #5's care plan was not updated following the 7/11/17 fall. A 7/15/17 I&A documented Resident #5 fell while walking out of the bathroom and hit her eye on the sink. Resident #5's care plan was not updated following the 7/15/17 fall. A 7/16/17 I&A documented Resident #5 fell while walking out of the bathroom and hit her head at	F 280	Incident/Accident report in PCC and in what circumstances to complete the I/A. 4. Processes that monitor performance to ensure effectiveness and compliance: a. QA audit tool- QA/QI Incidents/Accidents will be done weekly x 4 and monthly x3 and included in the monthly QAPI meeting for review and action plans developed as appropriate.	

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 07/21/2017

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 280	Continued From page 21 approximately 8:30 pm. Resident #5's care plan was not updated following the 7/16/17 fall. On 7/18/17 at 2:56 pm, the Director of Nursing Services stated Resident #5's Fall Care Plan should have been updated with new interventions to help prevent accidents after Resident #5's repeated falls and seizure activity.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, review of clinical records, and Incident and Accident Reports (I&A), it was determined the facility failed to ensure the neurological status of residents was consistently assessed after falls with the potential for head injury. This was true for 1 of 3 residents (#5) reviewed for falls and created the potential for more than minimal harm if changes in a resident's neurological status went undetected and untreated. Findings included: Resident #5 was admitted to the facility on 6/12/17 with diagnoses that included Type II diabetes mellitus, pseudo seizures, and repeat falls. Resident #5's Admission Minimum Data Set (MDS) assessment, dated 6/19/17, documented	F 281	Facility failed to ensure the neurological status of residents was consistently assessed after falls with the potential for head injury. 1. The resident negatively impacted by the deficient practice no longer resides at the facility. 2. All resident who experience falls/ dx seizures/convulsions have the potential to be impacted by the negative practice. a. Neuro-check policy was developed which instructs licensed nursing staff to begin and complete neuro-checks on residents who are witnessed to have hit their head in a fall or other incident, on all unwitnessed falls, and/or following a seizure. b. Neuro-check policy also addresses	9/11/17

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 **07/21/2017**

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 281	Continued From page 22 moderate cognitive impairment and history of falls prior to admission. A Convulsions and History of Falls Care Plan, dated 7/14/17, documented staff was to monitor Resident #5 for convulsions, ensure her safety, record the length of time during her convulsions, complete neuro checks if there was a suspected head injury, and report convulsions to the physician. The care plan did not include interventions to prevent falls or safety measures for seizures. Resident #5's Activities of Daily Living Care Plan documented an intervention that she required assistance of 1 staff member for transfers, initiated 6/12/17. A Nurse's Note, dated 6/24/17, at 3:47 am documented, "Resident had a seizure after supper ... Resident had to be lowered to the floor as she began to have a seizure lasting 2-3 minutes ... Resident c/o (complained of) blackout periods ... spots before her eyes ... headaches ... Resident had two seizures during the day shift." Resident #5's clinical record did not contain evidence that neurological checks were initiated following the three seizures on 6/23/17 or identify whether she hit her head during the first two seizures. A Nurse's Note, dated 6/25/17 at 3:47 pm, documented Resident #5 was "FOF (Found on Floor) with seizure like activity." The note documented Resident #5 complained of a headache and neurological assessments were initiated.	F 281	need to complete neuro-check as directed, until completion. c. Licensed staff were trained on the policy and use of the neuro-check form. The were also trained that in the I/A form in PCC there is a place to check if neuro-checks were started. d. Residents with a history of seizures/seizure activity/convulsions were assessed and care plans updated to include interventions to prevent falls and safety measures for residents having seizures. e. Care plans for all residents were reviewed and revised based on a numerous factors, including disease processes (seizures, convulsions) 3. Measures/Systemic Changes are: a. Progress notes are reviewed in the daily Clinical Meeting, as well as the 24-hour report- typically this is where documentation exists when a resident experiences a change of condition, e.g. seizures, convulsion. b. Incident/ Accidents reports are reviewed in the daily Clinical Meeting and there is a place in the report to check if a neuro-check was started. Follow-up is then done by the DNS to ensure the neuro-check is in progress and completed as directed. c. Physician orders are reviewed in the daily Clinical Meeting to ensure appropriate interventions/care plans/ care plan changes are completed. d. Facility policies were adopted/ revised for Neuro-checks and Alert Charting, including need to assess for neurological	

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 **07/21/2017**

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 281	Continued From page 23 Resident #5's Neurological Assessment for the 6/25/17 seizure documented staff completed neurological assessments with the exception of 4 missing entries and 3 incomplete entries. There was no reason given for the missing or incomplete entries. The neurological assessment was to be completed for 3 days, 6/25/17, 6/26/17, and 6/27/17 per facility policy. A 7/2/17 I&A documented Resident #5 fell in her room while trying to transfer from a wheelchair into her bed. The report documented Resident #5 struck her head and back. The I&A documented while repositioning Resident #5 from a lying to a sitting position she began to seize and following the seizure, the resident's speech was garbled and slow. The I&A documented Resident #5 was transferred to the hospital and neurological checks where initiated. Resident #5's Neurological Assessment for the 7/2/17 fall and seizure documented staff completed neurological assessments with the exception of 12 missing entries. There was no explanation given for 6 of the missing entries; the other 6 entries were attributed to Resident #5 being in the hospital for evaluation. The neurological assessment was to be completed for 3 days, 7/2/17, 7/3/17, and 7/4/17 per facility policy. A Nurse's Note, dated 7/11/17 at 10:07 pm, documented Resident #5 experienced a seizure at 11:00 am and was assisted to the floor as she slid out of her wheelchair. The note documented Resident #5 complained of a headache following the seizure.	F 281	condition of resident under certain circumstances such as falls, seizures, etc. 4. Processes that monitor performance to ensure effectiveness and compliance: a. QA audit tool- QA/QI Incidents/ Accidents will be done weekly x4 and monthly x3 and included in the monthly QAPI meeting for review and action plans developed as appropriate.	

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 **07/21/2017**

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 281	Continued From page 24 Following the 7/11/17 seizure, Resident #5's clinical record did not contain evidence that neurological checks were initiated. A 7/15/17 I&A documented Resident #5 fell while walking out of her bathroom and hit her eye on the sink. The I&A documented neurological checks where initiated. Resident #5's Neurological Assessment for the 7/15/17 fall and documented staff completed neurological assessments with the exception of 12 missing entries. There was no explanation given for 10 of the missing entries; the other 2 entries documented Resident #5 was "sleeping." The neurological assessment was to be completed for 3 days, 7/15/17, 7/16/17, and 7/17/17 per facility policy. A Nurse's Note, dated 7/16/17 at 10:23 am, documented Resident #5 "had no significant changes in behavior r/t (related to) fall this am (morning)." Following the 7/16/17 morning fall, Resident #5's clinical record did not contain evidence that neurological assessments were initiated or identify whether she hit her head. A 7/16/17 I&A documented Resident #5 fell while walking out of her bathroom and hit her head at approximately 8:30 pm. The I&A documented neurological checks where initiated. Resident #5's Neurological Assessment for the 7/16/17 fall at 8:30 pm documented staff completed neurological assessments with the	F 281		

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 **07/21/2017**

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 281	Continued From page 25 exception of 12 missing entries. There was no explanation given for 4 of the missing entries; the other 8 entries documented Resident #5 was "sleeping." The neurological assessment was to be completed for 3 days, 7/16/17, 7/17/17, and 7/18/17 per facility policy. On 7/17/17 at 5:14 pm, Resident #5 stated she had experienced multiple falls and the facility had not addressed it until that day. She stated she would activate her call light and staff would not come fast enough. She stated the staff would come after she had fallen. She stated she would like a fall mat and the facility had not offered her one. Resident #5 stated she would also like a pole to assist her with transferring, which was offered to her that day. On 7/18/17 at 2:56 pm, the DNS stated neurological checks should be completed every 15 minutes for 1 hour; every 30 minutes for 2 hours; every hour for 5 hours; and every 8 hours for 16 hours. She could not explain why the neurological checks were not completed. The DNS stated staff should be completing neurological assessments if a resident hit their head, or it was suspected a resident hit their head. The facility failed to ensure Resident #5's neurological assessments were consistently completed following eight unwitnessed falls or seizures like activity.	F 281		
F 309 SS=K	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that	F 309		9/11/17

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 **07/21/2017**

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 309	Continued From page 26 applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents	F 309	The facility failed to ensure residents diagnosed with diabetes mellitus received care consistent with their needs,	

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 07/21/2017

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 309	Continued From page 27 diagnosed with diabetes mellitus received care consistent with their needs, professional standards of practice, and facility policy. This was true for 2 of 4 (#5 and #7) residents reviewed for diabetic management, and 1 of 1 closed record (Resident #1) reviewed for diabetic management. As a result: * Residents' blood glucose (BG) levels were not monitored as ordered or in a timely manner * Hyper/hypoglycemic BG levels were not reported to physicians as ordered * Insulin refusals, meal refusals, and BG assessment refusals were not reported to the physician * The facility's hyper/hypoglycemia policies were not followed * Insulin was administered inconsistent with physician orders * Glucometers were used without completing controls to ensure readings were accurate * Care plans did not provide direction for how staff was to manage residents' diabetes * Residents did not have specific physician-ordered parameters for physician notification These systemic practice failures placed the health and safety of Resident #5 and 17 other residents in the facility with a diagnosis of diabetes mellitus (DM) in immediate jeopardy of serious harm, impairment, or death due to diabetic ketoacidosis (an acute, life-threatening complication of diabetes which may result in diabetic coma or death) related to hyperglycemia, and/or severe hypoglycemia, which has the potential for injury, coma, and death.	F 309	professional standards, and facility policy. 1.Three residents were identified as being affected by the deficient practice. One of the residents no longer resides at the facility. The other two resident's physician orders and care plans were updated to reflect current and professional standards and facility policy (see below). 2. All current residents with a dx of diabetes mellitus have the potential to be impacted by the deficient practice. a. All Licensed Nursing Staff inserviced related to use of Hypoglycmic Protocol, parameters for physician notification/interventions, to administer insulin within timeframe ordered and per directives (e.g. within 30 minuets following a meal if resident eats at least 50% of meal-for short-acting insulins and 70/30 insulin, to notify physician if resident consumes less than 50% of meal), to notify physician if resident refuses BG testing and/or insulin administration, policy for Diabetes Management- Hypoglycemia and Hyperglycemia Protocols, glucometer testing per manufacture's guidelines, Point of Care policy, and to obtain AC/HS BG's within 30 minuets prior to a meal, documentation requirements for the above scenarios, need for site rotation for insulin injections and BG's. b. Resident diabetic orders were updated to reflect use of Hypoglycemic Protocol in the event of blood glucose levels <80 mg/dl., insulin administration times and directives holding insulin and for physician notification, hyperglycemic	

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 **07/21/2017**

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 309	Continued From page 28 In addition, the facility failed to ensure: * Insulin administration sites were rotated per professional standards of practice * Self-testing glucometers were not used for multiple residents * Insulin and BG testing orders were clarified as needed Findings include: The facility's May 2017 Diabetes Management-Hypoglycemia and Hyperglycemia Protocols documented all diabetic testing would be conducted and reported per physician orders. The protocol documented: * Individualized care plans would be developed outlining residents' diabetic care needs * Glucometers would be calibrated per manufacturer specifications and those calibrations would be logged * Residents with diabetes "should have resident specific physician ordered parameters for hyperglycemia. For those residents who do not have a physician ordered parameter, notify the physician for any one blood glucose greater than 250 mg/dl [all measurements in milligrams/deciliters]." * Staff was to administer insulin in accordance with physician orders * Staff were to repeat BG assessments in 15 minutes or as directed by the physician for hyperglycemic episodes. * Staff were to repeat BG assessments in 15 minutes for hypoglycemic episodes and instructed to notify the physician for hypoglycemic episodes per parameters.	F 309	protocol, BG testing times with instructions for AC/HS checks to be done within 30 minutes prior to meal, to reflect hypo and hyperglycemic parameters for physician notification, and individualized diabetic management interventions. c. Care plans for those residents with a diabetic diagnosis were updated to reflect interventions in the event resident experiences BG's < or > than parameters, use of Hypoglycemic Protocol for BG's <80 mg/dl, observe for s/s of hypo and hyperglycemia, ability to obtain a PRN BG if s/s of hypo or hyperglycemia is present, licensed nurse to provide nail care, insulin administration and associated times/directives. 3. Measures/ Systemic Changes: a. All existing sliding scale insulin orders were discontinued. BRP policy - Diabetes Management- Hypoglycemia and Hyperglycemia Protocols was updated to include reference to admitting residents with sliding scale insulin orders and a protocol for hyperglycemia. b. BRP policy- Point of Care was updated to include testing of glucometers per manufacturer's guidelines. c. Diabetic order sets were established in PCC to help ensure consistency with new or revised insulin orders. d. BG's and insulin administration is reviewed in the daily Clinical Meeting and followed up on as appropriate by the DNS/designee. e. Physician orders, 24-hour report, and progress notes are reviewed in the daily Clinical Meeting and care plans are	

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 **07/21/2017**

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 309	Continued From page 29 According to the American Diabetes Association, Standards of Medical Care in Diabetes - 2016, from the Diabetes Care Journal, Volume 39 Supplement 1, BG levels in the elderly who were "very complex" with "end stage chronic illnesses" and poor health should be 100-180 mg/dl before meals. The journal documented BG levels in the elderly who were "complex" with multiple comorbidities should have BG levels in the 90-150 mg/dl range. The journal documented older adults with diabetes in a long term care (LTC) facility were at higher risk of experiencing hypoglycemic episodes, and providers should be called "immediately" in case of hypoglycemic episodes or when BG levels were less than 70 mg/dl. A position statement from the American Diabetes Association documented LTC facilities should increase the frequency of glucose monitoring, call the practitioner, and confirm high glucose values by laboratory testing. These steps were to be completed if residents experienced BG's greater than 300 during all or part of 2 consecutive days. In addition, the position statement documented monitoring frequency should be based on complexity of residents and their risk for hypoglycemia. (Munshi, M. N., Florez, H., Huang, E. S., et al. "Management of Diabetes in Long-term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association." Diabetes Care, vol. 39, Feb. 2016, pp. 308-318.) 1a. Resident #5 was admitted to the facility on 6/12/17 with diagnoses that included Type II DM, insulin use, and repeated falls.	F 309	updated as appropriate by the DNS/designee. f. Insulin administration sites are set up in PCC as supplemental documentation for each insulin injection and nurse can see previous injection sites in order to ensure rotation. BG administration sites are set up in PCC as supplemental documentation for each BG and nurse can access previous test sties in order to ensure rotation. 4. Processes that monitor performance to ensure effectiveness and compliance. a. A QA audit tool, Diabetes was implemented and audits to occur weekly x4 and then monthly x 3, results of this audit will be reviewed and acted upon, as necessary, at the monthly QAPI meeting. This audit will be conducted by the Administrator or administrators designee.	

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 **07/21/2017**

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 309	Continued From page 30 Resident #5's Admission Minimum Data Set (MDS) assessment, dated 6/19/17, documented moderate cognitive impairment and the use of insulin required daily. Resident #5's care plan did not include an individualized care plan outlining diabetes care. An Altered Diet Care Plan, dated 6/16/17, documented Resident #5 required a diabetic diet related to diabetes. This was the only care plan in the resident's clinical record addressing DM. Resident #5's July 2017 Physician's Orders, documented: * BG before meals and at bedtime for Type II DM, ordered 6/12/17. * Staff were to follow hypoglycemic protocols for BG levels less than 80 mg/dl and document all interventions and results in a progress note, ordered 6/12/17. * 27 units of Insulin Glargine solution once daily for DM, ordered 6/23/17. * 10 units of Insulin Lispro solution "before meals" for DM, ordered 6/12/17. * Insulin Lispro solution "after meals" per sliding scale (SSI) for BGs of: 151-199 = 1 unit 200-249 = 2 units 250-299 = 3 units 300-349 = 4 units 350+ = 7 units for diabetes, ordered 6/15/17. * 1000 milligrams (mg) of Metformin two times a	F 309		

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 **07/21/2017**

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 309	Continued From page 31 day for DM, ordered 6/12/17. Resident #5's physician orders did not include parameters for when staff was to notify the physician of hyperglycemic episodes. Resident #5's Medication Administration Record (MAR) from 6/12/17 through 7/8/17 documented 10 units of Lispro insulin was to be given at 7:00 am "before meals," and the SSI Lispro insulin was to be administered at 8:00 am "after meals." Resident #5's MAR from 7/8/17 through 7/17/17 documented the 10 units of Lispro insulin that was to be given "before meals" and the SSI Lispro insulin that was to be given "after meals" were both administered at 8:00 am. On 7/18/17 at 8:24 am Resident #5 was observed eating breakfast. At 8:41 am, Resident #5 stated staff "always" gave her insulin after her meals and that she "never" received insulin before her meals while at the facility. Resident #5 stated she "only received insulin four times a day, after meals and before bed." On 7/18/17 at 8:46 am, Licensed Nurse (LN) #2 was observed drawing into a syringe 13 units of Lispro insulin. LN #2 stated she drew up 10 units of (before meals) insulin and 3 units of (after meals) SSI Lispro insulin for Resident #5's pre-breakfast BG of 271 mg/dl. LN #2 administered the 13 units of insulin and stated she "always" provided Resident #5's insulin in this manner as directed by the DNS. At 9:30 am, Resident #5 stated she sensed the facility was not managing her diabetes insulin therapy appropriately.	F 309		

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 **07/21/2017**

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 309	Continued From page 32 On 7/18/17 at 11:55 pm, Resident #5 was observed in the dining room eating cottage cheese and fruit. At 12:35 pm, Resident #5 received 11 units of insulin from LN #2. LN #2 stated Resident #5's pre-meal BG level was 163 mg/dl, which required 1 unit of post meal sliding scale insulin in addition to the 10 units of pre-meal scheduled insulin. b. On 7/18/17 at 8:41 am, Resident #5 stated staff "always" woke her up to assess BG levels at 5:00 am, which she did not like. Resident #5 said she received her first dose of insulin after she ate breakfast and the staff did not recheck her BG level until just before lunch. She stated she had been diabetic for 35 years and she didn't know why the facility waited "so long" to recheck her BG level or why there was an extended period of time between her first BG assessment and her first insulin administration. On 7/18/17 at 8:46 am, LN #2 stated BG levels were assessed at 6:00 am, 11:00 am, 5:00 pm and before bed. LN #2 stated the first time she checked residents' BG levels was at 11:00 am and that night nurses were responsible for assessing the 6:00 am BG level. She said she did not reassess residents' BG levels before breakfast unless a resident's clinical condition indicated a reassessment may be necessary. c. Resident #5's MAR from 6/12/17 through 6/30/17 documented: * BG levels ranged from 119 to HI (high - above 600 mg/dl). * 40 BG results greater than 250 mg/dl, including	F 309		

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 **07/21/2017**

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 309	Continued From page 33 8 BGs greater than 400 mg/dl and 2 BGs greater than 500 mg/dl. * Resident #5's MAR did not document BG assessments were performed on 6 of 72 opportunities; there was no explanation on the MAR for 4 of the 6 missed opportunities. Resident #5's clinical record documented the physician was notified on 1 of 40 hyperglycemic assessments (6/13/17) from 6/12/17 through 6/30/17. A Nurse's Note, dated 6/13/17 at 5:24 pm, documented Resident #5's physician was notified of an elevated BG and the physician directed staff to administer additional insulin. The BG was reassessed as 576 mg/dl. When notified of this BG assessment, the physician provided additional direction to staff. The 576 mg/dl BG was not documented on the 6/13/17 MAR. Resident #5's MAR from 7/1/17 through 7/17/17 documented BG levels ranging from 115 mg/dl to 379 mg/dl; 37 BG results were greater than 250 mg/dl. Resident #5's record did not contain documentation of staff interventions from 7/1/17 through 7/17/17 or whether the physician was notified of the 37 hyperglycemic BG assessments. A Nurse's Note, dated 7/7/17 at 5:44 pm, documented Resident #5's BG was 59 mg/dl. The note documented the facility followed the hypoglycemic protocol and her BG level was 165 mg/dl when checked a "half hour later." The clinical record did not document whether the	F 309		

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 **07/21/2017**

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 309	Continued From page 34 physician was notified, or what, if any, interventions were provided. The 59 mg/dl BG was not documented on the 7/7/17 MAR or BG record. On 7/17/17 at 5:14 pm, Resident #5 stated the facility "did not recheck" her hyperglycemic BG levels, staff "might have" reassessed her hypoglycemic BG levels. d. Resident #5's Food Intake log from 6/12/17 through 6/30/17 documented she refused meals or was not provided a meal 6 of 48 opportunities on 6/15/17, 6/16/17, 6/19/17, 6/24/17, 6/29/17, and 6/30/17. The 6/12/17 through 6/30/17 MAR did not document post-meal insulin was withheld on these days related to the meal refusal. The MAR documented post-meal insulin was not administered on 6/18/17, twice on 6/25/17, 6/28/17 and 6/29/17 as it was not warranted per parameters (150 mg/dl or lower did not require insulin therapy). The clinical record did not contain evidence the resident's physician was notified of the refused meals. Resident #5's Food Intake log from 7/1/17 through 7/17/17 documented she refused meals or was not provided a meal 9 of 27 opportunities on 7/5/17 - 7/10/17, 7/12/17, 7/13/17, and 7/16/17. The 7/1/17 through 7/17/17 MAR did not document post-meal insulin was withheld on these days related to the meal refusal. The MAR documented post-meal insulin was withheld on 7/5/17 and 7/14/17 as it was not warranted per parameters. The clinical record did not contain evidence the resident's physician was notified of the refused meals.	F 309		

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 **07/21/2017**

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 309	Continued From page 35 On 7/18/17 at 4:55 pm, Resident #5 stated staff administered insulin on those occasions when she refused meals. On 7/19/17 at 6:00 pm, the Medical Director stated he expected staff to notify him when a resident refused to eat a meal and that staff would withhold the post-meal insulin until he had been notified a meal had been refused. e. Resident #5's 6/12/17 through 6/30/17 MAR Insulin Administration Location Record documented the site of administration was not rotated 9 of 19 opportunities on 6/20/17 - 6/24/17, 6/26/17, 6/27/17, 6/29/17, and 6/30/17. Resident #5's 7/1/17 through 7/17/17 MAR Insulin Administration Location Record documented the site of administration was not rotated 6 of 17 opportunities on 7/2/17, 7/5/17 - 7/8/17, and 7/11/17. On 7/19/17 at 4:39 pm, the DNS stated staff should rotate the site of insulin administration "every time" they administer insulin. f. Resident #5's clinical record did not document: * Reassessment of BG levels for 76 of 78 hyperglycemic episodes. * Physician notification, per facility protocol, for 76 of 78 hyperglycemic episodes. * Evidence the facility followed its hyperglycemic and hypoglycemic protocols when applicable. * Evidence the facility followed professional	F 309		

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 **07/21/2017**

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 309	Continued From page 36 standards of practice with insulin administration and the withholding of insulin. * Development of a complete care plan for Resident #5's diabetes management. * Parameters for when staff was to notify the physician of hyperglycemic episodes. On 7/18/17 at 2:56 pm, the Director of Nursing Services (DNS) stated facility staff were to notify the physician per parameters identified by the physician. She stated she could not find specific parameters identified for Resident #5 and that she referred to the protocol for direction as to when the physician should be notified. The DNS stated staff were expected to reassess hyperglycemic BGs within 15 minutes of interventions or as directed by the physician when BG levels exceeded physician-specified parameters. For a resident experiencing a hypoglycemic episode, the DNS said staff was to recheck the BG 15 minutes after administering 15 grams [g] of carbohydrates and that this process would be repeated until the BG level reached 70 mg/dl or greater. The DNS stated she did not know why the facility's protocols were not followed for Resident #5's hypoglycemic and hyperglycemic episodes. On 7/18/17 at 4:13 pm, the Clinical Regional Director (CRD) LN stated there should be BG-insulin parameters identified by the physician and if there were none identified staff was to refer to the protocol and notify the physician for "any" BG level greater than 250 mg/dl. The CRD LN stated staff should not have "combined" Resident #5's pre- and post-meal insulin dosages. She	F 309		

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 **07/21/2017**

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 309	Continued From page 37 stated the "after meal" insulin administration was to be based on post-meal BG assessment and that there should not be more than a 30- to 60 minute interval between BG assessment and insulin administration. On 7/19/17 at 6:45 pm, LN #2 stated she would notify a physician when BG levels were outside established parameters and document that she called the physician in a Nurses Note. She stated she would reassess BG levels depending on physician orders and document those reassessments in a Nurses Note or on the MAR. On 7/19/17 at 5:45 pm, the Medical Director stated when staff called to notify him of BG levels outside of parameters he would order insulin and instruct staff to reassess residents' BG levels in 1 hour. He stated he "hoped" there would be evidence of these conversations in the record and although there were no parameters identified in Resident #5's orders, this "was not an excuse" for not calling and notifying the physician. The Medical Director stated he expected Resident #5's post-meal insulin to be administered "immediately" after meals. The Medical Director said the post-meal insulin "should have been based on the BG level before meals and if they ate the meal." The Medical Director stated if a resident refused a meal, he expected facility staff to hold the post-meal insulin and notify him for further instructions. On 7/20/17 at 2:12 pm, the facility was informed Resident #5, as well as all 17 residents in the facility diagnosed with diabetes, were at risk of immediate jeopardy of serious harm, impairment, or death due to the facility's deficient diabetes	F 309		

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 **07/21/2017**

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 309	Continued From page 38 management practices. On 7/25/17 at 1:07 mthe facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented with an effective date of midnight on July 25, 2017. The plan included: * BG levels and diabetic medication orders for Resident #5 and all other diabetic residents were reviewed with their physicians and changes made as necessary. * Care plans were reviewed and updated related to diabetic management. * Physician orders, including those for insulin, and MARs were audited for those residents diagnosed with diabetes to assure blood glucose parameters and physician notification requirements were specified. * Guidelines for managing hyper/hypoglycemic incidents were approved by the Medical Director. * The Interim Director of Nursing Services was to provide education to nursing staff prior to their next shift on BG level parameters for hypo/hyperglycemia; treatment guidelines for hypo- and hyperglycemia; notification to the physician and responsible party; appropriate documentation of notification and interventions for hyper/hypo glycemic episodes, meal refusal, insulin refusals and BG assessments; withholding insulin when residents refused meals; glucometer testing and calibration; and BGs not taken more than 30 minutes prior to a meal.	F 309		

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 **07/21/2017**

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 309	Continued From page 39 * The MDS Coordinator was to audit BG levels at each clinical meeting Monday through Friday and audits were to be conducted weekly for 4 weeks, and then monthly for 3 months by the IDNS. 2. Resident #1 was admitted to the facility on 6/15/11 with diagnoses that included dementia, muscle weakness, Type II diabetes mellitus, and chronic pain. Resident #1's quarterly MDS (Minimum Data Set) assessment, dated 5/30/17, documented severe cognitive impairment, delusions, extensive staff assistance required for bed mobility, transfers, dressing and hygiene, and insulin required daily. Resident #1's care plan directed staff to assess BGs every morning as allowed and administer insulin per physician order, as well as to observe for- and report to the physician any signs and symptoms of excessive appetite/voiding/thirst, and changes in level of consciousness, mood, and diaphoresis (sweating). Resident #1's care plan did not include interventions to notify the physician when the resident refused BG assessments, insulin administrations, meals, and/or nutritional supplements. Resident #1's June 2017 and July 2017 Physician's Orders directed staff to assess BGs every morning as allowed (initiated 11/24/15) and administer 20 units of Lantus Insulin daily for Type II diabetes. The Physician's Orders specified the insulin was not to be withheld (initiated 4/18/17).	F 309		

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 **07/21/2017**

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 309	Continued From page 40 a. Resident #1's physician orders did not include parameters for when staff was to notify the physician of hypo/hyperglycemic episodes. The facility Diabetic Management Protocol, revised May 2017, documented residents with diabetes "should have resident specific physician ordered parameters for hyperglycemia. For those residents who do not have a physician ordered parameter, notify the physician for any one blood glucose greater than 250 mg/dl." Resident #1's June 2017 MAR documented her BG was assessed 5 times that month with results exceeding 250 mg/dl without physician notification as follows: * 6/11/17 - 4:52 am: BG = 307 mg/dl. * 6/12/17 - 3:38 am: BG = 345 mg/dl. * 6/20/17 - 4:00 am: BG = 345 mg/dl. Resident #1's MAR from 7/1/17 to 7/10/17 documented her BG was assessed 3 times that month with results exceeding 250 mg/dl without physician notification as follows: * 7/8/17 - 5:07 am: BG = 471 mg/dl. * 7/9/17 - 3:43 am: BG = 263 mg/dl. b. The June 2017 MAR documented Resident #1 refused BG assessments on 25 of 30 days, of which the physician was not notified on 6/2/17, 6/4/17 - 6/10/17, 6/13/17 - 6/19/17 and 6/21/17 - 6/30/17. Resident #1's record did not include documentation of BG reassessments at a time closer to breakfast for the following days: 6/2/17,	F 309		

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 **07/21/2017**

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 309	Continued From page 41 6/8/17, 6/9/17, 6/13/17, 6/14/17, 6/15/17, 6/16/17, 6/19/17, 6/21/17, 6/22/17, 6/26/17, 6/28/17, 6/29/17 and 6/30/17. The July 1-10, 2017 MAR documented Resident #1 refused BG assessment on 7 days, of which the physician was not notified, reassessments attempted, and education provided. c. Resident #1's June 2017 MAR directed staff to administer 20 units of Lantus insulin once daily with the note, "Do not hold." Resident #1's June 2017 MAR included 9 dates insulin was not administered without physician notification; the resident "refused" insulin on 8 of those dates and staff withheld the insulin on one occasion that was not explained in the resident's clinical record. Resident #1's July 2017 MAR included 2 dates insulin was not administered without physician notification. On 7/19/17 at 5:10 am, when asked why Resident #1's BG was scheduled and assessed at 4:00 am, LN #4 stated, "I really don't know why, I wondered that myself. When I worked, I would try to get her BG after I gave report at the end of night shift. She didn't like getting a fingerstick for BG, it is painful and I wouldn't want it done at 4:00 am either." On 7/19/17 at 4:13 pm, the Clinical Regional Director (CRD) stated there should have been BG parameters identified by the physician, but if there were none identified then staff was to refer to the protocol and notify the physician of "any"	F 309		

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 **07/21/2017**

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 309	Continued From page 42 BG level greater than 250 mg/dl. On 7/19/17 at 5:45 pm, the Medical Director stated when staff called to notify him of BG levels outside of parameters he would order insulin and instruct staff to reassess residents' BG levels in 1 hour. He stated he "hoped" there would be evidence of these conversations in the clinical record and that he would expect the facility to notify him or his associates of any elevated BG results or refusals of BG testing and/or insulin administration. 3. Resident #7 was admitted to the facility on 6/16/17 with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD) with oxygen dependence, Type II diabetes mellitus, and obstructive sleep apnea (OSA). a. Resident #7's admission orders, dated 6/16/17, directed staff to administer Novolog Insulin per sliding scale following BG assessments before meals. Meal times for the facility's main dining room where Resident #7 ate were posted as 7:40 am for breakfast, 12:05 pm for lunch, and 5:50 pm for dinner. Resident #7's MAR and BG summary documented BGs were assessed after meals on 7/3/17, 7/4/17, 7/8/17, 7/9/17, and 7/12/17; no BG result was documented on 7/6/17, 7/10/17, 7/11/17, and 7/12/17; and that insulin was administered when not indicated by BG assessment on 7/5/17 and 7/9/17 on two occasions.	F 309		

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 **07/21/2017**

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 309	Continued From page 43 On 7/18/17 at 11:15 am, the DNS stated Resident #7's MAR and BG record did not include all BG assessment results, however she was unable to determine whether BGs assessments were performed and not documented, or not performed. The DNS stated if times were given for BG assessment and insulin administration were on the MAR, then both procedures should be performed and documented at that time.	F 309		
F 312 SS=G	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and clinical record review, it was determined the facility failed to: * Ensure residents were provided nutritional care and assistance with meals consistent with their assessed needs. This was true for 2 of 7 sampled residents (#1 and #3) reviewed for nutritional and dietary concerns; Resident #3 sustained psychosocial harm when the facility failed to provide dinner meals on a consistent basis and the resident lost weight. Resident #1 had the potential for harm from unplanned weight loss due to compromised nutritional status. * Provide necessary grooming, as well as personal and oral hygiene. This was true for 3 of 7 residents (#1, #2 and #3) reviewed for hygiene and could have resulted in harm from embarrassment or rejection by others due to appearance and/or personal odor.	F 312	Failed to ensure residents were provided nutritional care and assistance with meals consistent with their assessed needs, failed to provide dinner meals on a consistent basis and the resident lost weight, failed to provide necessary grooming, as well as personal and oral hygiene, failed to proved necessary repositioning and floating of heels in bed for residents who were dependent upon staff assistance for Activities of Daily Living. 1. Two residents were affected by the deficient proactice of failing to provide nutritional care and assistance with meals. One of the residents does not reside at the facility (resident #1). The other resident (resident #3) was evaluated for level of assistance with	9/11/17

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 **07/21/2017**

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 312	Continued From page 44 * Provide necessary repositioning and floating of heels in bed for residents who were dependent upon staff assistance for Activities of Daily Living (ADL) needs. This was true for 1 of 1 resident (#3) sampled for pressure ulcer prevention and repositioning. Resident #3 developed 3 pressure-related injuries to the dorsal 3rd, 4th, and 5th toes of his right foot. Findings include: 1. Resident #3 was admitted to the facility on 3/24/17 with diagnoses that included muscle spasms and fibromyalgia. A quarterly Minimum Data Set (MDS) assessment, dated 7/4/17, documented Resident #3 was cognitively intact, and required extensive assistance or was totally dependent on staff for all ADLs, including eating, bathing, transfers, and bed mobility. Resident #3's Admission Nursing Assessment, dated 3/29/17, documented range-of-motion (ROM) impairments affecting both hands and ankles, bedfast, and "very limited" ability to change body position. An Admission Skin Risk Predictor Assessment, dated 3/29/17, documented Resident #3 was at "high risk" for developing skin related issues. The Assessment defined "high risk" as the need for frequent repositioning, pressure-reducing devices, foam wedges for lateral positioning, floating of heels, nutrition, and moisture management. The ADL Care Plan, dated 3/29/17, documented Resident #3 required the assistance of 2 staff members for positioning. The care plan did not	F 312	meals and is provided assistance with meals 1:1 by direct care staff. Resident was referred to dietician for evaluation/intervention as appropriate for weight loss. Three residents were affected by the deficient practice of failing to necessary grooming, as well as provide personal and oral hygiene. One of the residents no longer resides at the facility. The other two residents were evaluated for grooming needs, including personal and oral hygiene and interventions were implemented as appropriate and staff educated. The resident who was affected by the deficient practice of not providing necessary repositioning and floating of heels in bed had his heels floated, staff educated, care plan updated to reflect needs. Resident identified as developing 3 pressure-related injuries shows no signs of these injuries and his feet are protected from pressure using a foot cradle on his bed. 2. All residents in the facility have the potential to be affected by the deficient practice. a. All residents were assessed for level of assistance needed with meals/hydration, grooming and hygiene, positioning needs, ADL's and weight maintenance. b. All care plans and C.N.A Kardex's were updated to reflect residents' current ADL needs and the results of assessments, e.g. Skin Risk Assessment. c. Physician orders were obtained, as necessary for supplements, assistive and pressure relieving/reducing devices, etc. as identified.	

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 **07/21/2017**

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 312	Continued From page 45 provide instruction for how often staff members were to reposition, offer toileting/pericare, and bathe Resident #3. The care plan also did not document the level of assistance Resident #3 required to eat. The Certified Nursing Assistant (CNA) ADL Flowsheet did not document that Resident #3 was repositioned from 5/1/17 through 7/18/17. Resident #3's CNA Bathing Sheets from 5/1/17 through 7/18/17 documented he was not showered/bathed from 5/9/17 to 5/16/17, 5/16/17 to 5/22/17, 6/13/17 to 6/20/17 and 7/11/17 to 7/18/17. The Bathing Sheets did not document staff offered to shower/bathe or Resident #3 or whether staff reapproached the resident if/when he refused to shower on the above dates. Resident #3's Resident Food Intake Sheets from 5/1/17 through 7/18/17 did not document meals were consistently offered and provided. The records documented Resident #3 was not provided breakfast 9 of 77 opportunities, lunch 9 of 77 opportunities, and dinner 51 of 77 opportunities. There was no explanation documented for the missed and (4) refused meals, and no documentation that staff offered either alternate meals or nutritional supplements. Resident #3's Weight Summary Log documented a 3.3-pound loss in 20 days, from 124 pounds on 6/29/17 to 120.7 pounds on 7/18/17. On 7/17/17 at 12:39 pm, Resident #3 was observed lying in bed on his back with a neck pillow under his neck and a small blue pillow separating his ankles. Resident #3's heels were	F 312	d. Weights were obtained on all residents and evaluated against previous weights and referred to Nutrition-at-Risk appropriate. e. Skin sweep was conducted on all residents and identified skin integrity issues were evaluated and interventions for pressure relief/reduction put into place, dressings ordered, if appropriate, referral to N-A-R as appropriate. f. Direct care staff in serviced to related to use of Care Plan and Kardex to guide and provide consistent, appropriate ADL assistance. g. All licensed nurses and C.N.A.'s and facility management staff will be in serviced related to ensuring care plan interventions are carried out are planned. 3. Measures/Systemic Changes: a. Room Rounds (using Room Round form) will be conducted each business day by facility management staff who have been assigned specific residents throughout the facility. These forms will be discussed/reviewed at IDT Stand-up and/or Stand-down. each business day and interventions initiated as appropriate. Facility management staff will be provided a current copy of each resident's care plan to help ensure interventions are being carried out. b. Weekly skin evaluations will be conducted on all residents and documented by the licensed nurse assigned by the resident. c. At the daily business day Clinical Meeting ADL flow sheets, meal monitors, and bath sheets will be reviewed and	

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 07/21/2017

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 312	Continued From page 46 touching the bed, his feet were pointing inward towards each other, and his right foot was touching the hard material of the foot board. Resident #3 stated he had remained in this position "all day" because no staff had repositioned him in bed. He stated his foot "really hurt" and he wanted assistance with repositioning. He stated he was totally dependent on staff for "almost everything." Resident #3 stated staff did not reposition him frequently enough and that he was "lucky" if he saw staff 2 - 3 times a day. Resident #3's right hand was contracted with the fingers closed in a fist. The resident stated he was right hand dominant, but he could not open his right hand. Resident #3's bed was positioned against the wall of his left side. Resident #3 stated staff "always" took his "extra" pillow away during the day despite his desire to have pillows behind his head and body. Resident #3 stated he was supposed to have showered the previous Friday, but that he had been "forgotten," and that the facility "forgets" him "often" on shower day. Resident #3 stated he enjoyed receiving showers. On 7/17/17 at 12:41 pm, CNA #6 entered Resident #3's room and assisted Resident #3's roommate. At 12:53 pm, CNA #6 entered Resident #3's room and emptied his urinal, but did not offer to reposition Resident #3 or float his heels. On 7/17/17 at 1:00 pm, Resident #3 activated his call light, which was answered by CNA #3 and CNA #6 at 1:08 pm. Resident #3 stated his right foot "really hurt" and he needed help moving up in bed. CNA #3 and CNA #6 assisted Resident #3 with repositioning. The resident's 3rd, 4th, and	F 312	acted on as appropriate. d. N-A-R for those residents at risk for losing weight have lost weight, and/or have pressure ulcers will be conducted on a weekly basis with Registered Dietician and facility staff participation. 4. Processes that monitor performance to ensure effectiveness and compliance. a. QA audit tools-QI/QA Skin Wounds and Resident-in-Room and Resident-in-Facility will be conducted weekly x4 and monthly x 3 with results of the audit reviewed at the monthly QAPI and acted upon as appropriate. This audit will be conducted by the Administrator or administrators designee.	

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 **07/21/2017**

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 312	Continued From page 47 5th toes on the right foot presented with a 1 centimeter (cm) rectangular dark red area on each toe. CNA #3 stated, "You need a pillow under your feet to make sure your heels are floating to prevent skin breakdown." On 7/17/17 at 1:15 pm, two surveyors observed a 1 cm dark red area on each of Resident #3's 3rd, 4th, and 5th toes on the right foot. On 7/17/17 at 4:55 pm, Resident #3's heels were observed touching the bed with the pillow used earlier to float his heels next to the wall. The resident stated the nurse who applied lotion to his feet did not replace the pillow to its original position. On 7/18/17 from 4:06 am to 4:27 am, Resident #3 was observed in bed on his back without a pillow floating his heels or behind his back. On 7/18/17 from 5:40 am to 8:26 am, Resident #3 was observed in bed with no changes to his positioning. The resident was awakened by Licensed Nurse (LN) #2, who entered the room to administer morning medications, but soon left the room to retrieve the medications. At 8:26 am, Resident #3 stated staff often did not come in and reposition him at night. Resident #3's feet were observed in contact with the bed and not floated. On 7/18/17 at 8:31 am, LN #2 returned to Resident #3's room with medications and lotion for the resident's feet and face. LN #2 administered the medications and applied lotion, but did not offer to reposition him or attempt to float his heels.	F 312		

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 **07/21/2017**

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 312	Continued From page 48 On 7/18/17 from 8:40 am to 9:08 am, CNA #4 was observed assisting Resident #3 with breakfast in bed. When CNA #4 finished assisting Resident #3 with his meal she neither offered to reposition him nor attempted to float his heels. On 7/18/17 at 9:16 am, CNA #4 was observed checking Resident #3's blood pressure, pulse, and blood-oxygen saturation. CNA #4 did not offer to reposition or attempt to float his heels. On 7/18/17 at 9:23 am, Resident #3 told CNA #4 he did was not showered on his scheduled day the previous Friday and asked asked when he would receiving a shower, telling the CNA he wanted to be sure he was "not forgotten again." CNA #4 stated she would check with the shower aides. CNA #4 then left the room without first offering to reposition or float his heels. On 7/18/17 at 11:21 am, Resident #3 was observed lying in bed on his back with a neck pillow under his neck and a small blue pillow separating his ankles. Resident #3's heels were in contact with the bed and his feet were pointing inward towards each other. There were no other pillows on the bed. Resident #3 stated he just returned from his shower and said he had been placed in the same position as before his shower. Resident #3 stated his right arm was aching and that he wished it was positioned differently. No staff members were observed offering to reposition Resident #3 or float his heels from 11:21 am to 12:00 pm. On 7/18/17 from 12:38 pm to 12:43 pm, Resident #3 was observed in bed with no changes. At	F 312		

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 **07/21/2017**

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 312	Continued From page 49 12:43 pm, LN #2 provided Resident #3 with pain medications, but did not offer to reposition or float his heels. On 7/18/17 from 12:44 pm to 1:06 pm, Resident #3 was observed in bed with no changes. At 1:06 pm CNA #4 and LN #6 offered to reposition Resident #3 and placed a pillow behind his back. The staff members did not attempt to float his heels. On 7/18/17 at 1:15 pm, Resident #3 said the assistance he received at 1:06 pm was the first that staff had repositioned him that day. On 7/19/17 at 5:25 am, Resident #3 was observed lying in bed on his back with a neck pillow under his neck, pillows covering his face, and a small blue pillow separating his ankles. Resident #3's heels were in contact with the bed and his feet were pointing inward towards each other. On 7/19/17 at 9:15 am, Resident #3 was observed lying in bed on his back with a neck pillow under his neck and a small blue pillow separating his ankles. Resident #3's heels were in contact with the bed and his feet were pointing inward towards each other. There were no other pillows on his bed. Resident #3 stated he was not sure if he was always offered three meals a day. He stated there might have been days when he was asleep for dinner and was not awakened for the meal. Resident #3 stated he knew he had lost weight while in the facility and that he did "not like" how the staff seemed to "forget" him by not providing showers, fluids, food, repositioning and adult brief changes. He stated it made him "feel	F 312		

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 **07/21/2017**

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 312	Continued From page 50 worthless" and sometimes he "wishes he was dead." He stated his legs and arms would start hurting severely because he could not move them himself. He stated he was dependent on staff for all ADLs and that just because he could not perform ADLs without help did not mean he "should be forgotten." On 7/19/17 at 4:39 pm, the Director of Nursing Services (DNS) stated staff should reposition Resident #3 every two hours "minimally" and offer fluids with every contact. The DNS stated staff did not inform her about the reddened areas on Resident #3's toes and she was not aware that he was not repositioned on a routine schedule. She stated Resident #3's feet should be floated for skin protection while he was in bed, and that he should be showered each Tuesday and Friday. The DNS stated she could not determine whether Resident #3 received adequate nutrition or hydration. 2. Resident #2 was admitted to the facility on 1/24/17 with diagnoses that included Down syndrome, severe intellectual disability, and obesity. Resident #2's quarterly MDS assessment, dated 5/1/17, documented severe cognitive impairment and total dependence upon staff for bathing and other ADLs. Resident #2's ADL Care Plan, dated 1/24/17, documented he was to receive a shower twice a week and required "total care." Resident #2's CNA Bathing Sheets from 5/1/17 through 7/19/17 documented the resident was	F 312		

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 **07/21/2017**

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 312	Continued From page 51 not showered on scheduled days from 6/8/17 to 6/16/17 (8 days), 6/16/17 to 6/27/17 (11 days), 6/27/17 to 7/4/17 (7 days) and 7/11/17 to 7/19/17 (8 days). The Bathing Sheets did not document consistent offers to bathe or whether the resident was reapproached on any of the 3 occasions he refused to shower/bathe. On Tuesday (shower day) 7/18/17 at 4:55 pm, Resident #2 was observed in the dining room with greasy hair and a notable urine odor emanating from him. On 7/19/17 at 4:39 pm, the DNS stated Resident #2 should be showered each Tuesday and Friday. 3. Resident #1 was admitted to the facility on 6/15/11 with diagnoses that included dementia, muscle weakness, Type II diabetes mellitus, and chronic pain. Resident #1's quarterly MDS (Minimum Data Set) assessment, dated 5/30/17, documented severe cognitive impairment, delusions, and staff assistance required for bed mobility, transfers, dressing, and hygiene. The MDS documented the resident was at "high risk" for developing skin-related issues and defined "high risk" as needing frequent repositioning, pressure reducing devices, floating of heels, nutrition, and moisture management. A Chronic Pain Care Plan, dated 12/19/11, documented Resident #1 was non-weight bearing and required staff assistance with mobility and repositioning.	F 312		

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 **07/21/2017**

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 312	Continued From page 52 An ADL Care Plan, dated 12/19/11, documented Resident #1 required full assistance with bed mobility and positioning, eating, incontinent care and locomotion. The care plan stated the resident was to be turned and repositioned at least every 2 hours, assessed for incontinence every 2 hours, and provided pericare as needed. Certified Nursing Assistant (CNA) ADL Flowsheets from 5/1/17 through 7/18/17 documented Resident #1 required extensive assistance for bed mobility and transfers, but did not include documentation that Resident #1 was being repositioned or the frequency of repositioning. Bath Sheets from 6/1/17 to 7/10/17 documented staff did not bathe/shower Resident #1 from 6/21/17 to 7/10/17, with refusals recorded for 6/28/17 and 7/5/17. The Bath Sheets did not document whether the resident was reapproached following the refusals. Food Intake Sheets for 5/1/17 through 7/18/17 did not document staff offered Resident #1 assistance during meals on a consistent basis. The Food Intake Sheets documented Resident #1 refused breakfast 53 of 71 opportunities, lunch 17 of 71 opportunities, and dinner 11 of 70 opportunities. Resident #1's record did not include documentation she was offered alternative meals, additional snacks, or nutritional supplements during this period. A Weight Summary Log documented Resident #1 weighed 150 pounds on 5/31/17, 148 pounds on 6/21/17, and 144.8 pounds on 7/5/17.	F 312		

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 **07/21/2017**

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 312	Continued From page 53	F 312		
	On 7/19/17 at 10:30 am, the DNS stated the Food Intake Sheets documented Resident #1 refused most breakfasts, noting Resident #1 often slept late in the morning. The DNS was unable to determine whether Resident #1 was reapproached when bathing/showering was refused and that the 20-day span staff did not bathe/shower the resident was "unacceptable."			
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		9/11/17
	(d) Accidents. The facility must ensure that -			
	(1) The resident environment remains as free from accident hazards as is possible; and			
	(2) Each resident receives adequate supervision and assistance devices to prevent accidents.			
	(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.			
	(1) Assess the resident for risk of entrapment from bed rails prior to installation.			
	(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.			
	(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced			

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 **07/21/2017**

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 323	Continued From page 54 by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure adequate supervision was provided for residents at risk for falls. This was true for 2 of 4 residents (#1 & #5) reviewed for falls and resulted in harm to Resident #1, who sustained a fractured leg and hand, and other injuries requiring hospitalization from a fall in the dining room. Findings include: 1. Resident #1 was admitted to the facility on 6/15/11 with diagnoses that included dementia, muscle weakness, Type II diabetes mellitus, and chronic pain. Resident #1's quarterly MDS (Minimum Data Set) assessment, dated 5/30/17, documented severe cognitive impairment, delusions, bowel/bladder incontinence, and staff assistance required for bed mobility, transfers, dressing and hygiene. A Risk For Impaired Skin Integrity Care Plan, revised 11/13/16, documented Resident #1 had both urinary and bowel incontinence and directed staff to offer toileting and monitor possible incontinence every two hours. A Chronic Pain Care Plan, revised 11/20/16, directed staff to complete a pain assessment for Resident #1 every shift and apply topical medication to her knee every 6 hours as needed for arthritis pain. A Falls Care Plan, revised on 11/13/16, documented staff was to assist Resident #1 with all transfers in- and out of bed. The Care Plan did not include interventions related to the prevention	F 323	The facility failed to ensure adequate supervision was provided for residents at risk for falls. 1. One of the two residents affected by the deficient practice no longer resides at the facility (resident #1). The other resident (resident #5) was re-assessed for her risk for falls (upon re-admit since she was discharged shortly after the survey and re-admitted a week later) and care plan interventions put into place based on this assessment and prior history of falls/interventions put into place based on this assessment and prior history of falls/intervention in place prior to her discharge. 2. All residents have the potential to be affected by the deficient practice. a. All residents were re-assessed for their potential to fall and care plan interventions were put into place, as identified appropriate. C.N.A. Kardex was updated as well. 3. Measures/Systemic changes: a. All Licensed nurses were in serviced related to the Incident/Accident reporting system in PCC and expectations related to fall prevention intervents, physician notification, and investigation and documentation and on Alert Charting policy and form. Licensed staff were alson inserviced on the Neuro assessment policy and the need to start neuro checks in the event of a fall where the resident hit their head, unwitnessed falls, and/or in the event of a seizure. b. Residents who experience a fall will be	

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 **07/21/2017**

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 323	Continued From page 55 of falls from a wheelchair. An Incident Report, dated 7/5/17 and revised 7/14/17, documented Resident #1 fell from a wheelchair to the dining room floor at 1:41 pm. The Report documented Resident #1's fall was due to "weakness/fainted. Res[ident] had sudden onset weakness, slumping to right side in chair and leaning forward in w/c [wheelchair] when overbalanced and fell to floor. "Res[ident #1] was in dining room leaning in chair and fell forward hitting face/head on floor landing on left hip/side. Nursing was immediately notified and assessment started. Pressure held to stop nose bleed, skin tear cleansed and treated. Due to limited ROM [Range of Motion] in LLE [left lower extremity], order obtained, records copied and 911 was called to transport res[ident] to Emergency room. MD and family notifications complete." The 7/5/17 Incident Report documented LN (Licensed Nurse) #1, who was assigned to care for Resident #1 that day, completed the report, however LN #1 stated on 7/18/17 at 9:48 am that she did not witness Resident #1's fall. A 7/5/17 Emergency Room Provider Note documented Resident #1 sustained a fracture of the right hand and lower left leg, and she presented with a hematoma to the right forehead and a skin tear with bruising to the right hand. A written statement from a State Ombudsman, dated 7/13/17, documented a video at the facility from the main dining room on 7/5/17 documented staff had "very brief" contact with Resident #1, who was left in the dining room unattended for	F 323	re-assessed for their risk for falls using the Fall Risk Assessment. Results will be incorporated into their care plan. c. A resident who experinces a fall will be put on Alert Charting for at least 72 hours to assess for effectiveness of prevention interventions and latent injuries. (Alert Charting form and policy developed). d. Incident/Accidents will be reviewed at IDT stand-up and in the Clinical Meeting all follow-up investigations will be completed and necessary follow-up, care plan interventions, etc. will be done during that meeting. e. Fall Committee will be conducted weekly to review all previous fall and incidents/accidents from the previous week to ensure complete investigations were conducted, interventions put into place, etc. and documented as such in the specific resident's medical record. 4. Processes that monitor performance to ensure effectiveness and compliance. a. QI audit tool- QI/QA Incident/ Accidents will be conducted weekly x4 and monthly x 3 with results of the audit reviewed at the monthly QAPI and acted upon as appropriate. This audit will be conducted by the Administrator or administrators designee.	

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 **07/21/2017**

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 323	Continued From page 56 approximately 7 hours (Please refer to F223). The Ombudsman documented Resident #1's head was dropping to the table and back to the chair. Approximately 10 minutes prior to the fall, Resident #1 was rocking side to side in her wheelchair before she leaned to the left side, reached down to the floor as if to retrieve an object and fell to the floor. Resident #1 was described as not having any visible movement once she was on the floor. The Ombudsman reported the response by nurses to Resident #1's fall was "rather slow" and staff appeared uncertain as how to clinically respond to the event. On 7/17/17 at 1:33 pm, the 7/5/17 video from 6:00 am to 2:10 pm was reviewed with the Administrator and Director of Nursing Services (DNS). During the 7 hours Resident #1 was in the dining room, it did not appear she was offered toileting assistance, physician-ordered supplements, fluids, or repositioning. The video did not include any meaningful interaction between Resident #1 and staff, nor was the resident assessed for pain or offered medications. During the observation of the video, the DNS stated LN #1 was assigned to Resident #1 and did not come into the main dining room during the time Resident #1 was there. On 7/19/17 at 10:30 am, the DNS stated Resident #1 was not offered toileting assistance and pain assessments were not performed. The DNS stated there was confusion that day regarding nursing staff assignments and Resident #1's toileting, personal care, and pain	F 323		

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 **07/21/2017**

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 323	Continued From page 57 assessments were not provided prior to the resident's fall in which she sustained a fractured left leg and right hand, as well as a hematoma to her face and a skin tear with bruising to her right hand. Refer to F223 2. Resident #5 was admitted to the facility on 6/12/17 with diagnoses that included Type II diabetes mellitus, pseudo seizures, and repeated falls. Resident #5's Admission MDS assessment, dated 6/19/17, documented moderate cognitive impairment and history of falls prior to admission. A Convulsions and History of Falls Care Plan, dated 7/14/17, documented staff was to monitor Resident #5 for convulsions, ensure her safety, record the length of time during the convulsions, complete neuro checks if there was a potential for head injury, and report convulsions to the physician. The care plan did not include interventions to prevent falls from a wheelchair or what safety measures should be in place for seizures. An Activities of Daily Living (ADL) Care Plan, initiated 6/12/17, documented Resident #5 required the assistance of 1 staff for transfers. A 6/18/17 (11:00 am) Incident and Accident Report (I&A) documented Resident #5 lost her balance, fell, and bumped her head on the way to her bathroom. The report documented the resident sustained a 3 centimeter (cm) pink raised area to the forehead and that she complained of a headache. The I&A documented	F 323		

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 **07/21/2017**

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 323	Continued From page 58 neurological checks where initiated. The Admission Fall Assessment Report, dated 6/18/17 at 11:42 am, documented Resident #5 had a history of falls, and received multiple medications as well as experienced gait difficulty, which placed her at greater risk for falls. She was identified at moderate risk for falls. The Admission Fall Assessment Report was completed 6 days after admission and after Resident #5 sustained a fall at the facility. Resident #5's clinical record did not contain evidence her care plan was updated following the 6/18/17 fall or Admission Fall Assessment report. A Nurse's Note, dated 6/24/17 at 3:47 am, documented, "Resident had a seizure after supper ... Resident had to be lowered to the floor as she began to have a seizure lasting 2-3 minutes ... Resident c/o (complained of) black out periods ... spots before her eyes ... headaches ... Resident had two seizures during the day shift." Resident #5's clinical record did not contain evidence that her care plan was updated, interventions implemented, or neurological checks initiated following three seizures on 6/23/17. A Nurse's Note, dated 6/25/17 at 3:47 pm, documented Resident #5 was "FOF [Found on floor] with seizure like activity." The note documented Resident #5 complained of a headache and neurological assessments were initiated. Resident #5's clinical record did not contain	F 323		

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 **07/21/2017**

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 323	Continued From page 59 evidence that her care plan was updated, interventions implemented, the physician notified, or whether an I&A was completed. On 7/18/17 at 2:56 pm, the DNS stated she did not complete an I&A for the 6/25/17 incident because Resident #5 was lowered to the floor during the seizure. She could not explain why a Nurse's Note documented the resident was found on the floor. A 7/2/17 (7:45 pm) I&A documented Resident #5 fell in her room while trying to transfer from a wheelchair to her bed. The report documented the resident hit her head and her back, which caused an injury to the top of her scalp and complaints of a headache. The I&A documented staff were transferring Resident #5 from a lying to a sitting position when she began to seize. Following the seizure, the I&A documented, Resident #5 exhibited slow and garbled speech. The I&A documented neurological checks were initiated and Resident #5 was transferred to a hospital. Following the 7/2/17 fall, Resident #5's clinical record did not contain evidence that the care plan was updated, interventions implemented, or that the facility performed timely post-fall risk assessments for Resident #5 to determine the cause of the fall and how to prevent future falls. A quarterly Fall Assessment, dated 7/10/17, documented Resident #5 was at "moderate risk" for falls related to the same identified issues as the Admission assessment. A Nurse's Note, dated 7/11/17 at 10:07 pm,	F 323		

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 **07/21/2017**

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 323	Continued From page 60 documented Resident #5 experienced a seizure at 11:00 am and was assisted to the floor as she was sliding out of her wheelchair. The note documented Resident #5 complained of a headache after she regained consciousness. Following the 7/11/17 seizure, Resident #5's clinical record did not contain evidence that her care plan was updated, interventions implemented, or that the physician was notified. A 7/15/17 (9:05 pm) I&A documented Resident #5 fell while walking out of her bathroom and hit her eye on the sink. The report document another resident in the facility was looking for a nurse because she saw Resident #5 on the floor. The I&A documented neurological checks where initiated. Following the 7/15/17 fall, Resident #5's clinical record did not contain evidence that her care plan was updated, interventions implemented, or that the facility performed timely post-fall risk assessments for Resident #5 to determine the cause of the fall and how to prevent future falls. A Nurse's Note, dated 7/16/17 at 10:23 am, documented Resident #5 "had no significant changes in behavior r/t (related to a) fall this am (morning)." Following the 7/16/17 fall, Resident #5's clinical record did not contain evidence that her care plan was updated, interventions implemented, the physician notified, neurological checks initiated and/or that an I&A was completed. A 7/16/17 (9:14 pm) I&A documented Resident	F 323		

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 **07/21/2017**

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 323	Continued From page 61 #5 fell while walking out of her bathroom and hit her head at approximately 8:30 pm. The I&A documented neurological checks where initiated. Following the 7/16/17 fall, Resident #5's clinical record did not contain evidence that the care plan was updated, interventions implemented, or whether the facility performed timely post-fall risk assessments for Resident #5 to determine the cause of the fall and how to prevent future falls. A Behavior Note, dated 7/17/17 at 10:20 am, documented Resident #5 was concerned with the number of falls she had experienced. The note documented she "gets up" by herself without help because she could not "get aides there fast enough." On 7/17/17 at 5:14 pm, Resident #5 stated she had experienced multiple falls, which the facility had not addressed until that day. She stated she often activated her call light for assistance, but staff would not respond fast enough. The resident stated she wanted a fall mat, but the facility had not offered one. Resident #5 stated she would also like a transfer pole, which had been offered to her that day. Resident #5's clinical record did not contain evidence that the facility had discussed her falls with her and different interventions attempted until 7/17/17. The facility failed to ensure Resident #5 was provided sufficient supervision and care plan updates to prevent repeated falls. The facility failed to perform timely post-fall risk assessments for Resident #5 to determine the cause of the fall	F 323		

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 07/21/2017

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 323	Continued From page 62 as well as how to prevent future falls, and failed to consistently notify Resident #5's physician of the seizures and falls.	F 323		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents received sufficient fluids to meet hydration needs. This was true for 2 of 4 residents (#1 and #3) whose hydration needs were reviewed. This deficient practice created the potential for residents to become dehydrated and develop urinary tract infections and/or experience other medical complications due insufficient fluid intake. Findings include: 1. Resident #3 was admitted to the facility on 3/24/17 with diagnoses that included muscle spasms and fibromyalgia. A quarterly Minimum Data Set (MDS) assessment, dated 7/4/17, documented Resident #3 was cognitively intact required extensive assistance or was totally dependent on staff for	F 327	The facility failed to ensure resident received sufficient fluids to meet hydration needs. 1. There were two residents affected by the deficient practice. One of the residents (resident #1) no longer resides at the facility. The other resident (resident #3) was provided a smaller mug, which he agreed to use and demonstrated use. His bed/furniture was also re-arranged to provide an easier environment to retrieve fluids and watch his television, etc. His care plan/ Kardex was also updated to offer fluids with each interaction and during meals. 2. All residents have the potential to be affected by the deficient practice, particularly thoses dependent on staff for their ADL's. a. Licensed Nurses and C.N.A.'s were	9/11/17

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 **07/21/2017**

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 327	Continued From page 63 all Activities of Daily Living (ADL), including eating. Resident #3's Admission Nutrition Assessment, dated 4/4/17, documented he required an estimated 1600 milliliters (mL) to 1800 mL of fluids per day. Resident #3's ADL Care Plan, dated 3/29/17, did not provide instruction for how often staff members were to offer fluids. The Resident Food Intake Sheets from 7/1/17 through 7/17/17, documented Resident #3's fluid intake with meals reached its highest total fluid intake of 1200 mL on 7/4/17. Resident #3 received the lowest total fluid intake of 240 mL on 7/6/17, 7/8/17, and 7/10/17. Resident #5's average fluid intake for the dates above was 502.5 mL's. Resident #3 refused one fluid offer on 7/15/17 at dinner and there were no documented fluid intakes or refusals on 7/7/17 and 7/9/17. Similar findings were found for May and June 2017. On 7/17/17 at 12:39 pm, Resident #3 was observed lying in bed on his back with a neck pillow under his neck and a small blue pillow separating his ankles. Resident #3 had a bedside table near him on his right side with a urinal containing approximately 2.5 centimeters (cm) of dark and cloudy amber urine. A 28-ounce (oz) water pitcher was on a dresser to the right upper corner of Resident #3's bed above his head/ pillow. Resident #3 stated he could not reach the water pitcher in its current location on the dresser. He demonstrated using his left hand to reach across his body as far as his bedside table	F 327	inserviced related to ensuring that fresh water is available for all applicable residents and to offer fluid when providing care/ have interaction with a resident, ensuring complete and accurate documentation on meal/fluid monitors, and reviewing meal monitor books following each meal to ensure completeness and accuracy. b. Residents were assessed for most appropriate vehicle in thich to proved fluids/hydration e.g. small cup, smaller much, two- handled mug etc. and care plans/Kardex's updated as appropriate. c. Staff were instructed to pass fresh water when snacks were passed at 10 am, 3 pm and HS 3. Measures/ Systemic Changes: a. Room Rounds will be conducted by facility management on each business day and includes ensuring fresh water is available for residents and are reviewed at each ITD stand-up and stand-down meetings and identified issues communicated to staff. b. Staff assignment sheet includes the name of the aide that is responsible for passing fresh water on each shift. c. Meal/fluid monitors are reviewed at each business day Clinical Meeting for completeness and identified issues communicated to staff. b. Staff assignment sheet includes the name of the aide that is responsible for passing fresh water on each shift. c. Meal/fluid monitors are reviewed at each business day Clinical Meeting for completeness and identified issues	

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 07/21/2017

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 327	Continued From page 64 where the urinal sat. Resident #3 stated the 28 oz water pitch on the dresser was too heavy for him to pick up so staff had to offer him fluids with a cup. He stated he was afraid of becoming dehydrated as he had experienced dehydration at the facility before. On 7/17/17 from 12:41 to 12:53 pm, staff members observed interacting with Resident #3 did not offer fluids. At 12:53 pm, Certified Nursing Assistant (CNA) #6 entered Resident #3's room and emptied his urinal, but did not offer the resident fluids. On 7/17/17 at 1:00 pm, CNA #3 and CNA #6 entered the room and Resident #3 stated his right foot "really hurt" and that he needed help moving up in bed. The CNAs assisted Resident #3 with his needs, but did not offer Resident #3 fluids. On 7/18/17 at 8:26 am, a 28 oz water pitcher was observed on Resident #3's bedside table next to his urinal. Resident #3 stated the water pitcher, which was full, was the same water from the day before. He stated he wanted fresh water and for staff to offer him more fluids. On 7/18/17 at 8:31 am, Licensed Nurse (LN) #2 provided Resident #3 with medications, but did not offer Resident #3 any fluids. LN #2, at the resident's request, emptied the full water pitcher and replaced it with fresh water and ice before leaving the room. On 7/18/17 at 9:16 am, CNA #4 was observed assessing Resident #3's blood pressure, pulse, and blood-oxygen saturation. CNA #4 did not	F 327	communicated with staff. 4. Processes that monitor performance to ensure effectiveness and compliance. a. QI audit tool- Resident-in-Room (which includes ensuring fresh water is readily available to residents) will be conducted weekly x 4 and monthly x 3 with results of the audit reviewed at the monthly QA/PI and acted upon as appropriate. This audit will be conducted by the Administrator or administrators designee.	

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 **07/21/2017**

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 327	Continued From page 65 offer Resident #3 fluids and the pitcher containing water remained full and untouched on the bedside table. On 7/18/17 at 9:23 am, Resident #3 activated his call light and CNA #4 responded. After providing assistance, CNA #4 left the room without offering fluids to Resident #3 and the pitcher with water remained full and untouched on the bedside table. On 7/18/17 from 11:21 am to 12:00 pm, staff members were observed interacting with Resident #3, however none of those staff offered fluids to the resident and the pitcher containing water remained full and untouched on the bedside table. On 7/18/17 from 12:38 pm to 12:43 pm, Resident #3 was observed in bed with no changes. At 12:43 pm LN #2 provided Resident #3 with pain medications, but did not offer him fluids and the pitcher remained full and untouched on the resident's bedside table. On 7/18/17 at 1:06 pm, CNA #4 and LN #6 offered to reposition Resident #3 and placed a pillow behind his back. The staff members did not offer fluids and the resident's urinal containing approximately 1.5 cm of cloudy dark yellow amber, as well as the pitcher containing water remained full and untouched on the bedside table. On 7/19/17 at 5:25 am, Resident #3 was observed sleeping in bed; the 28 oz water pitcher from the day before remained full and untouched on the bedside table.	F 327		

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 **07/21/2017**

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 327	Continued From page 66 On 7/19/17 at 9:15 am Resident #3 was observed lying in bed on his back with the full and untouched 28 oz water pitcher, and urinal, on the bedside table next to him. Resident #3 stated the pitcher contained the same water from the day before. On 7/19/17 at 4:39 pm, the Director of Nursing Services (DNS) stated Resident #3's fluid intake as documented on the intake monitor was inadequate. She said staff should offer fluids with every contact, which should occur at least every 2 hours. The DNS stated the small amount of urine she emptied the previous evening from Resident #3's urinal was dark yellow and may have indicated the resident was dehydrated. The DNS stated she knew Resident #3 could lift a small cup up, but not the 28 oz water pitcher. The DNS stated she thought the resident had been provided a small cup at bedside and did not realize the resident was provided only with the 28 oz water pitcher. 2. Resident #1 was admitted to the facility on 6/15/11, with diagnoses which included dementia, muscle weakness, DM Type II (Diabetes Mellitus adult onset), and chronic pain. Resident #1's quarterly MDS assessment, dated 5/30/17, documented severe cognitive impairment, delusions, staff assistance required for bed mobility, transfers, dressing and hygiene, and insulin administration required 7 days a week. An ADL Care Plan, dated 12/19/11, documented	F 327		

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 **07/21/2017**

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 327	Continued From page 67 Resident #1 required full assistance with eating. According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, adults within Resident #1's age range should consume 25 mL per kilogram of body weight per day. Using this calculation method, Resident #1 needed a total daily fluid intake of 1635 mL's. The Resident Food Intake Sheets from 7/1/17 through 7/10/17, documented Resident #1 received the highest total fluid intake of 960 mL on 7/5/17. Resident #1 received the lowest total fluid intake of 120 mL on 7/10/17. Resident #5's average fluid intake for the dates above was 514.1 mL's. Resident #1 refused fluid offers on 7/1/17 through 7/4/17 and 7/7/17 through 7/10/17. Similar findings were found for May and June 2017. On 7/19/17 at 10:30 am, the DNS stated Resident #1's record documented a low fluid intake, but she was independent with taking fluids. The DNS stated she felt staff did not chart accurately and record all of Resident #1's fluids.	F 327		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	F 328		9/11/17

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 **07/21/2017**

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 328	Continued From page 68 (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a	F 328		

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 **07/21/2017**

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 328	Continued From page 69 resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure physician orders were followed for a Continuous Positive Airway Pressure (CPAP) machine. This was true for 1 of 2 (#7) residents reviewed for oxygen management and had the potential for harm if the resident received inadequate or excessive oxygen therapy. Findings include: Resident #7 was admitted to the facility on 6/16/17 with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD) with oxygen dependence, Type II diabetes mellitus, and obstructive sleep apnea [OSA]. Resident #7's Admission MDS (Minimum Data Set) assessment, dated 6/22/17, documented severe cognitive impairment, extensive-to-total staff assistance required for bed mobility, transfers, dressing and hygiene, and bowel/bladder incontinence. A Physician Progress Note for Resident #7, dated 7/7/17, documented, "Recent sleep study received and indicates severe OSA. Extremely Severe OSA- initiate (resume) CPAP." A physician order, dated 7/7/17, directed staff to set Resident #7's CPAP on the "B" setting for	F 328	The facility failed to ensure physician orders were followed for Continuous Positive Airway Pressure (CPAP) machine. 1. The resident who was affected by the deficient practice is currently utilizing the machine as ordered. 2. All residents have the potential to be affected by this deficient practice. a. All physician orders and eMars were reviewed to ensure physician orders were being signed off and implemented as ordered. b. Care plans were updated to reflect the physician orders that were specific to the care of the residents. c. Licensed nurses and C.N.A. staff were inserviced to ensure that any equipment, devices, etc. that are not working to be reported to management/maintenance for resolution and to include on 24-hour report. 3. Measures/Systemic Changes: a. In the daily Clinical Meeting the 24-hour report, Physician orders, eMars, and progress notes are reviewed and acted upon as appropriate. This review is documented on the Clinical Meeting sheet. b. Room Rounds are conducted on each	

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 07/21/2017

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 328	Continued From page 70 sleep due to "dropping oxygen level." A Nursing Progress Note, dated 7/7/17 at 7:00 pm, documented, "Res[ident] has been exhibiting moist productive cough throughout shift. Res[ident] [family member] reported it was because he has not been using his CPAP machine." A Nursing Progress Note, dated 7/13/17, documented a medical supply company was called and informed Resident #7's CPAP was missing a piece. The progress note did not indicate if the piece was ordered, or if Resident #7 was able to use the CPAP without the part. On 7/17/17 at 12:56 am, Resident #7's family member stated she was concerned the facility did not assist the resident with the CPAP at night and that because of his sleep apnea, the resident was sleepy during the day if he did not use the CPAP. She stated she could tell the CPAP was not being used by Resident #7's behavior in the facility. Resident #7's family member stated she was told a piece to the CPAP mask was either broken or missing and the CPAP had not been used since his admission to the facility "over a month ago." On 7/18/17 at 7:25 am, the DNS stated Resident #7 used the CPAP on 7/9/17 and 7/10/17, and stated she saw him wearing it the week before. She went to his bedside cabinet to demonstrate how his mask was functioning, but was unable to find the piece that connected the mask to the tubing. She stated the mask was unusable without the missing connection piece. The DNS then found an unopened bag with a CPAP mask	F 328	business day and includes devices utilized are present and functioning as ordered. These are reviewed in each IDT Stand-up and Stand-down meetings. 4. Processes that monitor performance to ensure effectiveness and compliance. a. QI audit tool- Resident-in-Room (which includes ensuring devices are present and functioning) will be conducted weekly x 4 and monthly x 3 with results of the audit reviewed at the monthly QA/PO and acted upon as appropriate. This audit will be conducted by the Administrator or the administrators designee.	

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 **07/21/2017**

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 328	Continued From page 71 in the cabinet, which she stated did not appear to have been used. On 7/19/17 at 5:00 am, Resident #7 was observed sleeping in his room with oxygen delivered via nasal cannula. The CPAP was not in use. On 7/19/17 at 5:10 am, LN #4 stated the facility was missing a piece of the CPAP mask and Resident #7 was unable to use the device until it was replaced. She stated she was not aware the new mask had arrived, but she would ensure the resident used the CPAP from that point on. LN #4 stated Resident #7 did not use the CPAP on 7/10/17, 7/17/17 and 7/18/17 while she cared for the resident on night shift.	F 328		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 25, 2017

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

Provider #: 135084

Dear Mr. Smith:

On **July 21, 2017**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly. The complaint was investigated during an on-site complaint investigation survey conducted from July 17, 2017 to July 21, 2017.

The clinical records of six current residents and one closed record were reviewed. Three weeks of nursing schedules, assignment sheets and time cards were reviewed. The facility's Incident and Accident reports, Resident Council minutes, and Allegation of Abuse reports, all from May 2016 to July 2017, were also reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007576

ALLEGATION #1:

The facility failed to ensure residents were cared for, resulting in extended periods of time between incontinent care, assessments and repositioning. One resident was unattended for seven hours, was not assisted by staff for toileting, to her room to rest, and otherwise unattended. Another resident who was bedridden was unattended, which resulted in feces and urine spilling over from the bed to the floor.

FINDINGS:

The allegation that a resident had feces and urine overflowing onto the floor was unsubstantiated due to lack of evidence.

The allegation that the facility did not ensure all residents were cared for was substantiated and deficiencies were cited at F223, F281, F309, F312, F 323, and F327. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federaldeficiencies related to the allegation are cited.

ALLEGATION #2:

The facility does not have enough absorbent pads to provide for residents who are incontinent. As a result, residents remain in soiled beds after experiencing episodes of urinary and/or fecal incontinence.

FINDINGS:

The facility's laundry area was observed and laundry staff interviewed.

The clean laundry area included a linen closet observed with sheets, towels, washcloths and six bed protectors. The linen carts for the 100, 200 and 300 hallways were observed during survey without bed protectors.

A Certified Nursing Assistant stated the facility ran out of reusable soaker pads often on night shift, which she said made it difficult to ensure residents remained dry throughout the night. She stated disposable absorbent pads were available in limited quantity for specific residents.

Another Certified Nursing Assistant interviewed as part of the investigation stated the facility ran out of reusable absorbent pads often on night shift.

Several residents or their family members stated residents were not left in soiled beds and there were no instances observed during night- or day shift of residents remaining in beds that had become soiled through episodes of incontinence at any time during the survey.

The allegation that the facility did not have an adequate number of absorbent pads to meet the needs of residents was substantiated, however the allegation that residents remained in soiled beds after incontinence could not be substantiated.
ALLEGATION #3:

The facility does not have an adequate number of staff to meet resident needs.

FINDINGS:

Nurses and Certified Nurse Aides (CNAs) were observed responding to, and providing cares for, residents throughout the survey. Call light response times and resident requests to staff were also observed throughout the survey.

Several residents, nursing staff and the Director of Nursing were interviewed regarding quality of care concerns. The Administrator was interviewed regarding staffing concerns.

The assignment sheets, nursing schedules and timecards were compared with the census for the three week period from June 25, 2017 through July 15, 2017. Staffing data provided by the facility were verified with the actual hours worked and determined to be accurate and in excess of the state requirement.

The allegation of insufficient staffing was not substantiated, however other deficiencies were cited in relation to resident care and safety. Please refer to federal 2567 report for details.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

David Scott, R.N., Supervisor
Long Term Care

DS/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 26, 2017

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

Provider #: 135084

Dear Mr. Smith:

On **July 21, 2017**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly. The complaint was investigated during an on-site complaint investigation survey conducted from July 17, 2017 to July 21, 2017. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007579

ALLEGATION:

The facility has placed audio listening devices in resident rooms so the Director of Nursing Services (DNS) can listen to residents and their complaints about the facility and/or staff.

FINDINGS:

The Administrator and DNS denied listening devices were present in the facility. The Administrator demonstrated the video recording system the facility used and identified the cameras that recorded activities in the hallways, entrance, activity and dining rooms.
The Administrator stated the video recording device was video only, without ability to record sound. He stated resident rooms and other private areas such as shower facilities and conference rooms were not equipped to monitor and record.

The Administrator demonstrated how the recording device was set up and how it operated. There was no audio capability or input ports noted on the device.

The Administrator stated audio listening devices in resident rooms would violate the law and the residents' rights as American citizens. The Administrator offered the surveyor team access to resident rooms to inspect for listening devices. No devices were identified.

Based on observation and interview, it was determined the allegation of audio listening devices in the facility in general and resident rooms specifically was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

David Scott, R.N., Supervisor
Long Term Care

DS/lj