



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS 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](mailto:fsb@dhw.idaho.gov)

July 24, 2018

Anita Burdick, Administrator  
Oak Creek Rehabilitation Center Of Kimberly  
Oak Creek Rehabilitation Center Of Kimberly  
500 Polk Street East  
Kimberly, ID 83341-1618

Provider #: 135084

Dear Ms. Burdick:

On **July 10, 2018**, 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 an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **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

Anita Burdick, Administrator  
July 24, 2018  
Page 2

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 3, 2018**. Failure to submit an acceptable PoC by **August 3, 2018**, may result in the imposition of penalties by **August 26, 2018**.

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; and
- Include dates when corrective action will be completed in column (X5).

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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 14, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October**

Anita Burdick, Administrator  
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**8, 2018.** A change in the seriousness of the deficiencies on **August 24, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 10, 2018** includes the following:

Denial of payment for new admissions effective **October 8, 2018**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 10, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 8, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

Anita Burdick, Administrator  
July 24, 2018  
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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

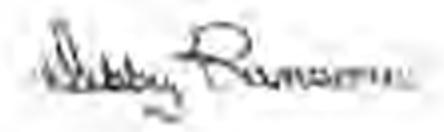
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **August 3, 2018**. If your request for informal dispute resolution is received after **August 3, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

dr/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/10/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>OAK CREEK REHABILITATION CENTER OF KIMBERLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 POLK STREET EAST KIMBERLY, ID 83341</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint survey of the facility. The survey team entered the facility on July 9, 2018 and exited the facility on July 10, 2018.  The surveyors were:  Edith Cecil, RN Suzy Devereaux, BSN, RN  Survey Abbreviations:  mg - milligram ml - milliliter PRN - as needed	F 000			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		8/13/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/01/2018

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

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F 758	Continued From page 1  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.  §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents received PRN psychotropic medications only when clinically indicated for the treatment of specific conditions. This was true for 1 of 3 residents (#1) sampled for psychotropic medication use and had the potential for harm should residents receive psychoactive medications that were unwarranted, ineffective,	F 758	Resident # 1 was discharged from Oak Creek Rehabilitation Center on 3-30-18.  All residents with orders for prn psychotropic medications could be affected.  Licensed staff will be inserviced regarding the requirements for the use of prn		

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F 758	<p>Continued From page 2 or used for excessive duration without benefit to the resident. Findings include:</p> <p>Resident #1 was admitted to the facility on 2/8/18 with multiple diagnoses, including dementia with behavioral disturbance and anxiety disorder.</p> <p>A physician order, dated 2/23/18, directed staff to provide Lorazepam 0.5 mg by mouth twice daily at 8:00 AM and 8:00 PM.</p> <p>A physician's order, dated 3/14/18, directed staff to provide Lorazepam concentrate 2 mg/ml and directed staff to provide 0.5 ml by mouth every 4 hours as needed (PRN) for anxiety for 2 weeks. This was provided to Resident #1 on 2/14/18 at 9:51 PM and on 2/15/18 at 8:03 AM.</p> <p>A nursing progress note, dated 3/15/18, documented Resident #1 was medicated 3 times with Ativan (Lorazepam) sublingual (under the tongue.) The Narcotic Log noted the times given were 6:00 AM, 12:00 noon, and 4:00 PM. The nursing note did not document anxiety was exhibited by Resident #1 prior to the medication being administered.</p> <p>A nursing progress note, dated 3/16/18, documented Resident #1 was medicated with Ativan 0.5 mg 4 times with good results. The Narcotic Log documented the medication was provided at 6:00 AM, 10:00 AM, 2:00 PM, and 6:00 PM. The nursing note did not document anxiety was exhibited by Resident #1 prior to the medication being provided.</p> <p>A nursing progress note, dated 3/17/18, documented Resident #1 refused to get out of</p>	F 758	<p>psychotropic medications. Licensed nurses must also notify the DNS or designee each time a prn psychotropic medication order is received.</p> <p>Behavior tracking and non-pharmacological interventions will be added to the MAR (medication administration record) for all residents that receive a prn psychotropic medication.</p> <p>All prn psychotropic medications will have an automatic stop order date on the 14th day. The physician or prescribing practitioner will be contacted to document their rationale in the medical record if he/she believes it is appropriate for the prn order to be extended and the duration for the prn order.</p> <p>All new prn psychotropic orders will be audited 5 x weekly x 4 weeks; then weekly x 4 weeks; then bimonthly x 2 months; then monthly x 3 by the DNS or designee to ensure compliance with the 14 day requirement. The QAPI team will review the audits monthly and determine if the audits continue to be indicated.</p> <p>The MARs (medication administration records) will be audited for behavior tracking and non-pharmacological intervention documentation 5 x weekly x 4 weeks; then weekly x 4 weeks; then bimonthly x 2 months; then monthly x 3 months for all residents on prn</p>		

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

PRINTED: 08/02/2018  
FORM APPROVED  
OMB NO. 0938-0391

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F 758	Continued From page 3 bed, declined fluids and food, slept most of the day.  On 7/10/18 at 11:45 AM, the nursing progress notes and Narcotic Log was reviewed with the Administrator. The Administrator stated she was not able to see where the indication of need was documented prior to Resident #1 being administered the antianxiety medication.	F 758	psychotropic medications by the DNS or designee to ensure compliance. The QAPI team will review the audits monthly to determine if the audits continue to be indicated.		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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April 2, 2019

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

Provider #: 135084

Dear Ms. Burdick:

On **July 9, 2018** through **July 10, 2018**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007831**

**ALLEGATION #1:**

Residents are not receiving personal care or nursing services because the facility was understaffed.

**FINDINGS #1:**

During the complaint investigation, observations and resident and staff interviews were conducted. Records, including facility staffing, resident clinical records, skin assessments, bathing flowsheets, and grievances were reviewed.

Five resident observations were conducted throughout the complaint survey. Facility staffing for the weeks of 4/1/18, 5/6/18, and 7/1/18 were reviewed for adequate staffing. 3 residents were interviewed regarding care provided by the facility staff. Call light response times were monitored. The shower flowsheets were reviewed.

Anita Burdick, Administrator  
April 2, 2019  
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It could not be established that the facility failed to provide sufficient staff or that staff did not provide residents the appropriate care to meet their needs. Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated with no identified deficient practice.

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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj



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DAVE JEPPESEN – Director

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June 7, 2019

Lucinda Angle  
10824 W. Linstock Ct.  
Boise, ID 83713

Dear Ms. Angle:

On **July 9, 2018** through **July 10, 2018**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly.

On behalf of the Bureau of Facility Standards, we extend our sincerest apologies for the delay in the response to your concerns regarding the care provided by Oak Creek Rehabilitation Center of Kimberly. We understand the importance of these concerns and take these matters very seriously. It is unfortunate we had a delay in our investigation and response to you. For that we deeply apologize.

Thank you for bringing your concerns to our attention and it is our hope these concerns were resolved.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007843**

**ALLEGATION #1:**

The facility failed to ensure the physician's orders for catheter care were followed.

**FINDINGS #1:**

Observations were conducted throughout the facility, multiple interviews were conducted with residents, families and staff members. Six residents were reviewed during the investigation; two with catheters. Observations of the residents with catheters did not identify issues with clogged lines or odors from leaking catheter tubing. One resident's record documented he had a liver catheter. The resident's discharge orders from the hospital directed staff to complete flushes of the resident's liver catheter.

The resident's record included documentation the flushes were completed as ordered. Three residents were interviewed regarding the provision of care and services and voiced no concerns about receiving treatments as ordered.

Based on the investigative findings, the allegation could not be substantiated, due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were not provided food at appropriate frequencies and amounts, and residents were encouraged to eat less to decrease fecal elimination.

FINDINGS #2:

Observations were conducted throughout the facility including the dining room and residents who ate in their rooms. Interviews were conducted with three residents and a family member about meals. The residents' and family member did not voice concerns with the availability and amount of food provided by the facility. Multiple staff members were interviewed and were knowledgeable of the facility's dining practices.

Six residents were reviewed during the investigation; two of which required special diets.

The residents with special diets were observed to receive meals in accordance with their diet orders and residents who ate in their rooms also received food consistent with their diets. One resident's record documented he was on a reduced calorie, carbohydrate consistent diet. The resident's meal and snack intake documentation was reviewed. The documentation did not show a lack of food intake for extended periods of time. A review of six months of facility grievances and progress notes of each of the six residents reviewed, did not include documentation of concerns about inappropriate staff communication related to food intake and its correlation to residents' elimination habits.

Based on the investigative findings, the allegation could not be substantiated, due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Family members were not notified in timely manner when residents were transferred out of the facility.

Lucinda Angle  
June 7, 2019  
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#### FINDINGS #3:

Residents and family members were interviewed, resident records were reviewed regarding transfer notification documentation, and the facility policy regarding notification was reviewed.

One resident's record documented he was transferred to a hospital emergency department in May 2018, and that he was his own representative and he had consented to the transfer. However, there was no documentation of the resident's family was notified of the transfer.

A review of other recent transfers documented the families had been notified in a timely manner. Interviews with other residents' family members verified they were notified of changes in residents' status and/or transfers in a timely manner.

Although the allegation the facility did not notify one resident's family of a transfer was substantiated, a deficiency was not cited as the facility corrected the problem prior to the complaint investigation survey.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

Even though incidents or events may have occurred as you described them, it is not always possible to find evidence that corroborates or substantiates each allegation in the complaint. When the allegation is referred to as unsubstantiated, it means that non-compliance with a regulation could not be proven. It does not mean that an incident did not occur or that a family member or visitor did not witness a problem. It means that an allegation could not be confirmed through the investigation process or the facility took corrective measures prior to the investigation.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program, or me, at (208) 334-6626, Option #2.

Sincerely,

Sylvia Creswell, LSW, Supervisor  
Long Term Care Program

SC/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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June 24, 2019

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

Provider #: 135084

Dear Ms. Burdick:

On **July 9, 2018** through **July 10, 2018**, an unannounced on-site complaint survey was conducted at Oak Creek Rehabilitation Center of Kimberly. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007811**

ALLEGATION:

Residents are not receiving the care needed to maintain personal hygiene because the facility was understaffed.

FINDINGS #1:

During the complaint investigation, observations and resident and staff interviews were conducted. Records, including facility staffing, resident clinical records, skin assessments, bathing flowsheets, and grievances were reviewed.

Five resident observations were conducted throughout the complaint survey. Facility staffing for the weeks of 4/1/18, 5/6/18, and 7/1/18 were reviewed for adequate staffing. Three residents were interviewed regarding care provided by the facility staff. Call light response times were monitored. The shower flowsheets were reviewed.

Anita Burdick, Administrator  
June 24, 2019  
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It could not be established that the facility failed to provide sufficient staff or staff did not provide residents the appropriate care to meet their needs.

Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents are provided with psychotropic medication without indication.

FINDINGS #2:

During the investigation, observations and resident and staff interviews were conducted. Records, including resident clinical records, incident and accident reports, and grievances were reviewed.

The records of two current residents and one closed record were reviewed for psychotropic medication therapy. The nursing notes and narcotic log for one record did not document indication for use of an anti-anxiety medication prior to administration to the resident for 7 doses over a 2-day period.

Due to investigative findings, it was determined the allegation was substantiated and the facility was cited at F758.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj