



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

September 10, 2019

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

Provider #: 135084

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

Dear Ms. Burdick:

On **August 28, 2019**, a Facility Fire Safety and Construction survey was conducted at **Oak Creek Rehabilitation Center of Kimberly** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Anita Burdick, Administrator  
September 10, 2019  
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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 23, 2019**. Failure to submit an acceptable PoC by **September 23, 2019**, may result in the imposition of civil monetary penalties by **October 15, 2019**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 2, 2019**, (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 **November 26, 2019**. A change in the seriousness of the deficiencies on **October 12, 2019**, may result in a change in the remedy.

Anita Burdick, Administrator  
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The remedy, which will be recommended if substantial compliance has not been achieved by **October 2, 2019**, includes the following:

Denial of payment for new admissions effective **November 28, 2019**.  
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 28, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 28, 2019**, 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  
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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:

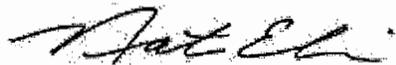
BFS Letters (06/30/11)

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

This request must be received by **September 23, 2019**. If your request for informal dispute resolution is received after **September 23, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 09/05/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135084</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/28/2019</b>
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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>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  The facility is a single story, Type V (III) construction, with multiple exits to grade. It was originally constructed in 1963 and is fully sprinklered with a complete, electronically monitored fire alarm/smoke detection system throughout. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator installed new in 2017. Currently the facility is licensed for 57 SNF/NF beds and had a census of 41 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on August 28, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101  Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		

**RECEIVED**  
SEP 20 2019  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anita Burdick</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-19-19</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 324	<p>Continued From page 1</p> <p>compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire suppression system for the kitchen hood in accordance with NFPA 96. Failure to maintain Kitchen hood suppression systems could result in a lack of system performance, allowing fires to grow outside the protected area. This deficient practice affected staff in the kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During document review on August 28, 2019, from approximately 10:30 AM to 12:30 PM, inspection records revealed the kitchen hood suppression system was not inspected during the last six months of 2018. Kitchen hood suppression systems were due for inspection in November of 2018 but were not inspected until May of 2019. When asked, at approximately 12:40 PM, the Maintenance Director stated the previous Maintenance Director had neglected</p>	K 324	<p>K324</p> <ol style="list-style-type: none"> <li>1. The kitchen hood suppression system was inspected in May of 2019 and is scheduled to be inspected in Nov. of 2019.</li> <li>2. The residents who dine in the 100 hall dining room or participate in therapy in the therapy room had the potential to be affected.</li> <li>3. The maintenance director or designee will complete quarterly audits to ensure the kitchen hood suppression system inspections are scheduled and completed at least every 6 months.</li> <li>4. The results of the audits will be reviewed by the QAPI committee on a quarterly basis to ensure continued compliance.</li> <li>5. Date of compliance 10-1-19.</li> </ol>	

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K 324	Continued From page 2 many of his responsibilities, including scheduling the ANSUL inspection.  Actual NFPA standard:  NFPA 96  11.2.1* Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.	K 324		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		

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K 353	<p>Continued From page 3</p> <p>by: Based on record review and interview, the facility failed to ensure fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect and maintain suppression systems has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected all residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on August 28, 2019 from approximately 10:30 AM - 12:30 PM, the following records were not available for review:</p> <p>1.) Documentation of weekly dry system gauge and control valve inspections. 2.) Documentation demonstrating completion of a quarterly waterflow alarm test for third and fourth quarter 2018.</p> <p>Interview of the Maintenance Director at approximately 12:45 PM, revealed the facility was aware of the missing documentation. The previous Maintenance Director had neglected many of his responsibilities, including the sprinkler system maintenance.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.</p>	K 353	<p>K353</p> <ol style="list-style-type: none"> <li>Weekly dry system gauge and control valve inspections have been completed and documented since the week of 9-2-19. The quarterly waterflow alarm tests have been completed for the first three quarters of 2019. (see attached)</li> <li>All residents had the potential to be affected.</li> <li>The maintenance director or designee will complete audits on the dry system gauge and control valve inspections weekly x 4 weeks, then bimonthly x 2, then monthly x 3, then quarterly. The maintenance director or designee will perform quarterly audits on the Quarterly waterflow alarm tests.</li> <li>The results of the audits will be reviewed by the QAPI committee on a quarterly basis to ensure continued compliance.</li> <li>Date of compliance 10-1-19.</li> </ol>	

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K 353	Continued From page 4 Chapter 13 Valves, Valve Components, and Trim 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353			
K 712 SS=F	5.3.3 Waterflow Alarm Devices. 5.3.3.1 Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly.  Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. The facility also failed to initiate the fire alarm signal and simulate emergency fire conditions. Failure to perform fire drills on each shift quarterly, simulating emergency fire conditions with the transmission of the fire alarm, could result in confusion and hinder the safe evacuation of occupants during a	K 712			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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K 712	Continued From page 5 fire event. This deficient practice affected all residents and staff on the date of the survey.  Findings include:  During record review on August 28, 2019, from approximately 10:30 AM to 12:30 PM, fire drill documentation revealed the facility failed to perform fire drills during first and third shifts, third quarter 2018. Interview of the Maintenance Director at approximately 12:50 PM, revealed the facility was aware of the missing fire drills. The previous Maintenance Director had neglected many of his responsibilities, including facilitating fire drills.  Actual NFPA standard:  21.7.1.4* Fire drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 21.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712	K712 1. Fire drills, including initiating the fire alarm signal and simulating emergency fire conditions, have been held at least quarterly on each shift since Dec. 2018 2. All residents had the potential to be affected. 3. The maintenance director or designee will complete fire drill audits on a quarterly basis. 4. The results of the audits will be reviewed by the QAPI committee on a quarterly basis to ensure continued compliance. 5. Date of compliance 10-1-19.	
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		

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K 918	<p>Continued From page 6</p> <p>capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 131 SNF/NF beds and had a census of 112 on the date of the survey.</p>	K 918		

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K 918	Continued From page 7  Findings include:  During review of the facility generator inspection and testing records on August 28, 2019, from approximately 10:30 AM to 12:30 PM, the facility could not produce weekly generator inspections prior to February 15, 2019. Monthly load tests were also missing for December 2018 and January 2019. When asked, at approximately 12:55 PM, the Maintenance Director stated the facility was aware of the missing documentation. The previous Maintenance Director had neglected many of his responsibilities, including generator maintenance.  Actual NFPA standard:  NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating	K 918	K918  1. The weekly generator tests have been completed since 2-15-19. The monthly load tests have been completed since 2-28-19. 2. All residents had the potential to be affected. 3. The maintenance director or designee will complete audits of the weekly generator tests and monthly load tests on a monthly basis x 3 months then quarterly. 4. The results of the audits will be reviewed by the QAPI committee on a quarterly basis to ensure continued compliance. 5. Date of compliance 10-1-19.		



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Anita Burdick, Administrator  
Oak Creek Rehabilitation Center of Kimberly  
500 Polk Street East  
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Provider #: 135084

RE: **EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Ms. Burdick:

On **August 28, 2019**, an Emergency Preparedness survey was conducted at Oak Creek Rehabilitation Center of Kimberly by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

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

Sincerely,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

PRINTED: 09/05/2019  
FORM APPROVED  
OMB NO. 0938-0391

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>08/28/2019</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	
E 000	<p><b>Initial Comments</b></p> <p>The facility is a single story, Type V (III) construction, with multiple exits to grade. It was originally constructed in 1963 and is fully sprinklered with a complete, electronically monitored fire alarm/smoke detection system throughout. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator installed new in 2017. Currently the facility is licensed for 57 SNF/NF beds and had a census of 41 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on August 28, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	E 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.