



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

October 3, 2019

Trent Clegg, Administrator  
Creekside Transitional Care and Rehabilitation  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

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

Dear Mr. Clegg:

On **September 24, 2019**, a Facility Fire Safety and Construction survey was conducted at **Creekside Transitional Care and Rehabilitation** 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 one that comprises a pattern 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.

Trent Clegg, Administrator  
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Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **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 **October 16, 2019**. Failure to submit an acceptable PoC by **October 16, 2019**, may result in the imposition of civil monetary penalties by **November 7, 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 29, 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 **December 23, 2019**. A change in the seriousness of the deficiencies on **November 8, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **October 29, 2019**, includes the following:

Denial of payment for new admissions effective **December 24, 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 **March 24, 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 **September 24, 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:

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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:

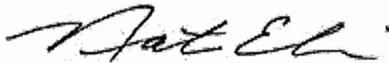
BFS Letters (06/30/11)

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

This request must be received by **October 16, 2019**. If your request for informal dispute resolution is received after **October 16, 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: 10/02/2019  
FORM APPROVED  
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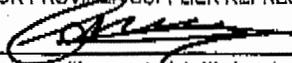
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE TRANSITIONAL CARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</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
K 000	INITIAL COMMENTS  The facility is a Type V (III) construction, single story with a partial second floor completed in March 1997. The second floor is only utilized for staff meetings, training and storage. The facility is fully sprinklered and has a complete fire alarm system with smoke detection throughout. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator with an annunciator and emergency stop. The facility is currently licensed for 139 SNF/NF beds and had a census of 105 on the dates of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on September 23 - 24, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The surveyor conducting the survey was:  Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction  K 353 SS=D 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	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  K- 353 Sprinklor System:  1. On 9/26/2019 Jim Scholl called Viking Automatic and scheduled for the sprinkler pendants to be replaced, Viking is scheduled to replace the pendants the week of 10/21/2019 according to code and regulations.  2. All residents, staff and visitors have the potential to be affected by this deficiency.  3. The affected sprinklers will be replaced on the dates outlined in #1 and the facility will introduce an auditing systems to ensure the sprinkler system stays within and is maintained according to federal and state regulation.  4. Aside from the existing quarterly and annual fire inspection being performed from "Viking" maintenance supervisor/designee will perform a routine	

RECEIVED  
OCT 16 2019  
FACILITY STAFF

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

TITLE

(X6) DATE



Administrator

10/16/2019

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

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K 353	Continued From page 1  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 by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstruction such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff in the kitchen on the dates of the survey.  Findings include:  During the facility tour conducted on September 23, 2019, from approximately 1:00 PM to 4:00 PM, observation of the dishwashing area in the kitchen revealed two (2) corroded sprinkler heads. When asked, at approximately 1:30 PM, the Maintenance Director stated the facility was not aware of the corroded heads.  Actual NFPA standard:  NFPA 25  5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign	K 353	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  audit/inspection of the sprinkler pendants to ensure they are free from obstruction and debris along with ensuring the pendants are not out of date. Audit will be performed monthly on-going. Audits will begin the week of 10/21/2019. Report findings to QA monthly.  5. Date of compliance is 10/28/2019.	

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K 353	Continued From page 2 materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101  Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	<b>K- 363 Corridor – Doors:</b>  1. On 9/26/2019 Jim Scholl called Door Service of Idaho and scheduled for the doors to rooms #205 and #303 to repair or replaced the resident room doors the week of 10/21/2019 to bring them into compliance.  2. All residents, staff and visitors have the potential to be affected by this deficiency.  3. The affected resident doors will be replaced or repaired on the dates outlined in #1 and the facility will introduce an auditing systems to ensure that all resident doors remain within and is maintained according to federal and state regulation.	

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K 363	<p>Continued From page 3</p> <p>of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice had the potential to affect 3 residents and staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 23, from approximately 1:00 PM to 4:00 PM, observation and operational testing of two resident room doors revealed gaps between the face of the door and the frame of the door that exceeded 1/2" when fully closed. Resident room #205 had an approximately 3/4" gap, and resident room #303 had an approximately 5/8" gap. When asked, at approximately 3:00 PM, the Maintenance Director stated the facility was unaware of the door gaps.</p> <p>Actual NFPA Standards:</p>	K 363	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4. Maintenance/designee will audit the facility monthly to ensure that all resident doors are maintained according to federal and state regulation. Audits will begin the week of 10/16/2019 and any negative findings will be reported monthly to the facility QA committee.</p> <p>5. Date of compliance is 10/28/2019.</p>	

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K 363	Continued From page 4  NFFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes	K 363	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with their listed assemblies and those requirements under NFFPA 70. Use of relocatable power taps (RPTs) outside of those defined in the referenced standard, UL 1363, has the potential to expose residents to risks of electrocution and arc fires. This deficient practice affected 12 residents and	K 511	<b>K-511 Utilities- Gas and Electric:</b>  1. On 10/24/2019 Jim Scholl (Maintenance Director) completed an audit of the facility to identify any additional issues with the improper use of electric receptacles, cables and proper use of electric appliances. Any issues were resolved immediately.  2. All residents, staff and visitors have the potential to be affected by this deficiency.  3. All staff in the facility will be educated on the facilities policy on electric receptacles, cables and proper use of electric appliances. Education will be finalized by 10/24/2019.  4. Maintenance/designee will audit the facility monthly to ensure the proper use of electrical receptacles and electric appliances. Audits will begin the week of 10/16/2019 and	

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K 511	<p>Continued From page 5 staff on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 23, 2019, from approximately 1:00 PM to 4:00 PM, observation of installed electrical systems revealed the following:</p> <ol style="list-style-type: none"> <li>1.) The beauty salon had two extension cords connected in series, (daisy chained), being used to power a salon hair drying chair,</li> <li>2.) Room number 210 was using an extension cord.</li> <li>3.) Nurse Unit managers office had a fridge plugged into a Relocatable Power Tap (RPT).</li> </ol> <p>Actual NFPA standard: NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be</p>	K 511	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>any negative findings will be reported monthly to the facility QA committee.</p> <p>5. Date of compliance is 10/28/2019.</p>	

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K 511	Continued From page 6 Identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511			



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DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
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October 3, 2019

Trent Clegg, Administrator  
Creekside Transitional Care and Rehabilitation  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

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

Dear Mr. Clegg:

On **September 24, 2019**, an Emergency Preparedness survey was conducted at Creekside Transitional Care and Rehabilitation 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

PRINTED: 10/02/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CREEKSIDE TRANSITIONAL CARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</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>Initial Comments</p> <p>The facility is a Type V (III) construction, single story with a partial second floor completed in March 1997. The second floor is only utilized for staff meetings, training and storage. The facility is fully sprinklered and has a complete fire alarm system with smoke detection throughout. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator with an annunciator and emergency stop. The facility is currently licensed for 139 SNF/NF beds and had a census of 105 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on September 23 - 24, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The surveyor conducting the survey was:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and 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.