

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2024
NAME OF PROVIDER OR SUPPLIER Oak Creek Rehabilitation Center of Kimberly		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Polk Street East Kimberly, ID 83341	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243</p> <p>Based on policy review, record review, facility investigation review, and staff interview, the facility failed to prevent physical abuse, verbal abuse, and neglect for 1 of 3 residents (Resident #15) reviewed for abuse. This deficient practice placed Resident #15 in immediate jeopardy of serious harm, impairment, or death when the facility did not protect him from physical and verbal abuse and neglect from LPN #1. Findings include:</p> <p>The facility's Abuse policy, undated, stated residents are to be free from abuse, neglect misappropriation of resident property, and exploitation. The policy further stated staff or management accused employees were immediately removed from resident contact and suspended from duty.</p> <p>Resident #15 was admitted on [DATE], with multiple diagnoses including personal history of a traumatic brain injury.</p> <p>A quarterly MDS assessment, dated 5/17/24, documented Resident #15 was severely cognitively impaired.</p> <p>Resident #15's care plan, dated 5/17/24, documented he had behaviors related to repetitive episodes of putting himself on the floor requiring assistance from staff to get him up had increased and had become more difficult for the staff, taking two staff members and sometimes a third staff member. The care plan documented before the staff left the area, Resident #15 would put himself on the floor again. The care plan further documented Resident #15 did not assist the staff to get him up; however, at times he was witnessed getting off the floor and back into his wheelchair. Interventions included activities and using a mechanical lift to get Resident #15 off the floor.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A facility investigation report, undated, documented an incident occurred on 2/28/24. The report documented NA #1 was assisting LPN #1 to get Resident #15 off the floor and back into his wheelchair. LPN #1 attached the [gait] belt [an assistance safety device that can be used to help a patient sit, stand, or walk around, as well as to transfer them from a bed to a wheelchair] around Resident #15's chest to get him up and she was yelling at him to get up and get on his feet. NA #1 went to grab him under his arm to help him and LPN #1 said no, he can do it, he knows how. After about a minute of LPN #1 pulling on Resident #15 and yelling, LPN #1 said, I'm not [expletive] doing this tonight and proceeded to pull him to the floor and as she was doing so, he hit his head on the door frame of his room as a result of her being rough and yanking him around. LPN #1 took the belt off, grabbed under his arms and pulled him part way into his room. He was holding his head in pain and LPN #1 said to NA #1 to leave him there. NA #1 did as she was told and left the room. NA #1 returned 45 minutes later to check on Resident #15 who was still on the floor. Resident #15 was soaked in urine and his shirt was pulled over his head. The shirt was soaked in saliva. NA #1 called for help to change Resident #15 and put him to bed. The investigation report documented the incident was reported to Human Resources on 2/29/24 by NA #1. The conclusion of the investigation documented abuse could not be substantiated. The facility investigation report documented the former Administrator was unable to substantiate.</p> <p>The RVP presented a copy of the former Administrator's email to the staffing agency that employed LPN #1 dated 3/1/24 at 7:54 PM, documenting the former Administrator wrote I want to terminate LPN #1's contract due to verbal abuse.</p> <p>During an interview on 7/3/24 at 5:19 PM, the RVP stated she thought the former Administrator thought that LPN #1 was overwhelmed. She did not have an explanation as to why the facility investigation did not substantiate abuse, however the email indicated verbal abuse did occur.</p> <p>During an interview on 7/3/24 at 6:29 PM, RN #1 stated when she came on duty at 6:00 AM on 2/29/24, NA #1, NA #2 and NA #3 approached her and reported what happened the night before (2/28/24). RN #1 stated that she, NA #2, and NA #3 wrote a statement, and the statements were given to the former Administrator.</p> <p>During a follow up interview on 7/3/24 at 6:47 PM, the RVP stated there was no documentation regarding a physical assessment or monitoring of Resident #15 after the incident. Resident #15 was not sent to the hospital emergency room for an evaluation. The RVP was unsure whether the attending physician was notified, and there was no incident report. The RVP stated they knew RN #1 had completed an assessment of Resident #15 but did not document the assessment because the former Administrator told RN #1 that she would take care of it.</p> <p>During an interview on 7/3/24 at 7:00 PM, the HR Personnel stated she recalled NA #1 reported the incident on 2/29/24 to her. She asked NA #1 to write a statement then she took it to the former Administrator personally.</p> <p>During an interview on 7/4/24 at 12:23 PM, NA #1 confirmed she did not report the incident that occurred on 2/28/24 until the next morning, 2/29/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/4/24, an Immediate Jeopardy (IJ) was determined at Past Non-Compliance for the facility's failure to ensure residents were safe from abuse by a staff member. The IJ was determined to exist on 2/28/24 when Resident #15 was verbally abused, physically abused, and neglected by LPN #1. The IJ was removed on 6/25/24.</p> <p>On 7/4/24 at 5:40 PM, the survey team notified the Administrator and DON of the Immediate Jeopardy and provided them a copy of the CMS Immediate Jeopardy (IJ) Template.</p> <p>On 7/4/24 at 7:30 PM, the facility provided a copy of their Corrective Action Plan. The facility's actions included the following:</p> <ul style="list-style-type: none"> - LPN #1 was terminated on 3/1/24. No statement obtained. Agency notified. - NA #1 was educated on abuse and when and how to report it according to the report. - The former Administrator's employment was terminated on 5/8/24. <p>Steps taken by Current Administrator since 5/13/24:</p> <ul style="list-style-type: none"> - On 5/24/24, the Administrator had mandatory all staff in-service and included in the agenda was Grievance policy and procedure, Abuse Coordinator, types of abuse and abuse reporting policy. - On 6/1/24, information was placed in common areas with Key Personnel that specifically named Current Administrator as abuse coordinator and phone number. - On 6/2/24, 27 residents were interviewed and asked if they felt safe and who they report concerns to. If they did not know, they were educated. - On 6/6/24, Abuse Training education was placed in the information book. - On 6/25/24, a QAPI [Quality Assurance and Performance Improvement] meeting was held. Reviewed Reportable incidents and grievances with Medical Director and Interdisciplinary Team (IDT) were reviewed. - On 7/4/24 at 8:30 PM, the survey team validated that the facility removed the IJ on 6/25/24 before the survey entrance. There were no other instances of abuse to residents after 6//24/24. Therefore, the facility was cited at IJ at F600, at past non-compliance, and found to be in compliance as of 6/25/24. 		

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<p>F 0609</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243</p> <p>Based on policy review, record review, facility investigation review, and staff interview, it was determined the facility failed to report an allegation of physical and verbal abuse and neglect to the State Survey Agency. This was true for 1 of 3 residents (Resident #15) reviewed for abuse. This failure resulted in harm to Resident #15 when the allegation of physical and verbal abuse was not acted on in a timely manner, investigated, and measures implemented to protect residents during the investigation. Findings include:</p> <p>The facility's Abuse policy, undated, stated, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and exploitation are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where State law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>Resident #15 was admitted on [DATE], with multiple diagnoses including personal history of a traumatic brain injury.</p> <p>A quarterly MDS assessment, dated 5/17/24, documented Resident #15 was severely cognitively impaired.</p> <p>A facility investigation report, undated, documented an incident occurred on 2/28/24. The report documented NA #1 was assisting LPN #1 to get Resident #15 off the floor and back into his wheelchair. LPN #1 attached the [gait] belt [an assistance safety device that can be used to help a patient sit, stand, or walk around, as well as to transfer them from a bed to a wheelchair] around Resident #15's chest to get him up and she was yelling at him to get up and get on his feet. NA #1 went to grab him under his arm to help him and LPN #1 said no, he can do it, he knows how. After about a minute of LPN #1 pulling on Resident #15 and yelling, LPN #1 said, I'm not [expletive] doing this tonight and proceeded to pull him to the floor and as she was doing so, he hit his head on the door frame of his room as a result of her being rough and yanking him around. LPN #1 took the belt off, grabbed under his arms and pulled him part way into his room. He was holding his head in pain and LPN #1 said to NA #1 to leave him there. NA #1 did as she was told and left the room. NA #1 returned 45 minutes later to check on Resident #15 who was still on the floor. Resident #15 was soaked in urine and his shirt was pulled over his head. The investigation report documented the incident was reported by NA #1 to the facility's HR personnel on 2/29/24, the day after the incident occurred.</p> <p>During an interview on 7/3/24 at 6:29 PM, RN #1 stated when she came on duty at 6:00 AM on 2/29/24 (the next day), NA #1, NA #2 and NA #3 reported what happened the evening before. RN #1 stated that she, NA #2, and NA #3 wrote a statement, and the statements were given to the former Administrator.</p> <p>During an interview on 7/4/24 at 12:23 PM, NA #1 confirmed that she did not report the alleged incident until the next morning, 2/29/24.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Actual harm Residents Affected - Few	<p>On 7/4/24 at 7:30 PM, the facility provided a copy of their Corrective Action Plan. The facility's actions included the following:</p> <p>Steps taken by Current Administrator since 5/13/24:</p> <ul style="list-style-type: none"> - On 5/24/24, the Administrator had mandatory all staff in-service and included in the agenda was Grievance policy and procedure, Abuse Coordinator, types of abuse and abuse reporting policy. - On 6/1/24, information was placed in common areas with Key Personnel that specifically named Current Administrator as abuse coordinator and phone number. - On 6/2/24, 27 residents were interviewed and asked if they felt safe and who they report concerns to. If they did not know, they were educated. - On 6/6/24, Abuse Training education was placed in the information book. - On 6/25/24, a QAPI [Quality Assurance and Performance Improvement] meeting was held. Reviewed Reportable incidents and grievances with Medical Director and Interdisciplinary Team (IDT) were reviewed. <p>The survey team validated the Corrective Action Plan was in place before the survey entrance and there were no further instances of failure to report alleged abuse to the State Agency. Therefore, the facility was cited at Past Non-Compliance and was found to be in compliance as of 6/25/24.</p>		