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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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

February 5, 2015

Cameron C. Prescott, Administrator
Cherry Ridge Center
501 West Idaho Boulevard
Emmett, ID 83617-9694

Provider #: 135095

Dear Mr. Prescott:

On **January 29, 2015**, a Recertification and State Licensure survey was conducted at Cherry Ridge Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes 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 and a similar State Form 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" (listed on page 2). **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. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and

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return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 18, 2015**. Failure to submit an acceptable PoC by **February 18, 2015**, may result in the imposition of civil monetary penalties by **March 10, 2015**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed 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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **March 5, 2015 (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 **March 5, 2015**. A change in the seriousness of the deficiencies on **March 5, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 5, 2015** includes the following:

Cameron Prescott, Administrator
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Denial of payment for new admissions effective **April 29, 2015**. [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 **July 29, 2015**, 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 Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. 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 **January 29, 2015** 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 noncompliance 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:

<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)

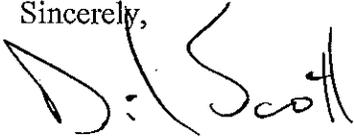
Cameron Prescott, Administrator
February 5, 2015
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2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **February 17, 2015**. If your request for informal dispute resolution is received after **February 17, 2015**, 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 Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a long horizontal stroke.

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 02/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617
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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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F 000 INITIAL COMMENTS

F 000

The following deficiencies were cited during the annual Federal recertification survey of your facility.

The surveyors conducting the survey were: Susan Gollobit, RN, team coordinator and Linda Kelly, RN.

The survey team entered the facility on Monday, 1/26/15, and exited the facility on Thursday, 1/29/15.

Survey Definitions:

MDS = Minimum Data Set
ADL = Activities of Daily Living
BIMS = Brief Interview of Mental Status
DON = Director of Nursing

F 252 483.15(h)(1)
SS=E SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined the facility failed to ensure a homelike environment for residents on each of three wings of the facility. The deficient practice had the potential to cause more than minimal psychosocial and physical harm when the building had toilets, floors, a sink, and a shower that were not clean and/or were in disrepair as

RECEIVED
FEB 17 2015
FACILITY COMPLAINTS

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

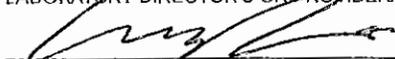
F 252

The toilets in rooms 2, 7,8,13, and C-hall shower room were deep cleaned by housekeeping on 1/30/15. Floor in room 16 cleaned on or before 2/13/15. The sink in room 9 was cleaned on 1/30/15. A bid to replace cracked and stained floors in rooms 7, 8, 13, and 15 will be obtained and approved on or before 3/5/15.

A review of all toilets, sinks, and floors to check for stains, dingy colors, and cracks was completed by

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

FILE (X6) DATE



Administrator

2/16/15

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 252 Continued From page 1
follows:
-Room # 2, 7, 8, 13, and C-hall shower room had dirty toilets.
-Room # 7, 8, 13, 15, and 16 floors were stained and dingy colored.
-Room #9's sink was stained and dirty.
Findings included:

On 1/26/15 at 7:45 to 8:45 AM, during the initial tour of the building, resident rooms were observed as follows:
-Room #2 had a tan-colored ring at the water level inside the toilet bowl; dark brown/black stains were observed covering the hole in the bottom of the toilet.
-Room #7's floor in the bathroom was dingy gray with darker stained areas.
-Room #8 had a thick tan-colored ring at the water level in the toilet bowl. The floor in front of the toilet had three lighter colored tan strips of linoleum surrounded by dingy gray linoleum.
-Room #13 had a thick tan-colored ring at the water level in the toilet bowl. The linoleum in the bathroom was dingy gray with dark gray stained areas. In front of the toilet was approximately a 1 inch area circling the base which had a dark brown build up. The main floor in the resident's room had light brown colored tile with black build up between the tiles. The tiles throughout the room had numerous cracks.
-Room #15 in the main resident room area had light brown tiles. The tiles were worn and cracked and between the tiles was black build up.

On 1/26/15 at 10:50 AM, Room #9's sink was observed to have yellow stains in the basin with a brown/black ring approximately 1/4 inch wide around the metal drain in the base of the basin.

F 252 the maintenance director or designee on or before 2/13/15. Corrections made as indicated.

Systematic Change:
A monthly review of tiles and weekly review of toilets and sinks will be completed by the Maintenance Director or designee to ensure cleanliness and upkeep. Notifications to the housekeeping supervisor as indicated. Notifications to the Administrator for capital expenditure requests as indicated.

An education was completed with housekeeping by the Administrator or designee on or before 2/20/15 on following the outlined toilet cleaning schedule as well as how to clean the toilets correctly. Capital expenditure request has been submitted and approved by the Administrator for flooring replacement on or before 3/5/15.

Beginning the week of 2/16/15 the administrator or designee will review toilets to ensure none have stains, and to ensure floors with cracks are scheduled to be replaced, weekly for four weeks and monthly for two months. Results will be reviewed in QAPI meetings monthly for a

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F 252	<p>Continued From page 2</p> <p>On 1/29/15 at 9:50 AM, during the environmental tour, the MD (Maintenance Director) was asked about the worn, cracked, brown tiles in Room #13 and #15. The MD stated the tiles were asbestos and "we would like to do all the rooms but these 2 rooms are on the top of the list." At 10:00 AM, the resident shower room on the C-hall was observed with a brown stain in the bottom of the toilet. At 10:35 AM, the MD was asked if the facility had a schedule to strip and wax floors, including the floor in Room #13. The MD stated Housekeeping had a schedule for the floors.</p> <p>On 1/29/15 at 11:10 AM, Housekeeper #2 was asked to describe the schedule for when floors were waxed. Housekeeper #2 stated, "The main boss does that I am not sure how often maybe two times a week. I am not really sure."</p> <p>On 1/29/15 at 1:45 PM, the IHD (Interim Housekeeping Director), with the surveyor, observed the toilet in Room #2 and stated, "That is gross." In Room #7, the IHD observed the toilet with black stains and stated, "There is definitely something in there. It (the problem) is more than one wing." In Room #9, when the IHD observed the sink, she stated, "That is something they would have to work on a little bit each day with lime away. It's from the water sitting in it." In Room #13m, the IHD acknowledged the toilet had a ring at the water level, and stated the bathroom floor was a "very old non-wax floor; after you use some cleaners on it, it eats it away. I think this one has been on the list to be replaced for a while." The IHD stated the dark area around the front base of the toilet was from where the old toilet had been before it was replaced.</p> <p>On 1/29/15 at 4:00 PM the Administrator and the</p>	F 252	<p>minimum of three months, or until compliance is sustained. Administrator is responsible for compliance.</p>	3/5/15

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F 252	Continued From page 3 DON were informed of the findings. No additional information was provided.	F 252		
F 278	483.20(g) - (j) ASSESSMENT SS=D ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	F 278	Resident #2's Range of Motion (ROM) functional status was re-assessed by the Director of Nursing Services (DNS) or designee and found to be without functional limitation to bilateral upper extremities on or before 2/13/15. MDS was modified by the DNS or designee on or before 2/20/15. Resident #9's Range of Motion (ROM) functional status was re-assessed by the Director of Nursing Services (DNS) or designee and found to be without functional limitation to bilateral lower extremities on or before 2/13/15. Resident #9's Minimum Data Set (MDS) was modified by the DNS or designee on or before 2/20/15. A review of the last 90 days of current residents' most recent MDS was completed on or before 2/13/15 by the DNS or designee to ensure that the ROM are reflected accurately on the MDS. Corrections made as indicated at the time of review.	

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F 278 Continued From page 4

ensure accuracy of the resident assessment for 2 (#2 & 9) of 9 residents whose assessments were reviewed. The deficient practice had the potential to cause more than minimal harm when Resident #2's and #9's ROM (range of motion) assessment were documented inaccurately, which could limit the residents from receiving the ROM program needed. Findings included:

1. Resident #2 was admitted to the facility on 6/13/12 with diagnoses that included Huntington's Chorea, paraplegia and abnormal involuntary movements.

The resident's annual MDS assessment, dated 6/21/14, documented functional limitations of an upper extremity, as well as bilateral lower extremities, were not assessed. The significant change MDS assessment, dated 9/16/14, and the quarterly MDS assessment, dated 12/17/14, documented the resident had impairment to both bilateral upper and lower extremities.

The resident's Nursing Assessment forms documented:

-6/21/14: ROM was assessed and the resident had no impairment to the upper extremity and bilateral impairment to the lower extremities.
-9/27/14 and 12/17/14: ROM was assessed as impairment to bilateral upper and lower extremities.

On 1/28/15 at 1:35 PM, when the MDS coordinator (MDSC) was asked why the resident's MDS assessment, dated 6/21/14, documented the resident's upper extremity was not assessed, the MDSC stated, "I don't know, but I will go look into that."

F 278

Systematic Change:
The MDS coordinator will discuss discrepancies of the MDS findings versus the nursing assessment with the Interdisciplinary Team (IDT). The MDS coordinator will complete a progress note for discrepancies to define coding.

The DNS or designee educated the MDS coordinator on coding and assessing on or before 2/20/15.

Beginning the week of 2/16/15 the DNS or designee will review three MDS' for accuracy weekly for 4 weeks then monthly for 2 months. Results will be reviewed in monthly QAPI meetings for 3 months or until compliance is sustained. DNS is responsible for compliance.

3/5/15

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F 278 Continued From page 5

On 1/28/15 at 2:25 PM, the DON stated the 6/21/14 MDS assessment "was inaccurate and she (MDSC) is amending it right now. The Nursing Assessment shows he was assessed."

On 1/29/15 at 9:20 AM, the resident was observed propelling himself into the building. The resident went through the door and propelled himself using both arms over the metal weather strip along the floor and down the hall to the dining room.

On 1/29/15 at 10:00 AM, the MDSC was asked if the resident had a change in his ROM of the upper extremities when he went from no limitations on the 6/21/14 assessment to limitation of both sides on the 9/27/14 and 12/17/14 assessments. The MDSC stated the nurse who documented the assessments on 9/27/14 and 12/17/14 no longer worked at the facility. "I personally do not ever believe he has been a 2-2 (limited on both upper and lower extremities)." The MDSC stated the MDS assessment dated 6/21/14, which documented he was not assessed for upper extremity ROM, was inaccurate and the two MDS assessments dated 9/27/14 and 12/17/14, which documented both upper and lower ROM limitations, were inaccurate. She stated she had a call into the Corporate MDS Consultant to decide how to accurately change each assessment.

On 1/29/15 at 4:00 PM, the Administrator and the DON were notified of the concerns. No additional information was provided.

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F 278	<p>Continued From page 6</p> <p>2. Resident #9 was admitted to the facility in September 2013 with multiple diagnoses which included uncomplicated senile dementia, generalized muscle weakness, and difficulty walking.</p> <p>Review of the resident's clinical records revealed functional limitation in range of motion (ROM) in the lower extremities was coded differently in the three most recent quarterly MDS assessments, dated 9/11/14, 12/12/14, and 12/18/14. The documentation included: * 9/11/14 = "0" which indicated no impairment to either lower extremity; * 12/12/14 = "2" which indicated impairment to both lower extremities; and, * 12/18/14 = "1" which indicated impairment to one lower extremity.</p> <p>On 1/29/15 at 1:30 p.m., the DON was asked about the MDS coding. The DON reviewed the resident's MDS assessments and acknowledged the different coding at functional limitation in ROM in the lower extremities. The DON said she would look into the issue and get back with the surveyor.</p> <p>On 1/29/15 at 1:50 p.m., the MDS Coordinator informed the survey team the variation in the coding regarding the resident's lower extremity ROM was a result of different nurses doing the assessments. The MDS Coordinator said she completed the 9/11/14 and 12/18/14 assessments and a different nurse completed the 12/12/14 assessment. The MDS Coordinator stated, "She [the resident] was weak but range of motion was not the problem." The MDS Coordinator added, "She never has had</p>	F 278		

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F 278	Continued From page 7 impairment on both legs." When asked about the accuracy of the coding, the MDS Coordinator stated, "I would suspect that it's inaccurate." On 1/29/15 at 4:00 p.m., the Administrator, DON, Nurse Consultant, and Regional Vice President were informed of the issue. The facility did not provide any other information regarding the issue.	F 278		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	Expired flu vaccines were discarded on or before 1/29/15 by the DNS or designee. A review of the medication storage room was completed by the DNS or designee on or before 2/13/15 to ensure there are no more expired flu vaccines. No further expired medications were found at the time of review. Residents are without signs and symptoms of any adverse reactions due to open vials of flu vaccination. Systematic Change: The medication room will be reviewed monthly and a log to be kept for future destruction dates to ensure there are no expired medications in the medication room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617
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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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F 431	<p>Continued From page 8</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure multi-dose vials of flu vaccine were not available for resident use more than 28 days after they were opened. The failure created the potential for oxidation and degradation of the vaccine and could result in sub-optimal benefit for new residents and other residents living in the facility who may have received the vaccine. Findings included:</p> <p>On 1/29/15 at 11:30 a.m., during an inspection of the medication room refrigerator with LN #1 present, two multi-dose vials of afluaria Influenza Vaccine (ten doses/vial) were found to have been opened for more than 28 days. One vial was opened 12/11/14 (49 days) and the other vial was opened 11/8/14 (82 days). Regarding storage, the manufacturer's package insert of information in the vaccine box stated, "Once the stopper of the multi-dose vial has been pierced, the vial must be discarded within 28 days." LN #1 confirmed the open date on both of the vials. The LN said the 2 vials of flu vaccine would be destroyed. She placed the vials in a container, labeled "Destroy," on the counter in the medication room.</p> <p>On 1/29/15 at 4:00 p.m., the Administrator, DON, Nurse Consultant, and Regional Vice President were informed of the issue. The facility did not provide any other information regarding the issue.</p>	F 431	<p>Licensed Nurses (LN) educated by the DNS on or before 2/20/15 that flu vaccinations expire 28 days after they have been opened and the medication expiration tracking log.</p> <p>Beginning the week of 2/16/15 the DNS or designee will review the medication storage room weekly for four weeks and monthly for 2 months to ensure there are no expired medications. Results will be reviewed in QAPI meetings monthly for a minimum of 3 months, or until compliance is sustained. The DNS is responsible for compliance.</p>	3/5/15
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F 514 483.75(l)(1) RES
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, it was determined the facility failed to ensure medical records were accurately filed, or maintained, for 2 of 10 sample residents (#s 4 and 9) and one random resident (#11). The failure created the potential for medical decision making for the residents to be based on incomplete information. Findings included:

On 1/29/15 at 9:15 a.m., during an interview with the Licensed Social Worker (LSW), the LSW found the December 2014 behavior monitor documentation for Resident #9 and an undated behavior monitor documentation for Resident #11 in Resident #4's paper chart. The LSW removed the misfiled behavior monitors from Resident #4's chart. The LSW said that 2 "new" people had recently helped with filing. When asked if the behavior monitors were documented electronically in addition to paper documentation,

F 514

Resident #'s 4, 9 and 11 behavior flow sheets were moved to their correct charts on or before 1/30/15 by the DNS or designee. Resident #9's recaps were moved to the correct medical record on or before 1/30/15 by the DNS or designee.

A review of current residents' medical records was completed on or before 2/20/15 by the Administrator or designee to ensure there is no misfiling of medical records. Corrections made as indicated through review.

Systematic Change:
The Administrator or designee will complete monthly audits of the current residents' un-thinned medical records to ensure no medical record misfiling occurs.

Health Information Manager (HIM) educated by the Administrator on or before 2/20/15 on keeping residents' records in the correct chart.

Beginning the week of 2/16/15 the Administrator or designee will review

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

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FORM APPROVED
OMB NO. 0938-0391

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F 514	Continued From page 10 the LSW indicated they were not and stated, "We don't have behavior monitors on the computer." The LSW also acknowledged the undated documentation for Resident #11 and said it was "probably" for December because he was in the facility for only a short time in December. On 1/29/15 at 4:00 p.m., the Administrator, DON, Nurse Consultant and Regional Vice President were informed of the misfiled documentation. The facility did not provide any other information regarding record maintenance.	F 514	three charts for accuracy weekly for four weeks and monthly for two months. Results will be reviewed in QAPI meetings monthly for three months at minimum or until compliance is sustained. Administrator is responsible for compliance.	3/5/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001270	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the annual State relicensure survey of your facility. The surveyors conducting the survey were: Susan Gollobit, RN, team coordinator and Linda Kelly, RN. The survey team entered the facility on Monday, 1/26/15, and exited the facility on Thursday, 1/29/15. Survey Definitions: FSD/FSS = Food Services Director/Food Services Supervisor DON = Director of Nursing Services RMCO = Regional Manager of Clinical Operations	C 000	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”	
C 362	02.108,07,a Interior Surfaces Clean & Sanitary a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: Refer to F252 for a clean and homelike environment.	C 362	Refer to F252	
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.	C 664	No residents were directly affected. No residents were directly affected.	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

2/16/15

Changed PM TC to admin
2/24/15 *AP/...*

Bureau of Facility Standards

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C 664 Continued From page 1

This Rule is not met as evidenced by:
Based on staff interview and review of the Infection Control Committee meeting minutes, it was determined the facility failed to ensure the dietary services supervisor was included in regularly scheduled meetings, which created the potential for a negative effect for all residents, staff, and visitors when all committee members did not participate in infection control meetings. Findings included:

On 1/28/15 at 2:05 p.m., the monthly Infection Control Committee meeting attendance records for July 2014 through January 2015 were reviewed with the Infection Control Nurse (ICN). The attendance records did not include the dietary services supervisor for any of those months and the ICN confirmed that the dietary services supervisor did not always attend the meetings.

On 1/29/15 at 4:00 p.m., the Administrator, DON, Nurse Consultant, and the Regional Vice President were informed of the issue. The Administrator said the dietary services supervisor "usually" arrived late to the meetings and therefore had not sign the attendance records.

C 664

Systematic Change:
Infection control meeting will be scheduled by the Administrator at a routine date and time to ensure the dietary manager can attend at the scheduled time. The Administrator will ensure the dietary manager is aware of the meeting date and time each month.

IDT educated by the administrator on or before 2/20/15 of the required attendees for the infection control meeting.

Beginning in February 2015 advanced notification and follow up will be directed to the dietary manager. An ongoing audit will be provided by the Administrator to the QAPI committee each month for a minimum of 3 months, or until compliance is sustained.

C 821 02.201,01,b Removal of Expired Meds

b. Reviewing all medications in the facility for expiration dates and shall be responsible for the removal of discontinued or expired drugs from use as indicated at least every ninety (90) days.

This Rule is not met as evidenced by:
Refer to F 431 as it related to expired flu vaccine.

C 821

Refer to F431

3/5/15

Bureau of Facility Standards

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C 881	02.203,02 Individual Medical Record 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F 514 as it related to maintenance of individual medical records.	C 881	Refer to F514	
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