



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

March 19, 2015

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

Provider #: 135095

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

Dear Mr. Prescott:

On **March 10, 2015**, a Facility Fire Safety and Construction survey was conducted at **Cherry Ridge Center** 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 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. 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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 1, 2015**. Failure to submit an acceptable PoC by **April 1, 2015**, may result in the imposition of civil monetary penalties by **April 21, 2015**.

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 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 **April 14, 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 **April 14, 2015**. A change in the seriousness of the deficiencies on **April 14, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 14, 2015**, includes the following:

Denial of payment for new admissions effective **June 10, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the

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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 **September 10, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **March 10, 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 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:

<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)

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

This request must be received by **April 1, 2015**. If your request for informal dispute resolution is received after **April 1, 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, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

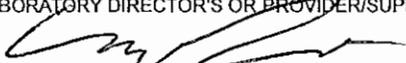
Printed: 03/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2015
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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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K 000	INITIAL COMMENTS The facility is a single story, Type V (000) building, constructed in 1959. The structure has a private well and storage tank as a sole source to supply the automatic fire extinguishment system which is equipped with quick response sprinklers in habitable spaces. There are five exits at grade level. Currently the facility is licensed for 40 SNF/NF beds. The following deficiencies were cited during the annual life safety survey conducted on March 10, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	PROVIDED APR - 2 2015 FACILITY STANDARDS "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."	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure attic areas were not used as an occupied space or for the storage of combustible materials. Failure to keep attic spaces clear and unoccupied in type V(000) structures creates a condition of fire exposure beyond a one-story building not permitted under the code. This deficient practice affected all residents, staff and	K 012	Attic area cleared of stored boxes and combustible materials on or before 3/13/15. Attic reviewed by the Administrator for stored boxes and combustible materials on or before 3/27/15. Systematic Change: Key to entrance to attic area removed on or before 3/13/15 and kept by Administrator and Maintenance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/31/15
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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 012	<p>Continued From page 1</p> <p>visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, inspection of the attic found storage of old boxes from television installations and supplies of combustible materials in an area exceeding 50 square feet, with a separated section of approximately six feet by six feet (36 square feet), which appeared to be utilized as an IT office. When asked, the Administrator, Property Management Director and Maintenance Director stated the area was used frequently by the IT department.</p> <p>Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied</p>	K 012	<p>Director to ensure attic area was accessed by authorized personnel only.</p> <p>Maintenance Director educated by the Administrator on or before 3/27/15 to keep boxes and combustible materials out of the attic space.</p> <p>Beginning the week of 3/30/15 the Administrator or designee will review the attic space weekly for four weeks and monthly for 2 months to ensure that the attic space is free of boxes and combustible materials. Results will be reviewed by the PI committee monthly for 3 months. The Maintenance Director is responsible for compliance.</p>
			4/14/15

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K 012 K 029 SS=F	<p>Continued From page 2 or protected throughout by an approved automatic sprinkler system.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with self-closing doors. Failure to provide protection for hazardous areas would allow smoke and dangerous gases to pass into corridors affecting egress during a fire. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 19 on the day of the survey.</p> <p>Findings include: During the facility tour conducted on March 10, 2015 from 8:45 AM to 2:00 PM, observation and operational testing of the following doors found they would not self-close: Main Laundry door to the corridor Door to old Therapy office which has been converted to Medical Records</p>	K 012 K 029	<p>Door self-closing devices installed by the Maintenance Director on Medical Records office and Storage area cited on or before 3/27/15. Laundry door self-closing device repaired by the Maintenance Director to ensure the laundry door self-closes on or before 3/27/15.</p> <p>All doors needing self-closing devices in the facility reviewed by the Administrator or designee on or before 3/27/15.</p> <p>Systematic Change: The Administrator or designee will review all self-closing doors monthly to ensure they have door closing devices on them as well as ensuring they close completely on their own.</p> <p>Maintenance Director educated by the Administrator on or before 3/27/15 to ensure doors that need self-closing devices have them and that they are functioning properly.</p> <p>Beginning the week of 3/30/15 the Administrator or designee will review all doors that require self-closing devices weekly for four weeks and monthly for two months to ensure the devices are in place and functioning</p>

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K 029	<p>Continued From page 3</p> <p>Old Oxygen storage room now used for general storage, approximately ten feet by ten feet (100 square feet)</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having 	K 029	<p>properly. Results will be reviewed at PI meetings monthly for three months. Maintenance Director is responsible for follow up.</p>
			4/14/15

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K 029	Continued From page 4 jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. K 034 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure space underneath attic access stairs was not used for storage. Failure to prevent storage underneath access stairs would add fuel and affect the integrity of the stairs during a fire event. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF beds and had a census of 30 on the day of the survey. Findings include: During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, observation of the area underneath the attic access stairs found it to be converted to Housekeeping storage. Further inspection found it housed combustibles (paper towels, toilet paper and chemical supplies) in a non-rated enclosure and was not equipped with a self-closing door. Observation of the floor level of the area found a	K 029	K 034 Housekeeping storage closet cleared of all combustible materials by the Housekeeping Supervisor on or before 3/20/15. Transfer grill was replaced by the Maintenance Director on or before 3/27/15. Review of the housekeeping storage closet completed by the Administrator on or before 3/27/15. Systematic Change: The Administrator will review the Housekeeping storage closet monthly to ensure there are no combustible materials stored beneath the stairs. Housekeeping Supervisor and Maintenance Director were educated by the Administrator on or before 3/27/15 to not store any combustible supplies under stairs. Beginning the week of 3/30/15 the Administrator or designee will review underneath access stairs weekly for	

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K 034	Continued From page 5 transfer grill approximately three inches by twelve inches installed in the wood riser, clearly revealing light from the corridor. When interviewed, the Maintenance Director stated this storage had always been under the attic access and he had never noticed the transfer grill prior to the survey. Actual NFPA standard: 7.2.2.5.3* Usable Space. There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress. Exception: Enclosed, usable space shall be permitted under stairs, provided that the space is separated from the stair enclosure by the same fire resistance as the exit enclosure. Entrance to such enclosed usable space shall not be from within the stair enclosure. (See also 7.1.3.2.3.)	K 034	four weeks and monthly for two months to ensure there are no stored combustibles and the transfer grill is replaced. Results will be reviewed in PI meeting monthly for three months to ensure compliance. The Maintenance Director is responsible for compliance.	4/14/15
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on operational testing and interview, the facility failed to ensure delayed egress doors would not release under applied 15 lbf for 3 seconds duration, activating the irreversible 15 second release feature. Failure for delayed egress doors to operate as designed could inhibit the safe evacuation of residents during an	K 038	Delayed egress was repaired by the Maintenance Director on the south facing "B" wing door and the north facing dining hall door on or before 3/13/15. A review of all delayed egress doors was completed by the Administrator on or before 3/27/15 to ensure the door alarms when excessive pressure is applied for 3 seconds. Systematic Change:	

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K 038	Continued From page 6 emergency. This deficient practice affected 30 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 30 on the day of the survey. Findings include: During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, operational testing of the delayed egress doors exiting the "B" wing to the south and the main dining hall to the north, found neither door would release when excessive pressure was applied for over 15 seconds. Further investigation found the doors would release under multiple safeguards abating an immediate jeopardy. Actual NFPA standard: 19.2.2 Means of Egress Components. 19.2.2.1 Components of means of egress shall be limited to the types described in 19.2.2.2 through 19.2.2.10. 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted,	K 038	The Administrator or designee will test all delayed egress doors monthly to ensure they alarm when excessive pressure is applied for 3 seconds. The Maintenance Director was educated by the Administrator on or before 3/27/15 to ensure that all delayed egress doors will alarm when excessive pressure is applied for 3 seconds. Beginning the week of 3/30/15 the Administrator or designee will review all delayed egress doors weekly for four weeks and monthly for two months to ensure they alarm when excessive pressure is applied for 3 seconds. The results will be reviewed in PI meeting monthly for three months to ensure compliance. The Maintenance Director is responsible for compliance.	4/14/15

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K 038	<p>Continued From page 7</p> <p>provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not</p>	K 038	

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K 038	Continued From page 8 less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on operational testing and interview, the facility failed to ensure that exit and emergency lighting with battery back-up was maintained. Failure to ensure that battery powered exit and emergency egress lighting operated under battery load could inhibit egress of residents during an emergency or power outage. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF residents and had a census of 30 on the day of the survey. Findings include: During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, operational testing of the following exit and emergency lights found the batteries were dead: Exit light at main front entry Exit light above convenience doors into "A" wing (2) Emergency lights in the attic Interview of the Maintenance Director found he was not aware that these lights had dead batteries. Actual NFPA standard:	K 046	The exit lights at the front entry and above the convenience doors into the "A" wing were repaired by the Maintenance Director on or before 3/20/15. The 2 Emergency lights in the attic area were removed by the Maintenance Director on or before 3/20/15. A review of emergency exit lights was completed by the Administrator on or before 3/27/15 to ensure they are maintained and functioning. Systematic Change: The Administrator will review emergency exit lights monthly to ensure they are functioning. The Maintenance Director was educated by the Administrator on or before 3/27/15 that all emergency exit lights must be maintained and functioning. Beginning the week of 3/30/15, the Administrator or designee will review

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K 046	Continued From page 9 7.9.2.4* Battery-operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electrical Code®. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	emergency exit lights weekly for four weeks and monthly for two months to ensure they are maintained and functioning. The PI committee will review the results monthly for three months to ensure compliance. The Maintenance Director is responsible for compliance.
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	Sprinkler heads in room #2 were changed by the facility's contracted sprinkler maintenance provider so both heads are quick response on or before 3/20/15. The sprinkler outside of room 12 was cleaned by the

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K 062	<p>Continued From page 10</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler systems were maintained in accordance with NFPA 25. Failure to maintain sprinkler systems could hinder system performance during a fire event, allowing fires to grow beyond incipient stages. This deficient practice affected 30 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, observation of the facility sprinkler system found the following: Sprinkler heads in resident room #2 were a mix of quick response and standard response Sprinkler head outside of room 12 had paint on it from recent painting of the ceiling Sprinklers in main dining abutting the private dining found (2) were loaded with lint and dust Sprinkler head in the "C" wing tub/shower room converted linen storage was higher rating than classified hazard. Head inside was listed for 286 degree response and adjacent heads were rated at 155 degrees</p> <p>When interviewed it was found the Maintenance Director was unaware of the noted sprinkler issues and that the closet was recently converted from an water heater enclosure.</p> <p>Actual NFPA standard:</p> <p>NFPA 13 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential</p>	K 062	<p>maintenance director on or before 3/13/15. The 2 loaded sprinkler heads in the main dining area were cleaned by the Maintenance Director on or before 3/13/15. The sprinkler head in the storage area in the "C" wing shower room storage area was changed by the facility's contracted sprinkler maintenance provider to a sprinkler head rated for a 155 degree response.</p> <p>A review of sprinkler heads was completed by the Administrator or designee on or before 3/27/15 to ensure they are clean and unloaded and heads are rated for the appropriate response temperature.</p> <p>Systematic Change: Housekeeping will create a monthly cleaning schedule for all sprinkler heads in the facility. The Administrator will ensure compliance on monthly the walk thru with the Housekeeping supervisor.</p> <p>The Maintenance Director and Housekeeping Supervisor were educated by the Administrator on or before 3/27/15 that sprinkler heads are to remain clean and unloaded and must be rated for an appropriate response temperature.</p>

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K 062	Continued From page 11 sprinklers, all sprinklers in a compartmented space shall be changed. 5-3.1 General. 5-3.1.1* Sprinklers shall be installed in accordance with their listing. Exception: Where construction features or other special situations require unusual water distribution, listed sprinklers shall be permitted to be installed in positions other than anticipated by their listing to achieve specific results. 5-3.1.4 Temperature Ratings. 5-3.1.4.1* Ordinary-temperature-rated sprinklers shall be used throughout buildings. Exception No. 1: Where maximum ceiling temperatures exceed 100°F (38°C), sprinklers with temperature ratings in accordance with the maximum ceiling temperatures of Table 3-2.5.1 shall be used. Exception No. 2: Intermediate- and high-temperature sprinklers shall be permitted to be used throughout ordinary and extra hazard occupancies. Exception No. 3: Sprinklers of intermediate- and high-temperature classifications shall be installed in specific locations as required by 5-3.1.4.2. NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	Beginning the week of 3/30/15 the Administrator or designee will review sprinkler heads to ensure they are clean and unloaded and that they are rated for an appropriate response temperature. The results will be reviewed in PI meeting monthly for three months to ensure compliance. The Maintenance Director is responsible for compliance.	4/14/15

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K 062	Continued From page 12 Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress were not impeded. Failure to keep means of egress free from impediments for their immediate use could hinder safe evacuation of occupants during an emergency. This deficient practice affected staff and vendors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 30 on the day of the survey. Findings include: During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, observation and operational testing of the door to the soiled linen in "B" wing and both of the entry doors to the Kitchen found they required more than a single operation to release from the egress side. Interview of the Maintenance Director found he was not aware of the requirement of single-operational locks, however the Property Management Director stated he was aware of this requirement.	K 130	Door handles on the soiled linen closet in "B" wing and both Kitchen doors were replaced by the Maintenance Director on or before 4/3/15. A review of doors completed by the Administrator or designee on or before 3/27/15 to ensure there was no more than a single operation to release the door from the egress side. Systematic Change: The Administrator or designee will check three doors monthly to ensure no more than a single operation is required to release from the egress side. The Maintenance Director was educated by the Administrator on or before 3/27/15 that doors must have no more than a single operation to release from the egress side of the door.	

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K 130	<p>Continued From page 13 Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when</p>	K 130	<p>Beginning the week of 3/30/15 the Administrator or designee will review door handles weekly for four weeks and monthly for two months to ensure that the doors require no more than a single operation to release from the egress side. Results will be reviewed by the PI committee monthly for three months to ensure compliance. The Maintenance Director is responsible for follow up.</p>
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K 130	Continued From page 14 the door is locked from the side from which egress is to be made. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 130		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	The generator was tested by the Maintenance Director on or before 3/27/15 under load for 30 minutes with transfer time, load percentage,	

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K 144	<p>Continued From page 15</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to document generator load testing or transfer time in accordance with NFPA 110. Failure to document results of load testing and transfer time provides no evidence for completion of generator testing under load and time needed for full transfer to emergency power potentially resulting in possible non-performance when needed. This deficient practice affected 30 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review conducted on March 10, 2015 from 8:45 AM to 10:00 AM, review of facility generator logs from December 10, 2013 to December 10, 2014 found the logs reviewed and compiled were TELS system records entered in by the Maintenance Director. The following are the deficiencies found in the compiled records: No documented transfer time No documented load percentage No documented amperage No documented temperatures No records provided of generator testing performed since December 10, 2014 No record of annual load bank testing having been performed</p> <p>When asked if he had any non-electronic backup</p>	K 144	<p>amperage, and temperature documented.</p> <p>A review of generator logs was completed by the Administrator or designee on or before 3/27/15 to ensure transfer time, load percentage, amperage, and temperature documented.</p> <p>Systematic Change: The Maintenance Director will provide a copy of the documented generator tests to the Administrator monthly to ensure compliance.</p> <p>The Maintenance Director was educated by the Administrator or designee on or before 3/27/15 to document transfer time, load percentage, amperage, and temperatures, as well as methods of completing the required tests.</p> <p>Beginning the week of 3/30/15 the Administrator or designee will review the generator test logs weekly for four weeks and monthly for two months to ensure the tests are being completed and documented according to the regulation. The results will be reviewed in PI committee meeting monthly for three months to ensure</p>

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K 144	<p>Continued From page 16</p> <p>documentation of the tests on the dates performed, the Maintenance Director stated he did not.</p> <p>2) During the facility tour conducted on March 10, 2014 from 10:00 AM to 2:00 PM, inspection of the generator room found the transfer switch was located inside the same room. When asked if he conducted any calculations of any amperage readings or stack temperature tests on the generator, the Maintenance Director stated he did not. When asked what method he used to test the generator under load the Maintenance Director stated he pushed the "test" button on the transfer switch.</p> <p>Further inquiry revealed the Maintenance Director was not aware of the requirement to document the transfer time of the EES, or of specific methods required to adequately test the generator under load.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>3-4.4.1 Maintenance and Testing of Essential Electrical System.</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p>	K 144	<p>compliance. The Maintenance Director is responsible for compliance.</p>
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K 144	<p>Continued From page 17</p> <p>(b) Inspection and Testing.</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>3-3.4.3 Recordkeeping. 3-3.4.3.1* General. A record shall be maintained of the tests required by this chapter and associated repairs or modification. At a minimum, this record shall contain the date, the rooms or areas tested, and an indication of which items have met or have failed to meet the performance requirements of this chapter.</p> <p>NFPA 110 Chapter 6 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be</p>	K 144	

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K 144	Continued From page 18 substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were in accordance to NFPA 70. Failure to ensure electrical connections and components are installed in a safe manner could result in loss of electrical services, electrocution and fire. This deficient practice affected 30 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 30 on the day of the survey. Findings include: 1) During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, observation of	K 147	The six open electrical junction boxes in the attic and one open electrical junction box in the pressure tank room abutting the Maintenance Shop were covered by the Maintenance Director on or before 3/20/15 so there is no exposed wiring. A review of electrical boxes was completed by the Administrator or designee on or before 3/27/15 to ensure there are no uncovered electrical boxes. Systematic Change:

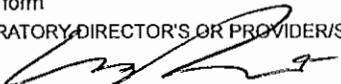
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K 147	<p>Continued From page 19</p> <p>the attic space above the facility found (5) open four-inch square electrical junction boxes with exposed wiring and (1) 2 inch by 4 inch electrical box with exposed wires.</p> <p>2) During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, observation of the fire pressure tank room abutting the Maintenance Shop found an open four inch square electrical junction box with exposed wiring.</p> <p>When asked, the Maintenance Director stated he was not aware these boxes did not have covers.</p> <p>NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged</p>	K 147	<p>The Administrator or designee will review electrical boxes monthly to ensure they are covered.</p> <p>The Maintenance Director was educated by the Administrator on or before 3/27/15 to ensure there are no open electrical boxes or exposed wiring in resident or staff areas.</p> <p>Beginning the week of 3/30/15 the Administrator or designee will review five electrical boxes weekly for 4 weeks and monthly for two months to ensure they are covered and no wires are exposed. The results will be reviewed in PI committee meeting monthly for 3 months to ensure compliance. The Maintenance Director is responsible for compliance.</p>
			4/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2015
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(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 147	Continued From page 20 parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.	K 147	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2015
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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C 000	16.03.02 INITIAL COMMENTS The facility is a single story, Type V (000) building, constructed in 1959. The structure has a private well and storage tank as a sole source to supply the automatic fire extinguishment system which is equipped with quick response sprinklers in habitable spaces. There are five exits at grade level. Currently the facility is licensed for 40 SNF/NF beds. The following deficiencies were cited during the annual life safety survey conducted on March 10, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	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." <p style="text-align: right;">RECEIVED APR - 2 2015 FACILITY STANDARDS</p>	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Please refer to federal "K" tags on CMS 2567:	C 226	Refer to federal "K" tags on CMS 2567.	

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



TITLE

Administrator

(X8) DATE

3/31/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2015
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(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)
C 226	Continued From Page 1 K-012 Allowable construction types K-029 Hazardous areas K-034 Stair access absent of storage K-038 Delayed egress door locks K-046 Maintenance of emergency lighting K-062 Maintenance of sprinkler systems K-130 Miscellaneous - Single operational locks K-144 Maintenance of the generator system K-147 Electrical installations	C 226	
C 264	02.106,10,a 10. Storage, Heating Appliances, Hazardous Substances. (7-1-93) a. Attics and crawl spaces shall not be used for storage of any materials. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep attic spaces free of storage and combustibles; maintain emergency equipment and provided storage of combustible materials underneath access. These deficient practices affected all residents, staff and visitors on the date of the survey. Refer to K-012 Findings include: During the facility tour conducted on March 10, 2015 from 10:00 AM to 2:00 PM, observation of the attic found combustible storage; (5) open electrical conduit boxes ranging from two inch by four inch to four inch square and two dead emergency lights. Actual IDAPA standards:	C 264	Refer to K-012

Bureau of Facility Standards

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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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C 264	Continued From Page 2 16.03.02.106.01 (a) a. The facility shall be structurally sound, maintained and equipped to assure the safety of patients/ residents, employees and the public. (1-1-88) 16.03.02.106.10 (a) 10. Storage, Heating Appliances, Hazardous Substances. (7-1-93) a. Attics and crawl spaces shall not be used for storage of any materials. (1-1-88)	C 264		
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