March 1, 2016

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 February 22, 2016, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when
you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 14, 2016**. Failure to submit an acceptable PoC by **March 14, 2016**, may result in the imposition of civil monetary penalties by **April 3, 2016**.

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 **March 28, 2016**, (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 28, 2016**. A change in the seriousness of the deficiencies on **March 28, 2016**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **March 28, 2016**, includes the following:

Denial of payment for new admissions effective **May 22, 2016**.

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 **August 22, 2016**, 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 **February 22, 2016**, 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:
Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

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

This request must be received by March 14, 2016. If your request for informal dispute resolution is received after March 14, 2016, 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,

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures
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 February 22, 2016. 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:

Nate Elkins
Health Facility Surveyor
Facility Fire Safety & Construction

K 018 NFPA 101 LIFE SAFETY CODE STANDARD

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are

"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."

The door stop moldings were replaced on rooms 13 and 15 to eliminate gaps around doors on or before 3/4/16 by the Maintenance Director.

A review of all doors in the facility was completed by the Administrator or designee on or before 3/11/16 to ensure there are no other doors with a gap between the door and door frame when the door is closed and latched.
# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## CENTERS FOR MEDICARE & MEDICAID SERVICES

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

135095

**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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## Summary of Deficiencies

**K 018** Continued From page 1

permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3

This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice affected 9 residents, staff, and visitors on the date of survey. The facility is licensed for 40 SNF/NF beds with a census of 23 on the day of survey.

Findings include:

1.) During the facility tour on February 22, 2016 at approximately 11:00 AM, observation and operational testing of the door leading to room 13 in "B" wing revealed a 1 inch gap between the top of the door and the door frame when closed and latched that would not resist the passage of smoke. When asked the Maintenance Supervisor stated the facility was unaware of the gap between the door and door frame.

2.) During the facility tour on February 22, 2016 at approximately 11:00 AM, observation and operational testing of the door leading to room 15 in "B" wing revealed a 1 inch gap between the top of the door and the door frame when closed and latched that would not resist the passage of smoke. When asked the Maintenance Supervisor stated the facility was unaware of the gap between the door and door frame.

**Actual NFPA standard:**

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**Provider's Plan of Correction**

The Administrator provided an education to the Maintenance Director on or before 3/11/16 to ensure that doors are adjusted or frames are repaired when a gap is present between the door and door frame when the door is closed and latched.

Beginning the week of 3/14/16 the Administrator or designee will do a review of 5 doors in the facility to ensure there are no gaps present between the door and door frame when the door is closed and latched. The results will be reviewed by the Interdisciplinary Team (IDT) in our Performance Improvement Committee monthly for three months or until compliance is sustained. The Maintenance Director is responsible for compliance.

**Completion Date:** 3/25/16

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**Provider Identification Number:** 135095

**Date Survey Completed:** 02/22/2016

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**Event ID:** 959S21

**Facility ID:** MDS001270

**Form CMS-2567(02-99) Previous Versions Obsolete**

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If continuation sheet Page 2 of 9
### K 018 Continued From page 2

19.3.6.3 Corridor Doors.

19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.

Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

### K 027 NFPA 101 LIFE SAFETY CODE STANDARD

SS=E Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

The Maintenance Director placed an astragal strip on the doors in order to close the gap on the double doors that separate the A hall from the lobby on or before 3/11/16.

A review of double doors was completed by the Administrator on or before 3/11/16 to ensure there are no gaps between the doors.
K 027  Continued From page 3  
This STANDARD is not met as evidenced by: 
Based on observation and operational testing, the facility failed to ensure smoke barrier doors would close when activated. Failure to ensure that smoke compartment doors close completely would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 12 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 23 on the day of the survey.

Findings include:

During the facility tour on February 22, 2016 at approximately 12:00 PM, observation and operational testing of the cross corridor doors located in the "A" wing revealed an 1 inch gap between the two doors when closed that would not resist the passage of smoke. When asked the Maintenance Supervisor stated the facility was unaware of the gap between the cross corridor doors.

Actual NFPA standard:

NFPA 101
19.3.7.6* 
Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.

8.3.4 Doors.
8.3.4.1*
Doors in smoke barriers shall close the opening

K 027 An education was completed with the Maintenance Director by the Administrator on or before 3/11/16 to ensure there are no gaps between double doors.

Systematic Change: The Maintenance Director or designee will do a quarterly review to ensure there are no gaps between double doors.

Beginning the week of 3/14/16 the Administrator or designee will do a review of double doors to ensure there is no gap between the doors. The results will be reviewed by the IDT in Performance Improvement Committee meeting monthly for three months or until compliance is sustained. The Maintenance Director is responsible for compliance.

3/25/16
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
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<td>Leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</td>
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<td>The Maintenance Director installed an automatic door closer to the C Wing Janitor's closet on or before 3/11/16.</td>
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<td>K029</td>
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<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
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<td></td>
<td>The Administrator did a review on or before 3/11/16 of all closets that house a fuel fired water heater to ensure they are all equipped with a self-closing device on the door.</td>
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<td></td>
<td>SS=E</td>
<td></td>
<td>One hour fire rated construction (with 0 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.</td>
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<td>An education was completed with the Maintenance Director on or before 3/11/16 regarding the regulation on self-closing doors for closets that house fuel fired water heaters.</td>
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</table>

This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 23 on the day of the survey.

Findings include:

During the facility tour on February 22, 2016 at approximately 10:30 AM, observation and operational testing of the Janitors Closet housing a fuel fired water heater located in "C" wing revealed the door was not equipped with a self closure. When asked, the Maintenance Director stated the facility was unaware the door was
K 029  Continued From page 5

required to self close.

Actual NFPA standard:

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.

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:

(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
jurisdiction
(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.

K 029

The Maintenance Director plugged the two refrigerators in Room 19 and the one refrigerator in Room 13 as well as the oxygen concentrators in Rooms 7 and 20 into wall outlets on or before 3/11/16.

A review of all refrigerators and oxygen concentrators was completed by the Administrator on or before 3/11/16 to ensure there were no other refrigerators or oxygen concentrators plugged into a relocatable power tap (RPT).

An education was completed with the Maintenance Director that refrigerators and oxygen concentrators are not plugged into a RPT.

Beginning the week of 3/14/16 the Administrator or designee will review 2 rooms with refrigerators and 2 rooms with oxygen concentrators weekly for 4 weeks and monthly for 2 months to ensure that there are no refrigerators or oxygen concentrators plugged into a RPT. The results will be reviewed by the IDT in the Performance Improvement meeting monthly for 3 months or until compliance is sustained.

1.) During the facility tour on February 22, 2016 at approximately 10:45 AM, observation of Room 19 located in "C" wing revealed two refrigerators plugged into a relocatable power taps (RPT) as a substitute for fixed wiring. When asked, the Maintenance Supervisor stated the facility was unaware two refrigerators were plugged into a Relocatable Power Tap (RPT).

2.) During the facility tour on February 22, 2016 at approximately 10:50 AM, observation of Room 20 located in "C" wing revealed an oxygen concentrator being powered by an inappropriate listed relocatable power tap (RPT). When asked, the Maintenance Supervisor stated the facility was unaware the oxygen concentrator was plugged into a Relocatable Power Tap (RPT).
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinical Identification Number:** 135095

**Name of Provider or Supplier:** Cherry Ridge Center

**Street Address, City, State, Zip Code:**

<table>
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<th>ID</th>
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<th>TAG</th>
<th>SUMMARIZE STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</table>
| K 147 | Continued From page 7 | 3.) During the facility tour on February 22, 2016 at approximately 11:00 AM, observation of Room 13 located in "B" wing revealed a refrigerator plugged into a relocatable power tap (RPT) being used as a substitute for fixed wiring. When asked, the Maintenance Supervisor stated the facility was unaware the refrigerator was plugged into a Relocatable Power Tap (RPT).

4.) During the facility tour on February 22, 2016 at approximately 11:10 AM, observation of Room 7 located in "B" wing revealed an oxygen concentrator being powered by an inappropriate listed relocatable power tap (RPT). When asked, the Maintenance Supervisor stated the facility was unaware the oxygen concentrator was plugged into a Relocatable Power Tap (RPT).

**Actual NFPA standard:**


Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:

1. As a substitute for the fixed wiring of a structure
2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors
3. Where run through doorways, windows, or similar openings
4. Where attached to building surfaces

Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.

5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors

**Maintenance Director is responsible for compliance.**

3/25/16
<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>A. BUILDING 01 - ENTIRE BUILDING</td>
<td>02/22/2016</td>
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NAME OF PROVIDER OR SUPPLIER
CHERRY RIDGE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
591 WEST IDAHO BOULEVARD
EMMETT, ID 83617

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
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<td>6.</td>
<td>Where installed in raceways, except as otherwise permitted in this Code</td>
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<td>Also see UL listings:</td>
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<tr>
<td>XBY5</td>
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE
2/22/2016