February 27, 2017

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 17, 2017, 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. 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 13, 2017. Failure to submit an acceptable PoC by March 13, 2017, may result in the imposition of civil monetary penalties by April 1, 2017.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies 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 24, 2017, (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 24, 2017. A change in the seriousness of the deficiencies on March 24, 2017, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by March 24, 2017, includes the following:

Denial of payment for new admissions effective May 17, 2017. 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 17, 2017, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on February 17, 2017, 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 13, 2017**. If your request for informal dispute resolution is received after **March 13, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
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 17, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction
NFPA 101 Building Construction Type and Height
Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5

Construction Type
1 II (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered
2 II (111) One story

"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."

Wall penetrations repaired by the Maintenance Director or designee on or before 3/10/2017.

Review of all Utility Closets was completed by the Center Executive Director (CED) or designee on or before 3/10/17 to ensure there are no penetrations in other Utility Closets.
<table>
<thead>
<tr>
<th>K 161</th>
<th>Continued From page 1</th>
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</thead>
<tbody>
<tr>
<td>non-sprinklered</td>
<td>Maximum 3 stories</td>
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<tr>
<td>sprinklered</td>
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<tr>
<td>3</td>
<td>III (200)</td>
</tr>
<tr>
<td>non-sprinklered</td>
<td>Not allowed</td>
</tr>
<tr>
<td>4</td>
<td>III (211)</td>
</tr>
<tr>
<td>sprinklered</td>
<td>Maximum 2 stories</td>
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<tr>
<td>5</td>
<td>IV (2HH)</td>
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<td>6</td>
<td>V (111)</td>
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<tr>
<td>7</td>
<td>III (200)</td>
</tr>
<tr>
<td>non-sprinklered</td>
<td>Not allowed</td>
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<td>8</td>
<td>V (000)</td>
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Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

K 161 The CED or designee educated the Maintenance Director on or before 3/17/17 on ensuring maintenance of the fire resistive properties of the facility by sealing penetrations in walls to prevent fire and smoke from passing between compartments during a fire event.

Beginning the week of 3/13/2017 the CED or designee will do a review of the Utility Closets in the facility weekly for 4 weeks and monthly for 2 months to ensure there are no wall penetrations. The results will be reviewed in Quality Assurance and Performance Improvement meeting monthly for 3 months or until compliance is sustained. The Maintenance Director is responsible for compliance.

3/23/2017
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/Clinic Identification Number</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>136095</td>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
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<tr>
<td></td>
<td>B. WING</td>
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</table>

<table>
<thead>
<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
<th>(X4) 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>
<th>COMPLETION DATE</th>
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<tr>
<td>02/17/2017</td>
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#### (K 161) Continued From page 2

During the facility tour on February 17, 2017, from approximately 10:30 AM to 12:00 PM, observation revealed two (2) large penetrations approximately 6" x 8" in the wall below the sink in the B-Wing Utility Closet. When asked, the Maintenance Supervisor stated the facility was unaware of the penetrations.

Actual NFPA standard:

19.1.6 Minimum Construction Requirements.  
19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)

8.2 Construction and Compartmentation.  
8.2.1 Construction.  
8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.

#### (K 211) NFPA 101 Means of Egress - General

**Means of Egress - General**  
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.  
18.2.1, 19.2.1, 7.1.10.1  
This STANDARD is not met as evidenced by:  
Based on record review and interview, the facility failed to ensure that smoke door assemblies were inspected in accordance with NFPA 105. Failure

The Maintenance Director or designee completed an inspection and testing of smoke door assemblies on or before 3/10/17 and completed the documentation for the inspection and testing.

A review of the documentation of the inspection and testing was completed.
**K 211** Continued From page 3
to inspect and test smoke doors, could result in a lack of system performance as designed which could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 25 residents, staff and visitors on the date of the survey. The facility is licensed for 40 SNF/NF beds and had a census of 25 on the day of the survey.

Findings include:

During record review on February 17, 2017, from approximately 8:30 AM to 10:30 AM, no record was available demonstrating an initial inspection and testing of smoke door assemblies. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of this requirement.

Actual NFPA standard:

**NFPA 101**

19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.

7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors

by the CED or designee on or before 3/10/17 to ensure compliance has been met.

The CED or designee completed an education with the Maintenance Director on or before 3/17/17 on annual inspection and testing of fire doors and keeping records of the inspection and testing.

Beginning the week of 3/13/17 a review of the documentation of the inspection and testing of smoke doors will be completed weekly for 4 weeks and monthly for 2 months by the CED or designee to ensure compliance. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. The Maintenance Director is responsible for compliance.

**3/23/17**
K211: Continued From page 4

(4) Door assemblies with special locking arrangements subject to 7.2.1.6

7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.

NFPA 105
5.2 Specific Requirements.
5.2.1* Inspections.
5.2.1.1 Smoke door assemblies shall be inspected annually.
5.2.1.2 Doors shall be operated to confirm full closure.
5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.

K355
NFPA 10 Portable Fire Extinguishers

Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.

18.3.5.12, 19.3.5.12, NFPA 10

This STANDARD is not met as evidenced by:

Based on observation and interview, the facility failed to ensure the class K portable fire extinguisher was installed, and maintained in accordance with NFPA 10. Failure to install and maintain the class K fire extinguisher could result in improper use in the event of a fire. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is

The Maintenance Director or designee installed the placard above the Class K fire extinguisher instructing the user to activate the hood suppression system prior to using the Class K extinguisher.
Continued From page 5

Findings include:

During the facility tour on February 17, 2017, from approximately 10:30 AM to 12:00 PM, observation of the Class K fire extinguisher in the kitchen revealed no placard instructing user to activate the hood suppression system prior to its use. When asked, the Maintenance Supervisor stated the class K never had a placard and the facility was unaware of the requirement.

Actual NFPA standard:

NFPA 10
6.5.5.3 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher.

NFPA 101 Corridor - Doors

Corridor - Doors
2012 EXISTING
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 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on

A review of Class K extinguishers was completed by the CED or designee on or before 3/10/17 to ensure that an instruction placard is conspicuously placed near the Class K extinguisher.

The CED or designee completed an education with the Maintenance Director on or before 3/17/17 on conspicuously placing an instruction placard near the Class K fire extinguisher.

Beginning the week of 3/13/17 the CED or designee will complete a review weekly for 4 weeks and monthly for 2 months to ensure the Class K extinguisher instruction placard is placed conspicuously near the extinguisher. The results will be reviewed in QAPI monthly for 3 months or until compliance is sustained. The Maintenance Director is responsible for compliance.

Room 3’s door latch was repaired by the Maintenance Director on or before 3/10/17.

A review of facility doors was completed by the CED or designee on
**K 363.** Continued From page 6

- Corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3. Unless the smoke compartment is sprinklered, fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485.

  Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

  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, preventing defend in place. This deficient practice has the potential to affect 4 residents, staff, and visitors on the date of survey. The facility is licensed for 40 SNF/NF beds with a census of 25 on the day of survey.

Findings include:

During the facility tour on February 17, 2017, from approximately 10:30 AM to 12:00 PM, observation and operational testing of the corridor door to resident room three (3) revealed the door would not latch. When asked, the Maintenance Supervisor stated the facility was unaware the doors latch when they are closed.

The CED or designee completed an education with the Maintenance Director on or before 3/17/17 to ensure quarterly door latch checks are being completed.

Beginning the week of 3/13/2017 the CED or designee will complete a review weekly for 4 weeks and monthly for 2 months to ensure that the facility doors are latching when closed. The results will be reviewed in QAPI monthly for 3 months or until compliance is sustained. The Maintenance Director is responsible for compliance.

**COMPLETION DATE:** 3/23/17
### SUMMARY STATEMENT OF DEFICIENCIES

**K 363** Continued From page 7

door would not latch.

Actual NFPA Standards:

19.3.6.3* Corridor Doors.
19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply:

1. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.
2. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.