October 15, 2018

Todd Russell, Administrator
Cherry Ridge Center
501 West Idaho Boulevard
Emmett, ID  83617-9694

Provider #:  135095

Dear Mr. Russell:

On September 27, 2018, a survey was conducted at Cherry Ridge Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. 

This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. **Waiver renewals may be requested on the Plan of Correction.**
After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 25, 2018**. Failure to submit an acceptable PoC by **October 25, 2018**, may result in the imposition of penalties by **November 17, 2018**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- Include dates when corrective action will be completed in **column (X5)**.

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **November 1, 2018 (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 **December 26, 2018**. A change in the seriousness of the deficiencies on **November 11, 2018**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 27, 2018 includes the following:

Denial of payment for new admissions effective December 27, 2018. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 March 27, 2019, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on December 27, 2018 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 October 25, 2018. If your request for informal dispute resolution is received after October 25, 2018, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
The following deficiencies were cited during the federal recertification and complaint survey conducted September 24, 2018 to September 27, 2018.

The surveyors conducting the survey were:

Jenny Walker, RN, Team Coordinator
Presie Billington, RN
Cecilia Stockdill, RN

ABBREVIATIONS:

ADL = Activities of Daily Living
CNA = Certified Nursing Assistant
DNS = Director of Nursing Services
LPN = Licensed Practical Nurse
LSW = Licensed Social Worker
MAR = Medication Administration Record
MDS = Minimum Data Set
mg = milligrams
mls = milliliters
PROM = Passive Range of Motion
RN = Registered Nurse
RNA = Restorative Nursing Assistant
ROM = Range of motion
TAR = Treatment Administration Record

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:

This Plan of Correction is prepared and

Electronically Signed

10/25/2018
### Statement of Deficiencies and Plan of Correction

**Provider's Plan of Correction**

*Each corrective action should be cross-referenced to the appropriate deficiency.*

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 641</td>
<td>Continued From page 1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interview, and record review, it was determined the facility failed to ensure MDS assessments accurately reflected the resident's status regarding pressure ulcers. This was true for 1 of 9 (#9) residents whose MDS assessments were reviewed. This failure created the potential for harm should residents receive inappropriate care due to inaccurate MDS assessments. Findings include:

- Resdient #9 was admitted to the facility on 12/21/17 with multiple diagnoses, including muscle weakness, rheumatoid arthritis, and encounter for other specified surgical aftercare.

- Resident #9's current care plan documented "Resident has actual skin breakdown related to sacral (tailbone area) wound, (chronic non-healing pressure ulcer, present on admit)."

- The care plan for the pressure ulcer was initiated on 12/22/17 and revised on 9/25/18.

- Resident #9's Admission MDS assessment, dated 12/21/17, documented he was cognitively intact, had no unhealed pressure ulcer, and did not receive pressure ulcer care.

- Resident #9's Skin Check, dated 12/21/17 at 2:17 PM, documented a pressure ulcer on the coccyx (tailbone area).

- Resident #9's Skin Check, dated 12/28/17 at 2:17 PM, documented a pressure ulcer to the sacral region.

- Resident #9's Skin Check, dated 1/4/18 at 2:17 PM, documented a pressure ulcer on the sacral region.

---

F 641 submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Center does not admit that the deficiencies listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for these deficiencies.

Residents affected:

- Resident #9 MDS has been updated/corrected to reflect surgical wound 10/1/18 by RAI specialist/CRC.

Potential residents:

- All residents with wounds are at risk for this deficient practice. A review of all MDS's of residents with wounds was completed by CNE/CRC on or before 11/12/18.

Systemic Change:

- The CRC will be retrained on coding on or before 11/12/18 by RAI specialist. The
<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>
</tr>
</thead>
<tbody>
<tr>
<td>F641</td>
<td>Continued From page 2</td>
<td>F641</td>
<td>CNE or designee will audit the MDS section M weekly following CRC completion of assessment for 4 weeks for residents with wounds. Review: Beginning the week of 11/12/18 the CNE or designee will review charts of residents with wounds weekly for 4 weeks and monthly for 2 months to ensure all wounds are coded and charted correctly. The results will be reviewed in QAPI monthly for 3 months or until compliance is sustained. The CNE/CRC is responsible for compliance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's Skin Check, dated 1/11/18 at 2:17 PM, documented a pressure ulcer on the sacrum (tailbone area) and the resident was followed by the wound clinic.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's Skin Check, dated 1/18/18 at 11:31 AM, documented a pressure ulcer on the sacrum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's Skin Check, dated 2/6/18 at 8:03 AM, documented a pressure ulcer on the coccyx.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's Skin Check, dated 2/13/18 at 8:03 AM, documented a pressure wound on the sacrum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's Skin Check, dated 2/20/18 at 8:03 AM, documented a chronic sacral wound.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's Significant Change MDS assessment, dated 2/26/18, documented he was cognitively intact, had no unhealed pressure ulcer, and did not receive pressure ulcer care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #9's quarterly MDS assessment, dated 5/29/18, documented severe cognitive impairment and he received pressure ulcer care for one Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) that was present upon admission which measured 8.0 cm by 8.8 cm and was 0.5 cm deep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A wound clinic note, dated 6/7/18, documented Resident #9 had a chronic Stage IV pressure ulcer on the sacrum that was not healed and measured 8 cm by 7 cm with a depth of 0.5 cm.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Resident #9's quarterly MDS assessment, dated 8/28/18, documented moderate cognitive impairment and he received pressure ulcer care for one Stage IV pressure ulcer that was present upon admission which measured 5.6 cm by 5.1 cm with a depth of 0.3 cm.

On 9/24/18 at 10:32 AM, Resident #9 was observed to have a dressing on his coccyx. Resident #9 said facility staff changed the dressing three times a week, or more frequently if the dressing became soiled. Resident #9 said he had a wound on his coccyx that started when a physician removed an arthritic nodule from his tailbone. CNA #4, also present, said Resident #9 came to the facility from the hospital with a wound on his coccyx, and he was seen by the wound clinic every Thursday.

On 9/25/18 at 11:39 AM, LPN #1, who was also the MDS nurse, said Resident #9's MDS assessments from 12/21/17 and 2/26/18 were incorrect. LPN #1 said Resident #9 had the pressure ulcers for years.

On 9/25/18 at 12:08 PM, LPN #1 said Resident #9's sacral/coccyx wound was actually rheumatoid nodules but she was getting clarification about that.

On 9/26/18 at 10:12 AM, LPN #1 said Resident #9 had a surgical wound on the sacrum/coccyx since 2015. LPN #1 said she would correct the MDS and educate staff. LPN #1 said the wound clinic called Resident #9's sacral/coccyx wound a pressure ulcer because the facility identified it as that.
### SUMMARY STATEMENT OF DEFICIENCIES

**F 656**  
**SS=D**

#### CFR(s): 483.21(b)(1)

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and
2. Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
3. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASAARR recommendations. If a facility disagrees with the findings of the PASAARR, it must indicate its rationale in the resident's medical record.
4. In consultation with the resident and the resident's representative(s):
   - (A) The resident's goals for admission and desired outcomes.
   - (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

#### F 656 11/12/18

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 656</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

CHERRY RIDGE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

501 WEST IDAHO BOULEVARD  
EMMETT, ID  83617
Continued From page 5

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and staff and resident interview, it was determined the facility failed to ensure person-centered comprehensive care plans were developed and implemented to address residents' needs. This was true for 2 of 9 (#6 and #15) whose care plans were reviewed. Resident #6's care plan did not address the specific side effects of his psychotropic medications and Resident #15's care plan did not address he needed a "carrot" (hand contracture orthosis/device) during the day and a splint during the night to prevent contractures. These failures created the potential for residents to experience side effects of psychotropic medication without detection and contractures due to lack of direction in their care plans. Findings include:

1. Resident #6 was admitted to the facility on 7/2/18 with multiple diagnoses, including major depressive disorder.

Resident #6's quarterly MDS assessment, dated 7/18/18, documented he was cognitively intact, had mild depression, and received antidepressant medication daily.

Resident #6's September 2018 physician orders documented he was to receive the antidepressant Paroxetine hcl (hydrochloride) 5 mg by mouth one time daily.

Residents Affected:
Resident #6 care plan has been updated by CNE to reflect side effects of psychotropic medications for proper side effect monitoring. Resident #15 care plan has been updated by CRC to reflect therapy carrot to left hand to help prevent contractures during the day, splint to left hand at night. Updates were completed by 10/1/18.

Potential Residents:
All residents taking psychotropic medications and using orthotic devices are at risk for this deficient practice. CNE or designee to audit care plans of all psychotropic medications to validate monitoring in place for each resident by 11/12/18. CNE or designee to pull orders for devices and validate that all devices are care planned by 11/12/18.

Systemic changes:
Beginning 11/12/18 CNE or designee will check all new orders in clinical meeting daily, CNE is to validate, using clinical f/u form, and verify care plans are initiated as needed for each new order. The Practice Development Specialist/CNE will educate nursing staff using skills checklist and policy and procedures for monitoring of side effects and behaviors on or before
### Summary of Deficiencies

**F 656** Continued From page 6

Resident #6's care plan, updated on 2/27/18, documented he had depression and his behaviors included irritability, making inappropriate comments towards others, self isolation, statements of depression, and concern regarding medical issues. The care plan interventions directed staff to monitor for side effects of medications, and observe and document for changes in mood, behavior and functional level.

Resident #6's care plan did not include the antidepressant medication he was taking and did not specify the side effects of the medication staff were to monitor him for.

On 9/26/18 at 12:16 PM, the LSW reviewed Resident #6's care plan and said it did not include the side effects staff were to monitor him for.

On 9/27/18 at 9:28 AM, the DNS said she did not find documentation of monitoring the side effects of Resident #6's antidepressant medication.

2. Resident #15 was admitted to the facility on 5/31/17 with multiple diagnoses, including a stroke that affected his left side.

A quarterly MDS assessment, dated 7/25/18, documented Resident #15 was cognitively intact, required extensive assistance from one person, and had one-sided ROM impairments to both upper and lower extremities.

A Physician's order, dated 8/7/18, documented Resident #15 was to have a carrot orthosis during the day and a resting splint at night to his

**Provider's Plan of Correction**

Review:
Beginning the week of 11/12/18 the CNE or designee will review 2 charts for new orders weekly for 4 weeks and monthly for 2 months to ensure all new orders have care plans initiated as needed. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.
| ID | PREFIX | TAG | SUMMARY STATEMENT OF DEFICIENCIES | ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION | COMPLETION DATE |
|---|---|---|---|---|---|---|---|---|---|
| F 656 | continued From page 7 | left hand for hemiparesis (one-sided paralysis or weakness) following a stroke. | F 656 | Continued From page 7 | left hand for hemiparesis (one-sided paralysis or weakness) following a stroke. | | |
| | | Resident #15's care plan did not include use of the carrot orthosis during the day or hand splint at night to his left hand. | | | | | |
| | | On 9/25/18 at 2:00 PM, Resident #15 was observed without a carrot orthosis in his left hand. | | | | | |
| | | On 9/26/18 at 9:30 AM, Resident #15 was observed without a carrot orthosis in his left hand. | | | | | |
| | | On 9/26/18 at 2:30 PM, Resident #15 was observed with a carrot orthosis in his left hand. Resident #15 stated he wore a carrot orthosis during the day and the staff applied a splint to his left hand at bedtime. | | | | | |
| | | On 9/26/18 at 11:43 AM, the Restorative Nurse, LPN #1 stated Resident #15's care plan did not include use of the carrot orthosis during the day or the hand splint at night to his left hand. | | | | | |
| F 657 | Care Plan Timing and Revision | CFR(s): 483.21(b)(2)(i)-(iii) | F 657 | | | | 11/12/18 |

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
F 657 Continued From page 8

(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, resident and staff interview, and facility policy and procedure review, it was determined the facility failed to ensure residents' care plans were updated to address the positioning of a bed against the wall and wound care instructions. This was true for 2 of 9 sample residents (#3 and #9) whose care plans were reviewed. This failed practice created the potential for harm if cares and/or services were not provided due to inaccurate or incomplete information on the care plan. Findings include:

The facility's policy and procedure for Person-Centered Care Plan, revised 3/1/18, documented the following:

* A comprehensive person-centered care plan must be created for each resident and must
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**
135095

**MULTIPLE CONSTRUCTION**

A. BUILDING _____________________________

B. WING _____________________________

**DATE SURVEY COMPLETED**

09/27/2018

**NAME OF PROVIDER OR SUPPLIER**
CHERRY RIDGE CENTER

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

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

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 657     |     | Continued From page 9
|           |     | describe the services to be provided.
|           |     | * The care plan must be tailored to reflect each resident's preferences and needs.
|           |     | * The care plan will be "Communicated to appropriate staff, patient...family..."
|           |     | * The care plan will be reviewed and updated by the interdisciplinary team following each resident assessment and as needed to reflect the resident's "response to care and changing needs and goals."

1. Resident #3 was admitted to the facility on 1/17/18 with multiple diagnoses, including muscle weakness, history of falling, and unspecified open wound, right hip.

Resident #3's significant change MDS assessment, dated 7/11/18, documented severe cognitive impairment, one stage IV pressure ulcer, and pressure ulcer care.

Resident #3's physician orders, dated 9/25/18, documented the following:

* Wound care was ordered on 9/7/18 as follows: Cleanse wound to the right hip with wound cleanser, irrigate wound with 5 mls of Normal Saline, insert collagen into wound, apply Skin-Prep around wound edges, apply TenderWet and cover with Optifoam (a type of dressing) every night shift.

* On 5/17/18, a named wound clinic was authorized to evaluate and treat the wound.

On 9/24/18 at 9:25 AM, 9/25/18 at 10:00 AM, and 9/26/18 at 10:14 AM, Resident #3's bed was positioned with the left side of the bed against the

for devices, and all consents are signed with care plans.

**Review:**
Beginning the week of 11/12/18 the CNE or designee will review all restrictive devices for current assessments weekly for 4 weeks and monthly for 2 months. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. CNE is responsible for compliance.
Continued From page 10

wall.

On 9/25/18 at 9:58 AM, Resident #3 was observed with a dressing to her right hip/buttock area. RN #1 said wound care was performed to Resident #3's right hip wound by the night shift staff every night.

Resident #3's current care plan did not document wound care to the right hip wound or the resident's bed against the wall.

On 9/25/18 at 4:08 PM, LPN #1 said the care plan did not document Resident #3's wound treatment.

On 9/26/18 at 10:04 AM, LPN #1 said the care plan did not document Resident #3's bed against the wall. LPN #1 said she would find out if bed against the wall should be on the care plan.

2. Resident #9 was admitted to the facility on 12/21/17 with multiple diagnoses, including muscle weakness and encounter for other specified surgical aftercare.

Resident #9's quarterly MDS assessment, dated 8/28/18, documented moderate cognitive impairment, one Stage IV pressure ulcer, and pressure ulcer care.

Resident #9's September 2018 physician orders documented the following:

* Wound care was ordered on 7/20/18 as follows: Cleanse wound and pat dry, apply Skin-Prep to wound edges, apply alginate with silver to wound bed, cover with foam pad and ABD (a type of
### F 657 Continued From page 11

- On 5/22/18 a named wound clinic was authorized to evaluate and treat the pressure ulcer.

Resident #9's current care plan documented "Provide wound treatment as ordered" was initiated on 9/25/18. Resident #9's care plan did not reflect wound care to the pressure ulcer on his coccyx prior to 9/25/18.

Resident #9's September 2018 TAR documented wound care was performed each day from 9/1/18 - 9/24/18, except for 9/2/18 and 9/21/18.

On 9/24/18 at 10:32 AM, Resident #9 was observed to have a dressing on his coccyx (tailbone area). Resident #9 said facility staff changed the dressing three times a week, or more frequently if the dressing became soiled. Resident #9 said he had a wound on his coccyx that started when a physician removed an arthritic nodule from his tailbone. CNA #4 said Resident #9 came to the facility from the hospital with a wound on his coccyx, and he was seen by the wound clinic every Thursday.

On 9/25/18 at 11:59 AM, RN #1 said she would expect to see wound treatment on Resident #9's care plan.

On 9/25/18 at 12:08 PM, LPN #1 said Resident #9's dressing change should be reflected on the care plan and she should have updated the care plan.

### F 688 Increase/Prevent Decrease in ROM/Mobility

- 11/12/18
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

135095

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**

CHERRY RIDGE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

501 WEST IDAHO BOULEVARD

EMMETT, ID  83617

**DATE SURVEY COMPLETED**

09/27/2018

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CENTERS FOR MEDICARE & MEDICAID SERVICES

**OMB NO. 0938-0391**

---

### SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 688</td>
<td>SS=D</td>
<td>Continued From page 12</td>
</tr>
</tbody>
</table>

**SS=D CFR(s): 483.25(c)(1)-(3)**

§483.25(c) Mobility.

§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

This REQUIREMENT is not met as evidenced by:

Based on resident and staff interview, resident record review, and facility policy and procedure review, it was determined the facility failed to ensure residents received ROM exercises and Restorative Nursing Services consistent with their needs. This was true for 2 of 2 residents (#3 and #15) reviewed for treatment and services related to ROM. This failure created the potential for harm should residents experience a decrease in mobility and function due to lack of range of motion exercises and Restorative Nursing Services. Findings include:

The facility's policy and procedure for Restorative Nursing, revised 3/15/16, documented the

**Residents Affected:**

Resident #3, ROM has been added to CNA ADL sheets by CRC for documentation and care plan updated to reflect staff to do ROM, no family involvement on 10/1/18.

Resident #15, Care plan updated on 10/1/18 by CRC to show RNA program is PROM, nursing to do Bioness as resident allows. Nustep has been removed from program as resident does not participate and does not benefit from nustep. RNA documentation to be done daily.

**Potential residents:**
### F 688

Continued From page 13

The facility may provide restorative nursing programs for residents who are admitted to the facility with restorative needs but are not candidates for rehabilitation therapy, have restorative needs that emerge during a longer stay, and who would benefit from restorative programs along with rehabilitation therapy.

The facility's policy and procedure for Range of Motion and Mobility, dated 3/1/18, documented the following:

* The facility will provide care, services, and equipment to ensure residents who enter the facility without limited range of motion do not experience a reduction in range of motion unless it is clinically unavoidable, and those with limited range of motion receive appropriate treatment and services to improve and/or prevent further decline in range of motion.

* Care plan interventions may be provided through the facility's restorative nursing program, or as ordered by the attending medical practitioner through specialized rehabilitation services.

These policies were not followed. Examples include:

1. Resident #3 was admitted to the facility on 1/17/18 with multiple diagnoses, including other abnormalities of gait and mobility, muscle weakness, history of falling, and dislocation of the right hip.

Resident #3's quarterly MDS assessment, dated 4/25/18, documented the following:

Residents on restorative nursing services and ROM exercises have the potential to be affected by this deficient practice. All residents reviewed for RNA orders and care plans. Review was completed on or before 11/12/18 by CNE or designee.

Systemic:
On or before 11/12/18, all RNA orders were reviewed and made current by CNE. All RNA programs and documentation to be reviewed weekly by CNE/CRC in CAR meeting. Reviewed monthly by CNE for need to continue or effectiveness of program. Practice Development Specialist and CNE to re educate all nursing staff regarding RNA program, CRC to educate CNA's on documentation of RNA/ROM, and observe to validate proper technique on or before 11/12/18.

Review:
Beginning the week of 11/12/18 the CNE or designee will review all RNA participants for care plan and order updates, observe CNA's performing RNA (including but not limited to ROM) weekly for 4 weeks and monthly for 2 months. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 688 Continued From page 14 | F 688 | * Moderate cognitive impairment.  
* Total dependence and required extensive assistance of 2 or more persons with bed mobility and transfers.  
* Ambulation did not occur.  
* Required the physical assistance of one person for locomotion, dressing, toileting, personal hygiene, and bathing.  
* Setup help only with eating.  
* A wheelchair was used.  
* Range of motion was not performed for at least 15 minutes a day the last seven days. |                      |

Resident #3's significant change MDS assessment, dated 7/11/18, documented the following:

* Severe cognitive impairment,  
* Total dependence and required the physical assistance of 2 or more persons with bed mobility, transfers, dressing, eating, toileting, personal hygiene, and bathing.  
* Ambulation did not occur.  
* Total dependence and required the physical assistance of one person for locomotion.  
* A wheelchair was used.  
* Range of motion was not performed for at least 15 minutes a day the last seven days.

Resident #3's physician orders, dated 9/25/18, documented the following:

* "May participate in activity and general conditioning program as desired. Activity as tolerated" was ordered on 1/17/18.

Resident #3's current care plan documented the
F 688 Continued From page 15 following:

* Resident #3 required assistance/was dependent for ADL in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting related to dementia, advanced age, and hip dislocation.
* The goal was for Resident #3 to maintain her highest level of ability with ADLs.
* Directed staff to assist Resident #3 with established therapeutic exercise program.
* Teach Resident #3 and her family to perform the ROM exercises.
* Provide reminders, supervision, or physical assistance with active and active assisted ROM to move Resident #3's extremity.

A physical therapy initial evaluation, dated 1/18/18, documented Resident #3 had impaired strength in both hips and knees and a brace to the right leg. Upon discharge from physical therapy, "focus is shifting towards ensuring staff can meet mobility needs and goals."

On 9/26/18 at 10:14 AM, the DNS said ROM would be documented with the resident cares and to check the ADL flowsheet. The DNS then said there was not a place to document ROM on the ADL sheet and she did not know where the staff would document it.

On 9/26/18 at 10:36 AM, CNA #1 said the CNAs performed ROM for Resident #3 every morning when they got her up. CNA #1 said it was documented on the ADL sheet that CNAs did range of motion through documenting things like assisting her with bed mobility and transfers. When asked to show the documentation that
Continued From page 16

specified ROM exercises were performed for Resident #3, CNA #1 said the ADL sheet was it.

On 9/27/18 at 9:32 AM, the DNS said Resident #3's family would not be taught the ROM exercises and they would not be participating with the ROM exercises because it was too upsetting for the resident to interact with her family. The DNS said Resident #3's family did not see her or want her to call them on the phone, and it should be removed from the care plan that the family would be educated about the ROM exercises. The DNS said the directions for ROM as documented on the care plan should also be on the ADL sheet for the CNAs to document, but it was not on the ADL sheet.

There was no documentation in Resident #3's clinical record ROM was performed as directed on the care plan.

2. Resident #15 was admitted to the facility on 5/31/17 with multiple diagnoses, including a stroke that affected his left side.

A quarterly MDS assessment, dated 7/25/18, documented Resident #15 was cognitively intact, required extensive assistance from one person, and had one-sided ROM impairments to both upper and lower extremities.

Resident #15's September 2018 Physician's Medication Review Report on 9/26/17, documented Resident #15 may participate in a RNA program.

Resident #15's restorative care plan, dated 9/25/17, directed staff to explain each active and
MARCH 2018:
Resident #15’s March 2018 Restorative Nursing Record documented the CNAs were to maintain the size of his left upper extremity by using Bioness (a device that delivers low-level electrical stimulation to activate the nerves that control the muscles in the hand and forearm) daily for a minimum of 15 minutes. The documentation on the Restorative Nursing Record included the following:

* The Bioness was used for 15 minutes 3 out of 31 opportunities.
* 27 out of 31 opportunities were documented as "NA" which was noted on the Record to mean it did not occur.
* The Bioness was used for 1 out of 31 opportunities for 10 minutes.

Resident #15’s March 2018 Restorative Nursing Record also documented the CNAs were to improve his leg strength, mobility, and range of motion by ensuring he used the Nustep (recumbent workout machine) five times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* Resident #15 used the Nustep for at least 15 minutes 15 out of 31 opportunities.
* 3 of 31 opportunities were documented as "N/A".
* 13 out of 31 opportunities were documented as "refused."
Resident #15's April 2018 Restorative Nursing Record documented the CNAs were to maintain the size of his left upper extremity by using Bioness daily for a minimum of 15 minutes. The documentation on the Restorative Nursing Record included the following:

* There was no documentation for 26 out of 30 opportunities.
* Resident #15 used the Bioness for 15 minutes on 4 out of 30 opportunities.

Resident #15's April 2018 Restorative Nursing Record also documented CNAs were to improve leg strength, mobility, and range of motion for Resident #15 by using the Nustep 5 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* 23 out of 30 opportunities were documented "N/A"
* There was no documentation for 7 out of 30 opportunities.

MAY 2018:
Resident #15's May 2018 Restorative Nursing Record documented CNAs were to provided PROM to his bilateral lower extremities 6 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* Resident #15 received PROM to his bilateral lower extremities for 15 minutes 13 out of 31 opportunities.
* 1 out of 31 opportunities was documented "N/A"
F 688 Continued From page 19

* 1 out of 31 opportunities was documented zero minutes
* There was no documentation for 16 out of 31 opportunities.

Resident #15's May 2018 Restorative Nursing Record also documented CNAs were to provide PROM to his left hand 6 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* Resident #15 received PROM to his hand for 15 minutes 4 out of 31 opportunities.
* 10 out of 31 opportunities were documented 10 minutes
* 1 out of 31 opportunities was documented zero minutes
* There was no documentation for 16 out of 31 opportunities.

JUNE 2018:
Resident #15's June 2018 Restorative Nursing Record documented CNAs were to provide PROM to his bilateral lower extremities six times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* Resident #15 received PROM for 15 minutes 18 out of 30 opportunities.
* 12 out of 30 opportunities were documented "N/A".

Resident #15's June 2018 Restorative Nursing Record also documented CNAs were to provide PROM to his left hand 6 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:
F 688 Continued From page 20

* CNAs provided PROM to his left hand for 15 minutes 16 out of 30 opportunities
* 14 out of 30 opportunities were documented "N/A."

JULY 2018:
Resident #15's July 2018 Restorative Nursing Record documented CNAs were to provide PROM to his bilateral lower extremities six times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* Resident #15 received PROM for 15 minutes 24 out of 31 opportunities.
* 6 out of 31 opportunities were documented "N/A"
* There was no documentation for 1 out of 31 opportunities.

Resident #15's July 2018 Restorative Nursing Record also documented CNAs were to provide PROM to his left hand 6 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* CNAs provided PROM to his left hand for 15 minutes 12 out of 31 opportunities.
* 7 out of 31 opportunities were documented "N/A"
* 11 out of 31 opportunities were documented 10 minutes
* There was no documentation for 1 out of 31 opportunities.

AUGUST 2018:
Resident #15's August 2018 Restorative Nursing
F 688 Continued From page 21

Record documented CNAs were to provide PROM to his bilateral lower extremities six times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* CNAs provided PROM to his bilateral lower extremities for 15 minutes 4 out of 31 opportunities.
* 21 out of 31 opportunities were documented "N/A"
* There was no documentation for 6 out of 31 opportunities.

Resident #15's August 2018 Restorative Nursing Record also documented CNAs were to provide PROM to his left hand 6 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* CNAs provided PROM to his left hand for 15 minutes 4 out of 31 opportunities.
* 20 out of 31 opportunities were documented "N/A"
* There was no documentation for 7 out of 31 opportunities.

SEPTEMBER:

Resident #15's September 2018 Restorative Nursing Record documented CNAs were to provide PROM to his bilateral lower extremities six times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:

* CNAs provided PROM to his bilateral lower extremities for 15 minutes 4 out of 25 opportunities.
<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 688</td>
<td>Continued From page 22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* 20 out of 25 opportunities were documented &quot;N/A&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* 1 out of 25 opportunities was documented 10 minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident #15's September 2018 Restorative Nursing Record also documented CNAs were to provide PROM to his left hand 6 times a week for 15 minutes. The documentation on the Restorative Nursing Record included the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* CNAs provided PROM to his left hand for 15 minutes 7 out of 25 opportunities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* 18 out of 25 opportunities were documented &quot;N/A&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On 9/24/18 at 9:25 AM, Resident #15 stated he would like to have more therapy for his left side which was weak from a stroke he had over a year ago. Resident #15 stated he was not on a restorative program.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On 9/25/18 at 1:30 PM, CNA #2 stated when she was assigned to Resident #15 she completed the Restorative PROM exercises and documented in the Restorative Nursing Record. CNA #2 stated Resident #15 was not receiving the PROM exercises per the documentation on the September 2018 Restorative Nursing Record.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On 9/26/18 at 11:10 AM, the Restorative Nurse, LPN #1 stated Resident #15 was not receiving restorative services six times a week.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 695</td>
<td>Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>§ 483.25(i) Respiratory care, including</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/12/18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## F 695

### Continued From page 23

Tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents’ goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and record review, it was determined the facility failed to ensure a physician’s order was obtained prior to administering oxygen therapy. This was true for 1 of 2 residents (#14) reviewed for the use of oxygen. This failure created the potential for harm if residents received unnecessary, excessive, or insufficient oxygen to maintain stability. Findings included:

- Resident #14 was admitted to the facility on 11/3/17, with multiple diagnoses, including Chronic Obstructive Pulmonary Disease (lung disease).

- Resident #14’s quarterly MDS assessment, dated 5/8/18, documented she was cognitively intact and received oxygen therapy.

- A care plan, dated 11/6/17, documented Resident #14 had an order for oxygen at 3 liters per minute (LPM).

- Resident #14’s clinical record did not include a physician order for oxygen therapy.

On 9/24/18 at 10:35 AM and 2:24 PM, Resident #14 was observed in her room receiving oxygen.

Resident affected:

Resident #14 order for oxygen has been received and care plan updated to reflect current oxygen order on 9/27/18 by CRC.

Potential residents:

All residents using oxygen are at risk for this deficient practice. Whole house audit on oxygen was conducted by CNE or designee on or before 11/12/18 to ensure all oxygen orders and care plans are in place.

Systemic:

On or before 11/12/18 CNE to validate all new orders for oxygen in clinical stand up meeting using clinical f/u form to verify that care plans and orders are in place. Staff was re educated on policy and procedures regarding orders and care plan updates by CNE and Practice Development Specialist on or before 11/12/18.

Review:

Beginning the week of 11/12/18 the CNE or designee will review all residents with oxygen for orders and current care plans.
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 695</td>
<td>Continued From page 24</td>
<td>via nasal cannula at 4 LPM.</td>
<td>F 695</td>
<td>weekly for 4 weeks then monthly for 2 months. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. CNE is responsible for compliance.</td>
<td></td>
</tr>
</tbody>
</table>

On 9/25/18 at 2:32 PM, CNA #3 said Resident #14 received oxygen at 2 LPM. The surveyor and CNA #3 went to Resident #14's room and checked her oxygen flow rate and it was at 4 LPM. The CNA then said she would check with the nurse for Resident #14’s oxygen order.

On 9/25/18 at 2:37 PM, CNA #3 said Resident #14’s oxygen flow rate should be at 3 LPM and she would go to the resident's room and change the oxygen flow rate to 3 LPM.

On 9/25/18 at 2:37 PM, LPN #1 said Resident #14’s oxygen saturation rate was monitored everyday, but she did not see the oxygen therapy order for the resident.

On 9/25/18 at 3:13 PM, the DNS said Resident #14 did not have a current order for oxygen therapy.

F 700 11/12/18

Bedrails

CFR(s): 483.25(n)(1)-(4)

§483.25(n) Bed Rails.
The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>135095</td>
<td>A. BUILDING</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) ID PREFIX TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/27/2018</td>
<td>F 700</td>
<td>Continued From page 25 represenative and obtain informed consent prior to installation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on observation, staff and resident interviews, policy review, and record review, it was determined the facility failed to ensure that prior to placement of bed rails, residents were thoroughly assessed for the risk of entrapment and a physician's order was in place. This was true for 3 of 4 residents (#6, #8 and #9) reviewed for bed rails and created the potential for harm from entrapment or injury related to use of bed rails. Findings include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The facility's policy and procedure for Bed Rails, effective 7/1/18, documented the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* The Bed Rail Evaluation is completed on admission, re-admission, change in bed or mattress, and with a significant change in the resident's condition.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* The risks and benefits of bed rails are reviewed with the resident or their representative.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Keep the consent form in the resident's chart.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Obtain an order for the bed rail from the physician or advanced practice provider.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Resident #6 was admitted to the facility on 7/2/13 with multiple diagnoses, including hemiplegia (paralysis on one side of the body)</td>
<td></td>
</tr>
</tbody>
</table>

Residents Affected:

Resident's #6, #8 and #9 Bed Rail Assessments were completed by CNE 10/1/18.

Potential residents:

All residents with bed rails are at risk for this deficient practice. On or before 11/12/18 Maintenance Director/CED visually completed whole house audit to check for side rails. On or before 11/12/18 CNE validated all residents with side rails had completed assessments and consents.

Systemic:

Beginning 11/12/18 during post admission meeting, quarterly care plan meetings and annual bed audits CNE will validate that assessments, orders and consents are in place. Maintenance Director/CED will do annual bed rail audits for TELs report and visual observation for SR use. CNE will re educate the licensed nursing staff regarding policy and procedures on completing assessments by 11/12/18.
### F 700 Continued From page 26

and hemiparesis (weakness on one side of the body) following a cerebrovascular accident (stroke).

Resident #6's quarterly MDS assessment, dated 7/18/18, documented he was cognitively intact, required limited assistance of one staff member for dressing, toileting and personal hygiene, and did not use a bed rail.

Resident #6's September 2018 physician orders documented he had 1/2 right bed rail for transfer, mobility to and from bed, ordered on 2/21/16.

A care plan, dated 2/8/16, documented Resident #6’s 1/2 bed rail was used as an enabler to aid in bed mobility.

Resident #6 Bed Rail Evaluation, dated 1/22/18 at 3:05 PM, documented bed rails were indicated and served as an enabler.

On 9/24/18 at 10:04 AM and 2:51 PM, Resident #6 was observed in his room sitting in his wheelchair. His bed was positioned against the wall with 1/2 right bed rail in the raised position. Resident #6 said he needed the bed rail to get in and out of his bed.

On 9/25/18 at 9:20 AM and 3:02 PM, Resident #6’s 1/2 right bed rail was observed in a raised position.

On 9/25/18 at 1:18 PM, the DNS said Resident #6 did not have a current bed rail assessment. She said the last bed rail assessment was done on 1/22/18, and it should have been done

### Review:

Beginning the week of 11/12/18 CNE or designee will review all new residents with orders for SR/restrictive devices weekly for 4 weeks then monthly for 2 months to ensure all assessments and consents are in place. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. CNE/CED are responsible for compliance.
### Continued From page 27 quarterly.

2. Resident #8 was admitted to the facility on 7/11/18 with multiple diagnoses, including congestive heart failure and Stage 4 chronic kidney disease (severe kidney disease).

   Resident #8's quarterly MDS assessment, dated 5/22/18, documented she was severely cognitively impaired, was dependent on two staff members for all ADLs, and did not use bed rails.

   Resident #8's September 2018 physician orders documented she had bilateral 1/4 bed rails for repositioning in bed, ordered on 12/1/16.

   A care plan, revised on 12/1/16, documented Resident #8's bilateral 1/4 bed rails were used as an enabler to help her turn side to side while in bed.

   Resident #8's Bed Rail Evaluation, dated 12/1/16 at 3:05 PM, documented bed rails were indicated and served as an enabler.

   On 9/24/18 at 9:16 AM, 9/25/18 at 9:53 AM, and 1:38 PM, Resident #8 was observed in bed with bilateral bed rails in the raised position.

   On 9/25/18 at 1:18 PM, the DNS said Resident #8 did not have a current bed rail assessment. The DNS said the last bed rail assessment was done on 12/1/16, and it should have been done quarterly.

3. Resident #9 was admitted to the facility on 12/21/17, with multiple diagnoses including muscle weakness and other abnormalities of gait.
Resident #9's quarterly MDS assessment, dated 8/28/18, documented moderate cognitive impairment and bed rail used daily.

Resident #9's September 2018 physician orders did not include an order for the use of bed rails.

Resident #9's current care plan documented his use of bed rails to help with mobility was added to the care plan on 12/30/17.

Resident #9's Bed Rail Evaluation, dated 12/30/17 at 12:43 AM, documented bed rails were indicated and served as an enabler.

On 9/24/18 at 10:30 AM, 9/25/18 at 9:21 AM, and 9/26/18 at 11:13 AM, Resident #9 was in bed and bed rails were present to both sides of his bed.

Resident #9's Device Evaluation, dated 9/25/18 at 10:19 AM, did not address the use of bed rails.

On 9/25/18 at 1:23 PM, the DNS said a bed safety action grid should have been done for Resident #9. The DNS said she missed checking the box for bed rails on the Device Evaluation that was performed on 9/25/18.

On 9/26/18 at 9:25 AM, the DNS said the last bed rail assessment for Resident #9 was performed in December 2017, and she was going to add it to the assessment from 9/25/18.

A Progress Note, dated 9/26/18 at 9:26 AM, documented Resident #9 had 1/4 bed rails that were used for bed mobility, and it was missed on
### Statement of Deficiencies and Plan of Correction

#### Cherry Ridge Center

**Provider's Plan of Correction**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 700</td>
<td>Continued From page 29</td>
<td>9/25/18 assessment.</td>
<td>F 758</td>
<td>Free from Unnec Psychotropic Meds/PRN Use</td>
<td>SS=E</td>
</tr>
</tbody>
</table>

#### Summary Statement of Deficiencies

**F 700**

Continued From page 29 the 9/25/18 assessment.

The facility did not obtain a physician's order for Resident #9's bed rails or perform a bed rail assessment from 12/21/17 to 9/25/18.

**F 758**

Free from Unnec Psychotropic Meds/PRN Use

CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

1. Anti-psychotic;
2. Anti-depressant;
3. Anti-anxiety; and
4. Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 758</td>
<td>Continued From page 30</td>
<td>F 758</td>
</tr>
</tbody>
</table>

in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:

Based on record review, staff interview, and facility policy and procedure review, it was determined the facility failed to ensure a) residents’ behaviors and potential side effects of psychotropic medications were routinely monitored, and b) physician orders for PRN (as needed) antianxiety medications were time limited. This was true for 5 of 5 residents (#3, #6, #7, #8 and #14) reviewed who received psychotropic medications. These failed practice created the potential for harm should residents receive psychotropic medications that were unnecessary, ineffective, or used for excessive duration, or should residents experience adverse reactions from psychotropic medications.

Findings include:

The facility’s policy and procedure for behavior monitoring, dated 7/1/18, directed staff “To evaluate effectiveness and monitor for side

Residents affected:
Resident #3, Consents for psychotics received, side effect monitoring in place by CNE 10/1/18.
Resident #7, Side effects for psychotropic medication in place by CNE 10/1/18.
Resident #6, Care plan and side effect monitoring in place for psychotropic medication by CNE 10/1/18.
Resident #8, Prn psychotropic medication now has stop date, care plan and side effect monitoring in place by CNE on 10/1/18.
Resident #14, side effect monitoring in place by CNE on 10/1/18.

Potential residents:
All residents using psychotropic medications are at risk for this deficient practice. On or before 11/12/18 a whole
### F 758
Continued From page 31

**Effects of Pharmacologic Interventions.**

The facility's policy and procedure for Management of Symptoms, revised on 11/28/17, documented "PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, he/she should document the rationale in the patient's medical record and indicate the duration for the PRN order.

1. Resident #3 was admitted to the facility on 1/17/18 with multiple diagnoses, including unspecified dementia without behavioral disturbance and anxiety disorder.

   Resident #3's Significant Change MDS assessment, dated 7/11/18, documented the following:

   - Severe cognitive impairment.
   - Antipsychotic and antidepressant medications were received on 7 of the last 7 days.

   Resident #3's physician orders, dated 9/25/18, documented the following:

   - Celexa (antidepressant) 20 mg one tablet once a day for anxiety related to depression
   - Risperdal (antipsychotic) tablet give 0.25 mg by mouth once daily for BPSD (Behavioral and Psychological Symptoms of Dementia)
   - Risperdal (antipsychotic) tablet give 0.5 mg by mouth once daily for BPSD

   Resident #3's current care plan documented she was at risk for complications due to the use of psychotropic medications. The house audit was completed by CNE on all residents taking psychotropic medication for stop dates, relevance of medication, consents, care plans reflecting current therapy. CNE/Practice Development Specialist re-educated licensed nursing staff and LCSW regarding behavior monitoring, side effect monitoring, and care planning by 11/12/18. CNE/Practice Development specialist educated all LN on 10/1/18 regarding PRN psychotherapeutic that behaviors need to be present and documented on behavior monitoring sheet prior to administering meds.

**Systemic:**

Beginning 11/12/18, all new orders and behavior sheets will be reviewed in morning clinical stand up meeting. CNE to validate, using clinical follow up form, all psychotropic medications have valid diagnosis, care plan, daily side effect monitoring, stop date for all PRN psychotropic medication, and behavior monitoring from previous day. Beginning 11/12/18, behavior sheets will also be reviewed by CNE in weekly CAR meeting to cross check notes with documentation.

**Review:**

Beginning the week of 11/12/18 the CNE or designee will review 2 charts for side effect monitoring daily, and care plans weekly for 4 weeks then monthly for 2 months. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. The CNE is
## F 758

Continued From page 32

Antidepressant and antipsychotic medications. Care plan interventions were initiated on 1/19/18 that directed staff to complete the behavior monitoring flowsheet, and interventions were initiated on 9/24/18 that directed staff to monitor for side effects and contact the physician and/or pharmacist as needed.

Resident #3's September 2018 MAR documented the Celexa and Risperdal were administered each day from 9/1/18 to 9/24/18.

Resident #3's September 2018 Behavior Monitoring Sheet documented the symptoms to be monitored included the following:

- Refusing cares
- Yelling
- Anxiety as exhibited by "up and down repetitive questions."

There was no documentation on the September 2018 Behavior Monitoring Sheet for refusing cares or yelling. Anxiety was documented on 4 days, 9/6/18, 9/23/18, 9/25/18, and 9/26/18.

Resident #3's clinical record did not document consent by the resident or her family member for use of the Celexa and Risperdal or monitoring of side effects for Celexa and Risperdal.

On 9/25/18 at 3:31 PM, the LSW said facility staff should document behaviors only if there were exhibited behaviors. The LSW said she thought the nurses documented medication side effects on the MAR.

On 9/25/18 at 3:47 PM, RN #1 said an order for

---

Resident #3’s September 2018 MAR documented the Celexa and Risperdal were administered each day from 9/1/18 to 9/24/18.

Resident #3’s September 2018 Behavior Monitoring Sheet documented the symptoms to be monitored included the following:

- Refusing cares
- Yelling
- Anxiety as exhibited by "up and down repetitive questions."

There was no documentation on the September 2018 Behavior Monitoring Sheet for refusing cares or yelling. Anxiety was documented on 4 days, 9/6/18, 9/23/18, 9/25/18, and 9/26/18.

Resident #3’s clinical record did not document consent by the resident or her family member for use of the Celexa and Risperdal or monitoring of side effects for Celexa and Risperdal.

On 9/25/18 at 3:31 PM, the LSW said facility staff should document behaviors only if there were exhibited behaviors. The LSW said she thought the nurses documented medication side effects on the MAR.

On 9/25/18 at 3:47 PM, RN #1 said an order for

---

Resident #3’s September 2018 MAR documented the Celexa and Risperdal were administered each day from 9/1/18 to 9/24/18.

Resident #3’s September 2018 Behavior Monitoring Sheet documented the symptoms to be monitored included the following:

- Refusing cares
- Yelling
- Anxiety as exhibited by "up and down repetitive questions."

There was no documentation on the September 2018 Behavior Monitoring Sheet for refusing cares or yelling. Anxiety was documented on 4 days, 9/6/18, 9/23/18, 9/25/18, and 9/26/18.

Resident #3’s clinical record did not document consent by the resident or her family member for use of the Celexa and Risperdal or monitoring of side effects for Celexa and Risperdal.

On 9/25/18 at 3:31 PM, the LSW said facility staff should document behaviors only if there were exhibited behaviors. The LSW said she thought the nurses documented medication side effects on the MAR.

On 9/25/18 at 3:47 PM, RN #1 said an order for

---

Resident #3’s September 2018 MAR documented the Celexa and Risperdal were administered each day from 9/1/18 to 9/24/18.

Resident #3’s September 2018 Behavior Monitoring Sheet documented the symptoms to be monitored included the following:

- Refusing cares
- Yelling
- Anxiety as exhibited by "up and down repetitive questions."

There was no documentation on the September 2018 Behavior Monitoring Sheet for refusing cares or yelling. Anxiety was documented on 4 days, 9/6/18, 9/23/18, 9/25/18, and 9/26/18.

Resident #3’s clinical record did not document consent by the resident or her family member for use of the Celexa and Risperdal or monitoring of side effects for Celexa and Risperdal.

On 9/25/18 at 3:31 PM, the LSW said facility staff should document behaviors only if there were exhibited behaviors. The LSW said she thought the nurses documented medication side effects on the MAR.

On 9/25/18 at 3:47 PM, RN #1 said an order for
### F 758 Continued From page 33

Side effect monitoring was to be generated upon admission and Resident #3 did not have one. RN #1 said she would monitor for medication side effects for Resident #3 by interacting with her every day, and she would realize if Resident #3 was having some kind of adverse effect. RN #1 said the facility did not have a form to document side effects.

On 9/26/18 at 2:00 PM, RN #2 said she monitored for medication side effects by noting residents' lack of luster for life, dulling, and not walking as well as they typically did. RN #2 said she monitored residents for medication side effects each time she worked, on every shift, and it should be documented if the resident exhibited signs of medication side effects.

On 9/27/18 at 9:20 AM, there were no consents for Celexa and Risperdal in Resident #3's clinical record. The LSW said consents for psychotropic medications were completed with the resident or family by her or a nurse. The LSW said she did not see a consent for Celexa and Risperdal in Resident #3's record, and she would look to see if was in the overflow records.

On 9/27/18 at 9:41 AM, the LSW said she would look in the nurse's notes for consents for Resident #3's Celexa and Risperdal, and she did not document anything about the consents. The LSW said if she did not find the consents then that meant the facility did not complete them.

The facility did not provide documentation of consents for Celexa and Risperdal for Resident #3.

---

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 758</td>
<td>Continued From page 33 side effect monitoring was to be generated upon admission and Resident #3 did not have one. RN #1 said she would monitor for medication side effects for Resident #3 by interacting with her every day, and she would realize if Resident #3 was having some kind of adverse effect. RN #1 said the facility did not have a form to document side effects. On 9/26/18 at 2:00 PM, RN #2 said she monitored for medication side effects by noting residents' lack of luster for life, dulling, and not walking as well as they typically did. RN #2 said she monitored residents for medication side effects each time she worked, on every shift, and it should be documented if the resident exhibited signs of medication side effects. On 9/27/18 at 9:20 AM, there were no consents for Celexa and Risperdal in Resident #3's clinical record. The LSW said consents for psychotropic medications were completed with the resident or family by her or a nurse. The LSW said she did not see a consent for Celexa and Risperdal in Resident #3's record, and she would look to see if was in the overflow records. On 9/27/18 at 9:41 AM, the LSW said she would look in the nurse's notes for consents for Resident #3's Celexa and Risperdal, and she did not document anything about the consents. The LSW said if she did not find the consents then that meant the facility did not complete them. The facility did not provide documentation of consents for Celexa and Risperdal for Resident #3.</td>
<td>F 758</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 758 Continued From page 34

2. Resident #7 was admitted to the facility on 7/20/13 with multiple diagnoses, including Alzheimer's disease, anxiety disorder, major depressive disorder, and dementia with behavioral disturbance.

Resident #7's quarterly MDS assessment, dated 8/14/18, documented the following:

* Severe cognitive impairment.
* Anti-anxiety and antidepressant medications were received on 7 of the last 7 days.

Resident #7's September 2018 physician orders documented the following:

* Lorazepam (anti-anxiety) 0.5 mg one tablet twice a day for anxiety.
* Sertraline (antidepressant) 25 mg 1.5 tablets once daily for depression.

Resident #7's care plan documented the following:

* She demonstrated distressed mood symptoms including anxiety exhibited by exit seeking, and depression as exhibited by tearfulness.
* She was at risk for complications due to the use of antidepressant and anti-anxiety medications.
* Staff were directed to complete the behavior monitoring flowsheet, monitor for changes in mental status and level of function and report to the physician as indicated, monitor for continued necessity of medication as it related to mood and behavior, monitor for side effects, and contact the physician and/or pharmacist as needed.

Resident #7's September 2018 MAR
continued From page 35

documented the Sertraline and Lorazepam were given each day from 9/1/18 to 9/26/18.

Resident #7's September 2018 Behavior Monitoring Sheet documented behaviors to be monitored included exit seeking and crying. The Behavior Monitoring Sheet was blank each day for the listed behaviors to be monitored.

Resident #7's clinical record did not document monitoring for side effects of Sertraline and Lorazepam.

On 9/26/18 at 2:37 PM, the DNS said medication side effects should be documented under Adverse Effects, and the facility was going to add it to the Behavior Monitoring Sheet. The DNS said the facility monitored side effects and behaviors by exception, meaning they would only document if a behavior or side effect occurred. The DNS said she would look for documentation of monitoring for adverse effects for Resident #7. The facility did not provide documentation of side effect monitoring for Resident #7's Sertraline and Lorazepam.

3. Resident #6 was admitted to the facility on 7/2/18, with multiple diagnoses, including major depressive disorder.

Resident #6's quarterly MDS assessment, dated 7/18/18, documented he was cognitively intact, had mild depression, and received antidepressant medication daily.

Resident #6's September 2018 physician orders documented he was to receive the antidepressant medication Paroxetine hcl
F 758 Continued From page 36

(hydrochloride) 5 mg by mouth one time daily for depression.

Resident #6's care plan, updated on 2/27/18, documented he had depression and his behaviors included irritability, making inappropriate comments towards others, self isolation, statements of depression and concern regarding medical issues. The care plan interventions directed staff to monitor for side effects of medications and observe and document for changes in mood, behavior and functional level.

Resident #6's care plan did not include the antidepressant medication he was taking and did not specify the side effects of the medications staff were to monitor.

Resident #6's Behavior Monitoring Sheets for August and September 2018 documented he was monitored for comments of depression, sexual comments, and inappropriate comments or gestures. The Behavior Monitoring Sheets directed staff to document Resident #6's behavior by exception only. No documentation meant behaviors were not present on that shift. Inappropriate comments or gestures were documented on 8/12/18, 8/13/18, 8/15/18, and 9/20/18.

The side effect monitoring sheets were not found in Resident #6's clinical record.

On 9/25/18 at 2:48 PM, RN #1 said if there was a behavior she would document it and if the resident did not have a behavior, she would not document anything on the Behavior Monitoring
### F 758

Continued From page 37

Sheet. RN #1 also said she would report to the resident's physician anything out of ordinary for the resident. When asked what she meant by anything out of ordinary, RN #1 said if she observed a resident being lethargic which was not usual for that resident, then she would report it to the physician.

On 9/25/18 at 3:31 PM, the LSW said residents' behaviors were monitored by exception only.

On 9/27/18 9:28 AM, the DNS said the nurses documented on the Behavior Monitoring Sheets by exception only. No documentation indicated the behavior did not occur on that shift. The DNS also said she did not find documentation Resident #6 was monitored for the side effects of Paroxetine hcl.

4. Resident #8 was admitted to the facility on 7/11/13, and was readmitted on 2/16/16, with multiple diagnoses which included depression and dementia with behavioral disturbance.

Resident #8's quarterly MDS assessment, dated 5/22/18, documented she was severely cognitively impaired, with mild depression, she received antipsychotic and antidepressant medications daily, and was on hospice care.

Resident #8's physician orders for September 2018 documented the following:

- Alprazolam (antianxiety) 0.25 mg (milligrams) tablet by mouth every two hours as needed for anxiety, ordered on 8/21/18
- Risperidone (antipsychotic) 0.25 mg tablet by mouth two times a day, ordered on 7/25/18
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 758</td>
<td>Continued From page 38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Monitor for adverse effects to medications, mark &quot;Y=yes and N=no adverse effects.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident #8's care plan, revised on 12/8/17, documented she exhibited disruptive behaviors as evidenced by yelling out and disrupting other residents' sleep, activities, or meals, nondistressing hallucinations and delusions, and was at risk for complications related to the use of psychotropic drugs. The care plan interventions directed staff to complete the Behavior Monitoring Sheet, monitor for changes in mental status and functional level and report to the physician, and monitor for side effects and consult physician and/or pharmacist.

Resident #8's care plan did not include the specific psychotropic medications she was taking and did not include the side effects of the medications staff to monitor.

Resident #8's Behavior Monitoring Sheets for August and September 2018, documented she was monitored every shift for the behaviors of calling out, hallucinations and delusions. The Behavior Monitoring Sheet directed staff to document Resident #8's behavior by exception only. No documentation meant behaviors were not present on that shift.

The Treatment Administration Records for August and September 2018 directed staff to monitor Resident #8 for adverse effects of her medications and staff to mark "Y" for yes and "N" for no.

The Treatment Administration Records did not include the side effects of medications the staff...
A Pharmacist Review of Medication, dated 9/21/18, recommended discontinuation of Resident #8's Alprazolam current order, then replacing it with an order for Alprazolam 0.25 mg by mouth every two hours as needed for anxiety with a stop order in six months.

A physician note, dated 9/23/18, documented the physician declined the pharmacist's recommendation and did not wish to implement any changes due to Resident #8's continued episodes of anxiety that impacted her quality of life and she was not always able to be redirected with non-pharmacologic interventions. The physician did not indicate the duration of Resident #8's PRN medication.

On 9/25/18 at 2:48 PM, RN #1 said if there was a behavior she would document it in the nursing notes and if the resident did not have a behavior, she would not document anything on the Behavior Monitoring Sheet. RN #1 also said she would report to the resident's physician anything out of ordinary for the resident. When asked what she meant by anything out of ordinary, RN #1 said if she observed a resident being lethargic which was not usual for that resident, then she would report it to the physician.

On 9/25/18 3:50 PM, the DNS said Resident #8 was prescribed Alprazolam on a PRN basis as part of the hospice protocol for her agitation, and nurses would document her behaviors by exception only. No documentation indicated the behavior did not occur on that shift. The DNS also she did not find documentation Resident #8
F 758 Continued From page 40

5. Resident #14 was admitted to the facility on 11/3/17, with multiple diagnoses which included bipolar disorder (mental health condition that causes extreme mood swing that include emotional highs and lows-depression).

Resident #14’s quarterly MDS assessment, dated 5/8/18, documented she was cognitively intact, had mild depression, no behaviors, and received antipsychotic medications daily.

Resident #14’s physician orders for September 2018 documented the following:

* Quetiapine fumarate (antipsychotic) tablet 400 mg by mouth at bedtime for bipolar disorder
* Sertraline hcl (antidepressant) tablet 175 mg by mouth one time a day for depression.
* Thiothixene (antipsychotic) capsule 5 mg by mouth one time a day for bipolar disorder.

A care plan dated 1/24/18, documented Resident #14 had verbal behaviors related to cognitive deficits due to traumatic brain injury, bipolar disorder, and mild intellectual disability. The care plan interventions directed staff to complete the Behavior Monitoring Sheet.

A care plan updated 9/24/18, documented Resident #14 was at risk for complications related to the use of antipsychotic and antidepressant medications. The care plan interventions directed staff to:

* Monitor for side effects and consult physician
and/or pharmacist as needed. Side effects may include sedation, dry mouth, blurred vision, constipation, headache, and excessive weight gain.

* Complete Behavior Monitoring Sheets

Resident #14's Behavior Monitoring Sheets for August and September 2018, documented she was monitored for the following behaviors every shift: verbal abuse, comments of suicide, and refusing cares. The Behavior Monitoring Sheet directed staff to document Resident #14's behavior by exception only. No documentation meant behaviors were not present on that shift. The Behavior Monitoring Sheets for August and September 2018 were blank, indicating the target behaviors did not occur.

On 9/25/18 3:50 PM, the DNS said nurses would document residents' behaviors by exception only. No documentation indicated the behavior did not occur on that shift. The DNS also did not find documentation Resident #14 was monitored for the specific side effects of the psychotropic medications.

On 9/26/18 at 2:14 PM, the LSW said she would expect the nurses to monitor the side effects of psychotropic medications.

Resident Records - Identifiable Information

CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.

(i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the
## F 842

Continued From page 42

agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.

§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.
§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure physician orders were transcribed to residents' MARs and TARs. This was true 1 of 9 sample residents (#15) whose records were reviewed. The deficient practice created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information in the resident's clinical record. Findings include:

1. Resident #15 was admitted to the facility on 5/31/17 with multiple diagnoses, including a stroke that affected his left side.

Resident affected:
Resident #15 care plan and MAR/TAR updated to include carrot orthosis and splint by CRC on 10/1/18.

Potential residents:
All residents with orthosis devices are at risk for the deficient practice. On or before 11/12/18 CNE performed audit on all residents with assistive devices, orders for devices and care plans.

Systemic:
Beginning 11/12/18 all residents with assistive devices will be reviewed in
**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 842</td>
<td>Continued From page 44</td>
<td></td>
<td>weekly CAR meeting by IDT for orders, care plans and MAR/TAR documentation. CRC to re educate nursing staff via policy and procedures regarding order input for MAR/TAR by 11/12/18. Review: Beginning the week of 11/12/18 CNE or designee will audit 2 charts weekly for 4 weeks then monthly for 2 months for use of assistive devices, that orders are in place, that care plans are current and documentation is present. The results will be reviewed in QAPI meeting monthly for 3 months or until compliance is sustained. CNE is responsible for compliance.</td>
</tr>
</tbody>
</table>

**Infection Prevention & Control**

<table>
<thead>
<tr>
<th>CFR(s):</th>
<th>483.80(a)(1)(2)(4)(e)(f)</th>
</tr>
</thead>
</table>

§483.80 Infection Control
The facility must establish and maintain an
infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation,
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 46</td>
<td></td>
<td>depending upon the infectious agent or organism involved, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(B)</td>
<td>A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(v)</td>
<td>The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(vi)</td>
<td>The hand hygiene procedures to be followed by staff involved in direct resident contact.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure licensed nursing staff performed proper hand hygiene during resident cares, while passing medications, and in between contact with residents. This was true for 2 of 9 residents (#8 and #9) observed for medication pass and 2 of 3 residents (#3 and #9) observed during resident cares. The deficient practices created the potential for the spread of infectious organisms from cross contamination

Residents affected:
Residents #8, #3, #9 suffered no adverse effects of this deficient practice.

Potential Residents:
All residents have the potential to be affected by this deficient practice.

Systemic:
On or before 11/12/18 all staff will be educated and inserviced by Practice
continued from page 47

which could harm all residents residing in the facility. Findings include:

The facility’s policy and procedure for Hand Hygiene, dated 11/28/17, documented hand hygiene is to be performed at the following times:

* Before patient contact;
* Before aseptic procedure;
* After any contact with blood or other fluids, even if gloves are worn;
* After patient care,
* After contact with patient’s environment.

This policy was not followed. Examples include:

1. Staff did not complete proper hand hygiene during medication pass and between contact with residents as follows:

   a. On 9/26/18 at 9:21 AM, RN #2 was observed as she gave Resident #9’s morphine sulfate 0.5 cc (cubic centimeter) via sublingual (under the tongue). The RN then went back to the medication cart and initialed the MAR and signed the narcotic book. RN #2 was not observed to perform hand hygiene upon entering or leaving Resident #9’s room. RN #2 then proceeded to prepare Resident #9’s morphine sulfate liquid medication when she dropped the oral syringe on the floor. RN #2 picked up the oral syringe, locked the medication cart, and went to the DNS’ office. RN #2 was observed to leave the DNS’ office, go to the eye wash room, and wash the oral syringe with water. RN #2 went back to the medication cart and prepared to withdraw 0.25 cc of morphine sulfate from the bottle when the surveyor asked RN #2 if she was using the same

Development Specialist on proper hand washing technique, to include when hand washing is to be performed. All nursing staff will be observed for deficient practice daily by CNE or designee.

Review:
Random observation of 6 nursing staff (to include minimum of one licensed staff during wound care) to be done weekly by Practice Development specialist or CNE for 4 weeks then monthly for 2 months. The results will be reviewed in QAPI monthly for three months or until compliance is sustained. The CNE is responsible for compliance.
F 880 Continued From page 48
oral syringe that fell on the floor. RN #2 said there was only one oral syringe that came with the bottle of morphine sulfate, and she said she would ask the DNS if they could get an extra oral syringe.

b. On 9/26/18 at 9:39 AM, RN #2 was observed as she administered Resident #8's 0.5 cc morphine sulfate sublingually. RN #2 checked Resident #8's call light, making sure it was within Resident #8's reach, and leaned to talk to Resident #8 with her right hand resting on her bed. RN #2 left Resident #8's room, went back to the medication cart, initialed the MAR, and signed the narcotic book. RN #2 was not observed to perform hand hygiene before entering and upon leaving Resident #8's room.

c. On 9/26/18 at 9:45 AM, RN #2 was observed talking to a male resident sitting in his wheelchair in the lobby. RN #2 knelt on one knee as she talked to the resident while her hand was resting on the resident's knee. RN #2 then got up and approached a female resident from behind who was sitting in her wheelchair facing the window. RN #2 rested her hand on the female resident's shoulder as she was talking to her. RN #2 was not observed to perform hand hygiene between contact with the two residents.

On 9/26/18 at 9:49 AM, RN #2 said she did not perform hand hygiene during her medication pass and in between contact with the residents.

2. Resident #3 was admitted to the facility on 1/17/18, with multiple diagnoses including muscle weakness and neuromuscular dysfunction of the bladder.
Resident #3's Significant Change MDS assessment, dated 7/11/18, documented severe cognitive impairment and indwelling catheter.

Resident #3's care plan documented the following:

* She required a Foley catheter due to acute urinary retention, an unstageable pressure ulcer in the area, and diagnosis of neurogenic bladder.
* A #16 French (size of the catheter) 10 ml (size of the balloon in the catheter) inserted prior to admission.

Resident #3's TAR documented Foley catheter care was performed each day from 9/14/18 - 9/24/18.

On 9/26/18 at 2:29 PM, RN #2 performed catheter care for Resident #3, including cleaning the peri area and cleaning the catheter near the peri area. After completing catheter care, RN #2 did not remove her gloves or perform hand hygiene and went into Resident #3's bathroom. RN #2 then came out of the bathroom wearing the same gloves for which she performed catheter care and touched Resident #3's dresser, opened the dresser drawer and touched items in the dresser drawer, repositioned the resident in bed, and drained the urine from Resident #3's Foley bag into a basin. After draining the urine from the Foley bag, RN #2 went into Resident #3's bathroom and emptied the urine into the toilet, returned from the bathroom, and without removing her gloves or performing hand hygiene RN #2 touched Resident #3's bed control and touched the resident on her right shoulder. RN #2
3. Resident #9 was admitted to the facility on 12/21/17 with multiple diagnoses, including muscle weakness, rheumatoid arthritis, and encounter for other specified surgical aftercare.

Resident #9's current care plan documented "Resident has actual skin breakdown related to sacral (tailbone area) wound, (Chronic non healing pressure ulcer, present on admit)." The care plan for the pressure ulcer was initiated on 12/22/17 and revised on 9/25/18.

Resident #9's quarterly MDS assessment, dated 8/28/18, documented moderate cognitive impairment, one Stage IV pressure ulcer that was present upon admission and measured 5.6 by 5.1 by 0.3, and pressure ulcer care.

Resident #9's September 2018 physician orders documented the following:

* Wound care was ordered on 7/20/18 as follows: Cleanse wound and pat dry, apply Skin-Prep to wound edges, apply alginate with silver to wound bed, cover with foam pad and ABD (a type of dressing) and paper tape every day shift or as
F 880 Continued From page 51

On 5/22/18 a named wound clinic was authorized to evaluate and treat the wound.

* On 5/22/18 a named wound clinic was authorized to evaluate and treat the wound.

A wound clinic note, dated 9/20/18, documented Resident #9 had a chronic Stage IV pressure ulcer on the sacrum that was not healed and measured 6.1 cm length by 4.7 cm width by 0.2 cm depth. Wound care was performed and a dressing was applied.

On 9/25/18 at 2:10 PM, RN #1 prepared to perform the dressing change to Resident #9's coccyx. RN #1 cleaned fecal material from Resident #9's rectal area and did not remove her gloves or perform hand hygiene. RN #1 then removed the dressings from Resident #9's coccyx and cleansed the wound with Skintegrity wound cleanser and gauze. After cleansing the wound, RN #1 removed her gloves, washed her hands, and donned new gloves. RN #1 then applied the dressing materials to the coccyx wound, did not remove her gloves or perform hand hygiene, and repositioned Resident #9. A staff member knocked on the door, and RN #1 answered the door and briefly spoke to the staff member then removed her gloves and did not perform hand hygiene. RN #1 then finished repositioning Resident #9, cleared off the bedside table, picked up Resident #9's dressing supplies and placed them on Resident #9's closet shelf, picked up the used trash bag and put a new trash bag in the trash can, and washed her hands. When asked about performing hand hygiene after cleaning fecal material and prior to performing wound care, RN #1 said she was still removing dirty material, so she did not need to perform hand hygiene between cleaning up
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 52</td>
<td>F 880</td>
</tr>
</tbody>
</table>

Resident #9's fecal material, removing the old dressing, and cleaning the wound. RN #1 said she still considered it a dirty part of the process.

On 9/25/18 at 2:32 PM, the DNS said the nurse should have removed her gloves and performed hand hygiene immediately after cleaning fecal material from Resident #9.
The following deficiencies were cited during the licensing survey conducted on September 24, 2018 to September 27, 2018.

The surveyors conducting the survey were:

Jenny Walker, RN, Team Coordinator
Presie Billington, RN
Cecilia Stockdill, RN

The Infection Control Committee attendance records dated 2/16/18, 5/18/18 and 9/21/18, documented the Dietary Manager and representatives from housekeeping and maintenance did not participate in the May 18, 2018 meeting.

On 9/26/18 at 1:28 PM, the Infection Control Nurse said the facility conducted quarterly Infection Control meetings. The Infection Control Committee attendance records dated 2/16/18, 5/18/18 and 9/21/18, documented the Dietary Manager and representatives from housekeeping and maintenance did not participate in the May 18, 2018 meeting.

Residents Affected:
No residents were affected by the deficient practice.

Potential Residents:
All residents have the potential to be affected by the deficient practice.

Systemic Changes:
On or before 11/12/18 CED will make certain, by invite, compliance for the requirement of attendance of the IDT for the Infection Control meeting.

Review:
CED or Infection Preventionist will review quarterly for attendance. The results will be reviewed in QAPI until compliance is sustained. CED is responsible for
<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>
</tr>
</thead>
<tbody>
<tr>
<td>C 664</td>
<td>Continued From page 1</td>
<td>Nurse confirmed Dietary Manager and representatives from housekeeping and maintenance did not attend the meeting in May 18, 2018.</td>
<td></td>
<td></td>
<td></td>
<td>compliance.</td>
<td></td>
</tr>
</tbody>
</table>
January 31, 2019

Todd Russell, Administrator
Cherry Ridge Center
501 West Idaho Boulevard,
Emmett, ID 83617-9694

Provider #: 135095

Dear Mr. Russell:

On September 27, 2018, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007550**

A Federal complaint investigation was conducted in conjunction with the facility's Federal recertification and state licensure survey from 9/24/18 to 9/27/18. Eight residents were observed, and their records were reviewed for quality of care and medication management. Residents and staff were interviewed.

**Allegation #1:** The facility was not addressing residents pain management.

**Findings #1:** Eight residents' clinical records were reviewed for pain management. Their clinical records included documentation of pain monitoring and pain medications were adjusted by the physician.

Two residents were interviewed and stated their pain management was being monitored and controlled with current physician's orders.
One resident's clinical record documented her pain was being managed by her pain clinic. Additionally, the clinical record documented the Medical Director would refer her complaints of pain to her pain clinic. The facility monitored her pain level twice a day, notified her pain clinic of increased pain, and pain medications were adjusted for her.

Residents' pain management was addressed by the facility. Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Residents antihistamine medications were ineffective and the facility refused to provide residents with specific medications.

**Findings #2:** A resident's clinical record was reviewed for seasonal allergy medications. She requested to have her antihistamine medication be changed due to ineffectiveness. The resident's clinical record included a medication order, dated 6/14/17, signed by the physician, for a new antihistamine medication, Zyrtec, for seasonal allergies. Her clinical record documented the new antihistamine medication for seasonal allergies was effective.

Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** Residents unable to sleep at night.

**Findings #3:** A resident's clinical record was reviewed for sleep monitoring. Her clinical record documented she was sleeping seven hours at night and three hours during the day.

Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** Residents do not get to choose their physician in the facility.

**Findings #4:** Three residents were interviewed and stated they were satisfied with the physician who followed their plan of care.

One resident requested to have another physician follow her care. The resident's clinical record documented a different Medical Director and nurse practitioner followed her care as requested.
Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #5:** Residents mailed is being delivered opened.

**Findings #5:** Three of three residents interviewed stated the facility delivered their mail unopened.

The Activity Director was interviewed and stated facility residents received their mail unopened.

Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #5:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #6:** Residents were not receiving adequate care and treatment for reoccurring pressure ulcers.

**Findings #6:** A resident's clinical record documented she had a reoccurring abscess to her abdomen, which was not the same as a pressure ulcer. Her clinical record documented she would remove her abscess dressing and, subsequently, developed an infection and rash.

The resident's physician ordered antibiotics and Benadryl for her infected abscess. After being treated for two days without improvement, her physician ordered her to go to the emergency room for her abdominal abscess, infection, and rash. When an ambulance arrived, the resident declined to go, and requested her guardian and family member take her to the emergency room by private vehicle.

The resident's abdominal abscess was diagnosed with a staph infection. The Benadryl previously used for her rash was not effective. The emergency room discontinued her Benadryl, started her on a steroid medication regimen, and antibiotic medication for her staph infection.

Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #6:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #7:** The facility did not respond to her concerns after filling out a grievance.

**Findings #7:** A licensed social worker was interviewed and stated she assisted residents with filling out grievances. She would then assist residents with taking their concerns to the appropriate Administrative staff for resolution.
The licensed social worker stated one resident had several grievances filed and had a care conference, with her guardian present, to address her concerns. After the care conference, the licensed social worker stated the facility's Administration resolved all of the resident's concerns and stated the resident was satisfied with the resolution.

However, the resident did not like her guardian and requested a new one. The licensed social worker provided the resident with the name and telephone number to the resident's court-appointed attorney to address her concerns.

Based on investigative findings the allegation was unsubstantiated due to lack of sufficient evidence.

**Conclusion #7:** Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/pmt