



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 4278

November 14, 2013

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

Provider #: 135095

Dear Mr. Prescott:

On **October 25, 2013**, a Recertification and State Licensure survey was conducted at Cherry Ridge Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column X5 Complete Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.

After each deficiency has been answered and dated, the administrator should sign both the Form

Cameron Prescott, Administrator
November 14, 2013
Page 2 of 4

CMS-2567 and State Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 27, 2013**. Failure to submit an acceptable PoC by **November 27, 2013**, may result in the imposition of civil monetary penalties by **December 17, 2013**.

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

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

Cameron Prescott, Administrator
November 14, 2013
Page 3 of 4

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 25, 2014**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

Cameron Prescott, Administrator
November 14, 2013
Page 4 of 4

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

This request must be received by **November 27, 2013**. If your request for informal dispute resolution is received after **November 27, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, Supervisor
Long Term Care

LK/lj
Enclosures

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual Federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, team coordinator; Nina Sanderson, LSW; and, Susan Gollobit, RN.</p> <p>The survey team entered the facility on Monday, 10/21/13, and exited the facility on Friday, 10/25/13.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview of Mental Status CNA = Certified Nurse Aide DNR = Do Not Resuscitate DX = Diagnosis FIDON/FIDNS = Former Interim Director of Nursing Services FTT = Failure to Thrive HCC = House Consistent Carbohydrate diet H&P = History and Physical IDON/IDNS = Interim Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment RMCO = Regional Manager of Clinical Operations RVP = Regional Vice President RNA = Restorative Nursing Assistant RSD/RSS = Resident Services Director/Resident Services Supervisor PCM = Protein Calorie Malnutrition POST = Physician's Orders for Scope of Treatment</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Care and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: center;">RECEIVED NOV 27 2013 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 11/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 RD = Registered Dietician TID = Three times daily UTI = Urinary Tract Infection WNL = Within Normal Limits	F 000			
F 152 SS=D	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure a resident who had been adjudicated incompetent had a court-appointed guardian acting on her behalf. This was true for 1 of 6 residents (# 6) sampled for appropriate decision making related to their care. The deficient practice had the potential for inappropriate or inconsistent care when the facility allowed at least 4 different individuals to make decisions on behalf of Resident #6 after her legal guardian passed away, although none were documented as to be her court-appointed legal representative. Findings included: Resident #6 was originally admitted to the facility	F 152	The social services designee contacted adult protection services and the state ombudsman regarding resident # 6 on 11/2/13. A hearing date was set originally set for 11/13/13 and rescheduled by the court for 1/14/14. Until the hearing occurs, the center will follow the Idaho guide to healthcare decision making as outlined in state statute. A review of resident #6's medical record by social services designee will be conducted with the identified resident representative on or before 11/26/13. Resident's care plan was updated on or before 12/5/13 indicating who to contact. A review of other residents residing in the facility was conducted by the social services designee on or before 11/8/13 to ensure other residents deemed adjudicated have either guardianship or power of attorney for healthcare decision making representation in place. Education was provided to the social services designee by the center		

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F 152	<p>Continued From page 2 on 1/17/12, and re-admitted on 6/18/13, with multiple diagnoses which included cri-du-chat syndrome with severe developmental delay, and expressive language disorder.</p> <p>Resident #6's record contained a court document, dated 6/2/1982, which stated Resident #6 had been determined incapacitated and unable to either care for herself or make decisions for herself, related to her above diagnoses. The document named [Person #1] as Resident #6's legal guardian.</p> <p>Resident #6's record contained an H&P document, dated 4/22/13 (approximately 2 months before her admission to the facility) which documented, in part, "...Her legal guardian is deceased and that responsibility has been taken over by [Person #2]...Patient's service coordinator is [Person #3]."</p> <p>Resident #6's Pre-Admission Screening and Resident Review (PASARR) form, dated 4/25/13, documented [Person #4] as Resident #6's representative. [Person #4] signed that document in the space for, "Legal representative/Guardian."</p> <p>Resident #6's admission paperwork, dated 6/18/13, included authorization to disclose protected health information and consent to provide treatment. It was signed in the spaces for, "Legal Representative", by [Person #5]. The forms instructed documentation should be attached authorizing such legal representation; however, no such documentation was attached.</p> <p>Two Anti-Psychotic Medication Consent forms in Resident #6's chart, dated 6/18/13, for the use of Lorazepam and Seroquel, were signed in the</p>	F 152	<p>assist residents with guardianship or durable healthcare power of attorney if they have been deemed adjudicated. Education was also provided to the social services designee by the Administrator on the Idaho state statute to healthcare decision making on or before 11/22/13. <i>See addendum below</i></p> <p>Beginning the week of 11/25/13 a review of 3 charts weekly for 4 weeks then monthly for 2 months will be reviewed to ensure that residents have a guardian or power of attorney for healthcare decision making in place as indicated. The results will be discussed monthly at the Performance Improvement (PI) committee meeting for 3 months. The Administrator will be responsible for compliance.</p> <p><i>Addendum: New Admission Agreements will be reviewed at morning clinical meeting to assure that either resident or leg of representative has signed admission agreement per telephone conversation</i></p>	12/6/13	

*with
Cameron Prescott
12/12/13 @ 12:00 Noon
Anderson OSW*

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F 152	Continued From page 3 "Legal Representative Signature" area, by [Person #3]. A third "Anti-Psychotic Medications Consent" form, dated 5/3/13 (before Resident #3's admission, but still contained in her current record) was signed in the "Legal Representative Signature" area by [Person #5]. Resident #6's POST form was signed in the area for a surrogate decision maker, by [Person #5]. There was no date for this signature, but the facility RSS signed and dated the form as the health care professional completing the form on 5/3/13. Resident #6's physician signed and dated the form on 7/11/13. On 10/23/13 at 7:45 AM, the Administrator was asked about legal representation for Resident #6. The Administrator was not sure who Resident #6's legal representative was. The Administrator was asked if Resident #6's Guardian ad Litem [attorney designated by the court to be an advocate for Resident #6's legal needs] had ever been informed her guardian had passed away, so the court could be petitioned for a new guardian. The Administrator stated he did not know, but that should be documented in the social services notes. The surveyor informed the Administrator that information had not been found in the social services notes. On 10/24/13 at 6:15 PM, the Administrator, DNS, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.	F 152		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in	F 154	A Spanish speaking staff member informed resident # 4 on 11/6/13, of a	

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F 154	<p>Continued From page 4</p> <p>language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents were informed of their health status in a language they understood. This was true for 1 of 9 residents (#4) sampled for resident rights. The deficient practice had the potential to cause more than minimal harm when Resident #4's diet was limited, and her Zyprexa dose increased, without attempting an understandable dialogue with her. Findings included:</p> <p>Resident #4 was admitted to the facility on 9/19/12 with multiple diagnoses including recurrent persistent hypoglycemia, brittle diabetes mellitus, failure to thrive, hyperlipidemia, severe dementia, chronic anemia, mild hyponatremia, and chronic protein calorie malnutrition (PCM).</p> <p>Resident #4's Annual MDS assessment, dated 9/27/13, coded: -Wants or needs a translator to talk with health care professionals. -Preferred language is Spanish. -Unable to complete the BIMS, assessed by staff with long term and short term memory deficits, rarely or never makes daily decisions. [NOTE: It was determined the facility did not engage a</p>	F 154	<p>care conference that was being scheduled to inform her of her current health status in a language that she could understand. On 11/6/13 a RN who speaks Spanish informed resident # 4 of her current health status. At time of assessment, Spanish speaking RN informed resident of language line and resident wishes to use line as indicated if no available Spanish speaking staff available.</p> <p>A call was also placed to the daughter Social Services Designee (SSD) on 11/5/13 to participate in a care conference. Daughter spoke with SSD on or before 11/26/13. Daughter stated to SSD that she will attend care conference via phone or in person at first available date. Daughter updated at that time of Resident #4's current health status.</p> <p>A copy of the language line phone number and instructions was also placed in the front of resident #4 MAR by manager of clinical operations on 11/6/13. Care plan updated on or before 12/5/13.</p> <p>A review of other non-English speaking residents was completed by social services designee on or before 11/8/13. No other residents were identified.</p>		

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F 154	<p>Continued From page 5</p> <p>translator for Resident #4's assessments.] -Unable to participate in the mood interview. Staff assessed no depressive symptoms. -Has delusions. [NOTE: There was no indication how delusions were assessed, given the language barrier.] -Weight 197 pounds, a 47 pound weight gain since admission. -No significant weight gain. [NOTE: This weight change represented an increase of 15.2% since the MDS 3/22/13.]</p> <p>On 10/21/13 at 9:40 AM, during the initial tour of the facility with the SDC and DNS, the SDC stated Resident #4 did not speak English, but only spoke Spanish. The SDC stated Resident #4, "seems to understand English, we're just not sure how much." The SDC was asked about translator services for Resident #4. The SDC stated, "We have a couple of staff members who speak Spanish. We can use them if we need to." The SDC was asked about translation when the staff members were not available. The DNS stated she had just learned the facility had access to a translator telephone line, but the staff were unaware of it so she would have to train them.</p> <p>The surveyor attempted to engage Resident #4 in conversation on the following occasions: 10/22/13 at 7:40 AM, in the Low Stimulus Dining Room: -The surveyor stated, "Good morning" twice. Resident #4 smiled and nodded her head, with good eye contact but no verbal response, -The surveyor asked, "Do you want coffee or cocoa?" Resident #4 stated, "Co." 10/22/13 at 11:00 AM, in Resident #4's room: -"Do you have children?" Resident #4 stated, "Yes. Three girls and one boy."</p>	F 154	<p>Center staff was reeducated on or before 11/22/13 to ensure that non-English speaking residents are informed of our interpretative service; The Language Line, and that this service can be used to communicate health related information with residents.</p> <p>Beginning the week of 11/25/13 the Director of Nursing or designee will review 5 charts weekly for 4 weeks and then monthly for 2 months to ensure that non-English speaking residents are offered the Language Line if necessary. Results will be discussed at the monthly PI committee meeting for 3 months. Director of Nursing shall be responsible for compliance.</p>	12/6/13

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F 154	Continued From page 6 -The surveyor pointed at a picture frame with the word, "Grandmother" painted on it, containing a photo of 3 children, and asked, "Do you have grandchildren?" Resident #4 stated, "No." -The surveyor pointed at the concave mattress on Resident #4's bed and stated, "Tell me about your mattress?" Resident #4 stated, "Thank you. What?" The surveyor repeated the question. Resident #4 stated, "Thank you." 10/23/13 at 3:55 PM, in Resident #4's room: -The surveyor asked Resident #4 if she liked her mattress. Resident #4 stated, "No." CNA #7 was present, and translated the question into Spanish. Resident #4 replied to CNA #7, in Spanish. CNA #7 then stated to the surveyor, "It's fine. She didn't understand you. She speaks Spanish." On 10/24/13 at 10:30 AM, while interviewing the RD about weight gain for Resident #4, the RD indicated she had not used a translator to discuss her concerns with Resident #4 directly. The RD was asked how she would access a translator in the facility. The RD stated, "There are language lines, I know. I'm not sure which one we use here." On 10/24/13 at 6:15 PM, the DNS, FI DNS, Administrator, and RDCO were informed of the surveyor's findings. The facility offered no further information. Please see F 309 as it pertains to delay in treatment for this resident, F 325 as it pertains to significant weight gain for this resident, and F 329 as it pertains to unnecessary medications for this resident.	F 154		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F 167		

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F 167	<p>Continued From page 7</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the results of the complaint surveys and plans of correction were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 9 of 9 sample residents (#1 - 9). Findings included:</p> <p>On 10/22/13 at 10:40 AM, a "State Survey Results" binder was located in a plastic pocket on the wall near the nurse's station. Inside the binder were the results from the last 2 annual recertification and re-licensure surveys, and the last 2 fire life safety surveys. However, the results from complaint surveys conducted on 5/30/13 and 7/24/13 were not present.</p> <p>On 10/22/13 at 10:45 AM, the RDCO was asked about the results of the missing complaint surveys. The RDCO stated, "They're not there?"</p> <p>On 10/22/13 at 10:45 AM, the RDCO placed the missing surveys in the binder, and replaced the</p>	F 167	<p>A copy of survey results was placed in results binder on or before 10/28/13 by manager of clinical operations. This binder is prominently displayed in the center's lobby.</p> <p>Residents 1, 3,5,7,9 were informed on or before 12/5/13 of the location of the survey results with no issues noted. Residents 2,4,6,8 families were notified on or before 12/5/13 of the location of the survey binder with no concerns stated at time of notification.</p> <p>On 11/6/13 the center's resident council was informed by center recreational director that survey results were posted in the binder that is located in the center's lobby. There were no concerns from the resident council noted.</p> <p>The Administrator was reeducated by manager of clinical operations on 10/31/13 that results of the most recent survey, which is to include complaint surveys, conducted are to be displayed in the binder located in the center's lobby.</p> <p>Beginning the week of 11/25/13, Director of Nursing or designee will complete weekly audits of binder for survey results for 4 weeks then monthly for 2 months. Results to be reviewed by the PI committee meeting.</p> <p>The Administrator shall be responsible for</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 167	Continued From page 8 binder into the pocket on the wall. On 10/24/13 at 6:15 PM, the Administrator, DNS, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.	F 167	compliance.	
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a referral for home physical therapy and home medical equipment was completed for 1 of 1 closed records (#10) reviewed for discharge planning. The failure created the potential for the resident to not have physical therapy and needed medical equipment in the home. Findings included: Resident #10 was admitted to the facility on 9/18/13 with multiple diagnoses which included personal history of falls and other physical	F 204	<i>Compliance date 12/6/13</i> <i>per phone conversation with Cameron Prescott 12/12/13 @ 12:00 noon</i> <i>N. Souders</i> Resident # 10 discharge from facility on 9/24/13. A review of the last 30 days of discharges was completed by center health information manager on or before 10/29/13 to ensure that there was documented evidence that other residents had been offered home health or durable medical equipment if applicable. No follow up with discharged residents required at time of review. On or before 11/22/13 the social services designee and licensed nurses were educated by center Administrator to make arrangements for and document in the resident's medical record, home health care services and durable medical equipment if so ordered by the discharging physician. Social services designee will bring recapitulation of stay to morning clinical meeting to ensure orders are arranged and/or implemented prior to resident discharge.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 204	<p>Continued From page 9 therapy.</p> <p>The resident was discharged from the facility on 9/24/13.</p> <p>Resident #10's closed medical record included the following physician orders: * 9/18/13 - "PT [physical therapy] Evaluate and treat;" * 9/20/13 - "PT clarification order: ...services 5-6x/wk [times per week] for 30 days...;" and, * 9/23/13 - "Resident ok [sic] to discharge to home with home health PT."</p> <p>Resident #10's "Resident's Recapitulation of Stay Discharge Plan and Instructions," dated 9/24/13, documentation included: * Social Services: "Discharge to: Home;" * Nursing Services: "Physical functioning status: Ambulatory[;] Assistive device(s) needed (specify): walker and wheelchair;" * Rehabilitation Services: Pt [patient] has good strength and activity tolerance but his balance makes him at risk of falling and use of a FWW [front wheeled walker or four wheeled walker] is highly recommended-Pt requires cues to use FWW due to his cognition/memory deficits. Home Health P.T. [physical therapy] is also recommended. Assistive devices: FWW is needed if not already owned by pt." Note: The resident's responsible party signed this form on 9/24/13.</p> <p>Interdisciplinary Progress Notes (IPN), dated 9/18/13-9/24/13, documented Resident #10 eloped twice (9/19/13 at 11:30 p.m. and 9/22/13 at 9:00 a.m.), staff found him on the facility grounds and returned him into the building without incident. The IPN also included:</p>	F 204	<p>Beginning the week of 11/25/13 the Director of Nursing or designee will review 2 new discharged records per week to ensure that residents are assisted with receiving and referrals made for durable medical equipment and home health services post discharge where applicable. The results will be discussed monthly for 3 months at center PI committee meeting. The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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

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F 204	<p>Continued From page 10</p> <p>* 9/23/13 - "Late entry for 9/19/13... admitted for short stay [with] PT ordered. ...very confused but easily redirectable..."</p> <p>* 9/23/13 at 6:35 p.m. - "...continues to work [with] PT. Resident is confused [and] going into other Residents [sic] rooms. Orders to discharge to home [with] Home health PT. Res[ident]...will [at] times forget to use walker..."</p> <p>* 9/24/13 at 2:00 p.m. - "...discharged from facility to home with spouse at side... Residents [sic] exit seeking behaviors discussed with spouse/caregiver, such as safety [sic] and possible safety [sic] plan. Spouse stated she understood and implenting [sic] a safety [sic] plan."</p> <p>On 10/24/13 at 2:05 p.m., the Resident Services Director (RSD) was asked about discharge planning for Resident #10. The RSD stated she was the facility's discharge planner. The RSD stated, however, that she was on vacation during Resident #10's stay in the facility and returned to work on 9/24/13, the date of the resident's discharge. The RSD stated LN #1 completed the discharge for Resident #10. When asked if there was any documentation regarding social services, the RSD stated, "Probably not because I wasn't here." The RSD reviewed Resident #10's closed record and stated, "I didn't see anything [documented] regarding the home health, or which one it would be, or if the information was sent."</p> <p>On 10/24/13 at 2:15 p.m., LN #1 joined the interview with the RSD. When asked to provide documentation regarding a referral, communication, or contact with a home health provider for physical therapy and/or a durable medical equipment provider for a FWW and/or</p>	F 204			

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F 204	Continued From page 11 wheelchair for Resident #10, LN #1 stated the resident's wife had contacted a home health provider and the wife also said they had the necessary equipment. The LN stated, "I didn't document any of that." The LN added that a home health provider had called the facility and she provided them with the necessary information. LN #1 stated, "But I didn't document that either." There was no documented evidence in Resident's 10's closed medical record that his wife had informed the facility she had contacted a home home care provider or already had medical equipment available. In addition, there was no documented evidence in the closed medical record that a home health care provider or durable medical equipment provider was contacted regarding the need for home PT and medical equipment following discharge from the facility. On 10/24/13 at 6:10 p.m., the Administrator, IDON, the previous IDON, and the RMCO were informed of the issue. However, no other information or documentation was received from the facility.	F 204			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241	Resident #2 was assessed by licensed social worker on 10/29/13 for adverse psychosocial affect related to the incident with no adverse findings. Resident assessed on 10/29/13 by Licensed Nurse (LN) for any adverse effects		

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F 241	<p>Continued From page 12</p> <p>Based on observation and record review, it was determined the facility did not ensure assistance at meals was provided in such a way to maintain or enhance each resident's dignity. This was true for 1 of 6 residents (#2) sampled for dignity. The deficient practice had the potential to cause more than minimal psychosocial harm if residents became embarrassed about the manner in which assistance was provided. Findings included:</p> <p>Resident #2 was admitted to the facility on 11/17/06 with multiple diagnoses which included dementia, macular degeneration, and celiac disease.</p> <p>Resident #2's most recent MDS assessment, dated 8/20/13, coded:</p> <ul style="list-style-type: none"> -Unable to complete the BIMS, with no staff assessment of his cognitive abilities. -Totally dependent of 1 for eating. <p>Resident #2's care plan documented, under the Focus area of "Nutrition", the Intervention of, "Adaptive equipment: Plastic tip spoon RNA dining: Cue to take bite, chew, and swallow with meals. (update 4/20/11)"</p> <p>On 10/22/13 at 12:30 PM, Resident #2 was served his meal, which was ground chicken, jello, and pureed peas. CNA #6 was assisting Resident #2 to consume his meal, when food overflowed from Resident #2's mouth onto his chin. CNA #6 took Resident #2's spoon, swiped the excess food (a mixture of ground chicken and pureed peas) from his chin, and placed the mixture back into his mouth, rather than assisting the resident to use a napkin. [Please see F 309 as it pertains to following the care plan for meals.]</p> <p>On 10/24/14 at 6:15 PM, the Administrator, FIDON, RDCO, and IDON were informed of the surveyors's observations. The facility offered no further information.</p>	F 241	<p>with none noted.</p> <p>A visual observation was completed by center staff on or before 11/13/13 in resident rooms and dining room to ensure no other residents were being affected. No negative findings were observed.</p> <p>The center staff including CNA # 6, was reeducated by the Administrator on or before 11/22/13 to ensure residents are assisted with dining according to their own pace and their dignity is preserved with hygiene assistance. On or before 11/15/13 members of the IDT were assigned a routine schedule by the center administrator for dining room supervision to ensure dignity issues are followed up on.</p> <p>Beginning the week of 11/25/13, 3 meals per week will be observed by Director of Nursing or designee for 4 weeks and then monthly for 2 to ensure residents are being assisted with dining at a safe pace and hygiene assistance is in place. Results will be discussed at centers PI committee for 3 months.</p> <p>The Director of Nursing shall responsible for compliance.</p>	12/6/13

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F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to ensure appropriate positioning and call light access to accommodate the needs for 2 of 9 sample residents (#'s 3 and 9). The deficient practice had the potential to cause more than minimal harm when Resident #9 was positioned at meals so that her ability to feed herself had the potential to cause a decrease in meal intake and/or embarrassment. Resident #3 had the potential for more than minimal harm when she could not access her call light to get the attention she needed. Findings included:</p> <p>1) Resident #9 was admitted to the facility on 7/11/2013 diagnoses included: dementia, morbid obesity, peripheral neuropathy, osteoarthritis, muscle weakness (generalized), muscular wasting and disuse atrophy.</p> <p>*A Significant Change MDS dated 8/12/2013 documented: -BIMS score of 13 (indicating mild cognitive impairment) -Bed Mobility: total dependence- 2+ persons physical assist</p>	F 246	<p>On 10/29/13, resident #9 was demonstrated to and accepted use of bedside table by LN to assist with easy accessibility of items during dining with use of bedside table, until a therapy evaluation could be completed. An order was obtained for a therapy evaluation on 10/30/13 for resident # 9 and the evaluation was completed on 10/31/13. The therapist evaluated resident #9's wheelchair positioning and her ability for self-dining while in bed. The therapy interventions were put into place and the resident's plan of care was updated on 11/18/13 by the director of nursing. Resident evaluated on or before 11/27/13 by LN for any adverse effects related to not being able to reach her call light, with none noted. CNA #5 was educated by Administrator on or before 12/5/13 regarding leaning comment. The Hoyer lift was removed out of resident # 3's room on or before 10/28/13 by center maintenance director. Resident #3 was evaluated by LN on 11/25/13 for Hoyer being stored in room. No adverse effects were noted from the call light being out of reach.</p> <p>A review of the dining room was conducted on 10/29/13 by the Interdisciplinary Team (IDT) to ensure residents that can dine independently and were able to reach their dishes and utensils.</p>	

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F 246	<p>Continued From page 14</p> <p>-Eating: Supervision-oversight, encouragement or cueing- set up help only</p> <p>-Functional Limitation in Range of Motion: A. upper extremity- impairment on both sides. B. lower extremity- impairment on both sides.</p> <p>Resident #9's care plan documented in the area for Potential for skin breakdown related to immobility, an intervention of "Use positioning devices as ordered," was dated as initiated 7/11/13. In the area of Pain / Potential for pain an intervention of "position pillows as needed for comfort," was dated as initiated on 7/11/13. NOTE: Resident # 9's care plan did not address how the facility was going to accommodate the resident's need for positioning while eating in bed or up to the dining table in her wheel chair.</p> <p>On 10/22/13 at 12:35 PM Resident #9 was observed to be in the dining room in her wheelchair eating lunch. Her wheelchair was positioned at the corner of the table. The right side of her body was closest to the table and she was leaning to the right. Both legs were in an extended upright position. She had her plate in the left hand with decreased mobility of this extremity, and fork in the right hand. Resident #9 was attempting to put what appeared to be chicken in her mouth. She dropped several pieces of it on her clothing protector. She then put the plate on the corner edge of the table and began eating from it with the fingers of her right hand. The resident was noted to call out for someone to move her cake close enough so she could reach it. A dietary aide moved the small bowl closer. The resident then moved the small bowl closer to herself by placing the tongs of the fork in the edge of the bowl, pulling it to the edge of the table. She then picked it up with the right</p>	F 246	<p>Residents who dine in the in rooms were observed by the IDT on or before 10/29/13 for proper positioning and the ability to self-dine.</p> <p>A review of resident rooms was also completed on 10/28/13 by the IDT to ensure that call lights were accessible and no Hoyer lifts were stored in rooms.</p> <p>The center staff was educated on or before 11/22/13 by Administrator to ensure that residents were able to reach their call lights and bed controls, and that Hoyer lifts were not stored in resident rooms. Staff were also educated regarding positioning and the residents' ability to reach their dishes and if any difficulty was noted to inform a licensed nurse or therapy services. Center administrator and director of nursing will round on units five times weekly to ensure accommodation of needs issues are followed up on and that equipment is not being stored in resident rooms. Members of the IDT were assigned resident rooms on or before 11/22/13 by center administrator for scheduled reviews to assist with rounding and ensuring accommodations are met.</p> <p>Beginning the week of 11/25/13 the Director of Nursing or designee will observe 3 meals weekly for 4 weeks and then monthly for 2 months to ensure residents are positioned and able to reach their dishes on the table.</p>		

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F 246	<p>Continued From page 15</p> <p>hand, placed it in her left hand and began eating.</p> <p>On 10/23/13 at 08:25 AM Resident #9 was observed eating her breakfast in bed. The resident's bedside table was across the bed, head of her bed was up, she was leaning towards the right. Her plate was in her left hand and she had her fork in the right hand. She jabbed at her food several times, dropping it on her self. The resident was noted to have eggs on her fingers and her clothes. When the resident was asked if she had troubles with eating she stated, "Yes." When asked if the facility had tried anything different for her she stated, "No they just bring it in here and leave." When asked if she can position herself in bed she stated she couldn't really move her legs, but she was able to use the control to position her head. The bed control was found to be under the bedside table and the resident was unable to reach it. CNA#5 was observed to come in and check on the resident. The CNA stated, "Looks like you are the leaning tower of Pisa this morning."</p> <p>On 10/23/13 at 08:53 AM during an interview with CNA #5, when asked about positioning of the resident she stated, "She has this problem of leaning." When asked how they accommodated this, the CNA stated, they leave her in bed in the morning because she has a lot of pain, mid-morning they get her up and bring her down to the dining room. When asked if the resident could reposition herself, the CNA stated, she is able to, that is why they leave her bed control, and water pitcher on the table where she can reach it.</p> <p>On 10/24/13 at 3:45 PM while surveyor was interviewing Resident #9 about her difficulty with</p>	F 246	<p>be conducted by center maintenance director or designee 3 times weekly and then monthly for 2 months to ensure call lights and bed controls are accessible and Hoyer lifts are not stored in resident rooms. The results will be discussed at center PI committee meeting for 3 months. The Director of Nursing shall be responsible for compliance.</p>	12/6/13	

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F 246	Continued From page 16 positioning for meals she agreed with the observations made by surveyors. On 10/24/13 at 6:15 PM the Administrator, IDON, FIDON, RDCO, were informed of the surveyor's findings. The facility offered no further information. 2. On 10/22/13 at 8:48 AM, and again on 10/23/13 at 10:50 AM, the Hoyer lift was observed to be stored in Resident #3's room. The base of the Hoyer was under Resident #3's bed, roughly midway between the head and the foot of the bed, with the Hoyer frame snug against the mattress of the bed. Resident #3 was sitting in her wheelchair towards the foot of the bed. Resident #3's call light was laying on the mattress of her bed, with access to the call light blocked by the frame of the Hoyer. Even if Resident #3 were able to move her wheelchair in closer proximity to the bed, the Hoyer frame would have prohibited her from accessing her call light. On 10/25/13 at 9:45 AM, the Administrator was informed of the surveyor's findings. The facility offered no further information.	F 246			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 250	A Spanish speaking staff member informed resident # 4 on or before 11/5/13, of a care conference that was being scheduled to inform her of her current health status in a language that she could understand. On 11/6/13 an RN who speaks Spanish informed resident # 4 of her current health		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 250	Continued From page 17 Based on observation, staff interview, and record review, it was determined the facility failed to provide medically related social services. This was true for 2 of 6 residents (#s 4 and 6) sampled for social services. The deficient practice had the potential to cause more than minimal harm when residents did not receive assistance to access interpreter services, assistance with arrangements to replace eyeglasses, or assistance with legal matters after a resident's guardian became deceased. Findings included: 1. a. Resident #4 was admitted to the facility on 9/19/12 with multiple diagnoses including recurrent persistent hypoglycemia, brittle diabetes mellitus, failure to thrive, hyperlipidemia, severe dementia, chronic anemia, mild hyponatremia, and chronic protein calorie malnutrition (PCM). Resident #4's Annual MDS assessment, dated 9/27/13, coded: -Wants or needs a translator to talk with health care professionals. -Preferred language is Spanish. On 10/21/13 at 9:40 AM, during the initial tour of the facility with the SDC and IDON, the SDC stated Resident #4 did not speak English, but only spoke Spanish. The SDC stated Resident #4, "seems to understand English, we're just not sure how much." The SDC was asked about translator services for Resident #4. The SDC stated, "We have a couple of staff members who speak Spanish. We can use them if we need to." The SDC was asked about translation when the staff members were not available. The DNS stated she had just learned the facility had access to a translator telephone line, but the staff were unaware of it so she would have to train them.	F 250	status. A call was also placed to the family to participate in a care conference. Daughter spoke with SSD on or before 11/25/13 and was updated regarding her health status. Daughter will attend care conference in person or via phone at earliest availability to daughter. An appointment for eye glasses made by center transportation and appointment held on 11/22/13 and follow up completed as indicated. The social services designee contacted adult protection services and the state ombudsman regarding resident # 6 on 11/2/13. A hearing date was originally set for 11/13/13 and rescheduled by the court for 1/14/14. Until the hearing occurs, the center will follow the Idaho guide to healthcare decision making as outlined in state statute. A review of resident #6's medical record was conducted with the identified resident representative on or before 11/22/13. <i>Correction of court date 1/14/14</i> A review of other residents with inadequate vision and no use of glasses per most recent MDS were completed by social services designee on or before 11/15/13. Arrangements were made for glasses if residents wished. Care plans were updated where applicable. A review of other residents residing in the facility was conducted by the social services designee on or before 11/8/13 to ensure		

*per phone conversation
c Cameron Prescott
12/12/13 @ 12:00 noon
[Signature]*

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 18</p> <p>On 10/24/13 at 10:30 AM, while interviewing the RD about weight gain for Resident #4, the RD indicated she had not used a translator to discuss her concerns with Resident #4 directly. The RD was asked how she would access a translator in the facility. The RD stated, "There are language lines, I know. I'm not sure which one we use here."</p> <p>On 10/24/13 at 6:15 PM, the IDON, FIDON, Administrator, and RDCO were informed of the surveyor's findings. The facility offered no further information.</p> <p>Please see F 325 as it pertains to significant weight gain; F 309 as it pertains to delay in treatment, and F 329 as it pertains to the use of anti-psychotic medications.</p> <p>b. Resident # 4's MD progress notes, dated 10/4/12, documented, "...complaints: 'I lost my glasses.'...Recommendations...Find eye glasses or have [patient] seen by optometrist for new pair of eye glasses."</p> <p>The surveyors observed Resident #4 without eyeglasses on the following occasions: -10/21/13 at 2:15 PM. -10/22/13 between 7:40 AM and 8:15 AM. -10/22/13 at 11:00 AM. -10/22/13 at 12:22 PM. -10/23/13 at 3:55 PM. -10/24/13 at 7:35 AM.</p> <p>On 10/24/13 at 12:52 PM, the FIDON was asked if Resident #4's eyeglasses had been found, or if they had to be replaced. The FIDON stated, "I'm not sure. I don't know that I have ever seen her</p>	F 250	<p>other residents adjudicated incompetent have either guardianship or power of attorney for healthcare decision making representation in place.</p> <p>Education was provided to the social services designee by the center Administrator on or before 11/15/13 to assist residents with guardianship or durable healthcare power of attorney if they have been deemed adjudicated. Education was also provided to the social services designed by the Administrator on the Idaho state statute to healthcare decision making on or before 11/15/13.</p> <p>The Center staff were reeducated by the Administrator on or before 11/22/13 if a resident has inadequate vision and glasses are not used or need repaired, to inform social services for follow up as indicated by resident.</p> <p>Beginning the week of 11/25/13 a review of 3 charts weekly for 4 weeks then monthly for 2 months will be reviewed to ensure that adjudicated residents have a guardianship or power of attorney for healthcare decision making in place. The Director of Nursing or designee will also review beginning the week of 11/25/13 3 charts weekly for 4 weeks and then monthly for 2 months to ensure residents found to have inadequate vision without the use of glasses are referred</p>		

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

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OMB NO. 0938-0391

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F 250	<p>Continued From page 19 with glasses. You'll have to ask [the RSS.]"</p> <p>On 10/25/13 at 10:05 AM, the RSS was asked about arranging for replacement eyeglasses for Resident #4. The RSS stated, "Nursing does that." The RSS was asked if helping to arrange that would be something she would do. The RSS stated, "I guess. If I know they're needed. But I didn't know she needed them."</p> <p>On 10/25/13 at 1:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.</p> <p>2. Resident #6 was originally admitted to the facility on 1/17/12, and re-admitted on 6/18/13, with multiple diagnoses which included cri-du-chat syndrome with severe developmental delay, and expressive language disorder.</p> <p>Resident #6's record contained a court document, dated 6/2/1982, which stated Resident #6 had been determined incapacitated and unable to either care for herself or make decisions for herself, related to her above diagnoses. The document named [Person #1] as Resident #6's legal guardian.</p> <p>Resident #6's record contained an H&P document, dated 4/22/13 (approximately 2 months before her admission to the facility) which documented, in part, "...Her legal guardian is deceased and that responsibility has been taken over by [Person #2]...Patient's service coordinator is [Person #3]."</p> <p>On 10/23/13 at 7:45 AM, the surveyor asked the Administrator about legal representation for</p>	F 250	<p>to social services for follow up. Results to be discussed monthly at the PI committee meeting for 3 months.</p> <p>The Director of Nursing shall be responsible for compliance.</p>	12/6/13	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 250	Continued From page 20 Resident #6. The Administrator was not sure who Resident #6's legal representative was. The Administrator was asked if Resident #6's Guardian ad Litem [attorney designated by the court to be an advocate for Resident #6's legal needs] had ever been informed her guardian had passed away, so the court could be petitioned for a new guardian. The Administrator stated he did not know, but that should be documented in the social services notes. The surveyor informed the Administrator that information had not been found in the social services notes.	F 250			
F 252 SS=E	On 10/24/13 at 6:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information. Please see F 152 as it pertains to the facility ensuring legally appointed representatives make decisions for residents. 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility did not ensure a clean, comfortable and homelike environment for the residents. This was true for 2 of 2 Hoyer lifts and affected 3 of 9 sampled residents (#3, #6, #9)	F 252	Resident numbers 3 and 6 were evaluated by LN on 11/25/13 for any adverse psychosocial effects related to not reaching her call light with none noted. Resident #9 was evaluated by LN on or before 11/27/13 for Hoyer being stored in room. No adverse effects were noted. The oxygen concentrator was removed from under the fire extinguisher on 10/28/13 by		

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

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OMB NO. 0938-0391

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F 252	<p>Continued From page 21</p> <p>residents residing in room #'s 14 and 15, and any resident needing to access the handrail or staff needing to access the fire extinguisher at the end of B Wing. The deficient practice had the potential for more than minimal harm when residents were unable to reach their call lights or having visits interrupted from medical equipment being stored in their rooms. There was also potential for harm when handrails and fire extinguishers were not accessible. Findings included:</p> <p>1 a. On 10/21/13 at 10:30 AM on Initial Tour of the facility the surveyors observed a Hoyer lift to be stored in Room #15. Resident in this room, when asked if she used the Hoyer, stated, "They just park it here."</p> <p>b. On 10/21/13 between 2:07 PM and 2:35 PM the Hoyer lift was observed by surveyors to be stored in Room #14. It was stored under/over one of the beds in the room. The Resident was not in the bed.</p> <p>c. On 10/22/13 at 7:45 AM and again at 08:45 AM the Hoyer lift was observed by surveyors to be stored in Room #23. It was stored under/over the Resident's #3 bed. The Resident #3 was not in the bed.</p> <p>d. On 10/22/13 at 08:48 AM the Hoyer lift was observed by surveyors to be stored under/over Resident #6's bed in Room #23. At this time Resident #6 was brought back in to the room. The CNA moved the Hoyer lift from Resident #6's bed and stored it under/over Resident # 3's bed. Resident #3 was in the room at this time.</p> <p>NOTE: The Hoyer lift was now stored under/over</p>	F 252	<p>maintenance director.</p> <p>The Hoyers were removed from rooms 14 and 15 by center staff on or before 10/28/13.</p> <p>Facility rounds were conducted by center maintenance director on 10/29/13 to ensure nothing is stored below fire extinguishers.</p> <p>The center staff was educated by the Administrator on or before 11/22/13 regarding Hoyer lifts not being stored in resident rooms or concentrators below fire extinguishers. The center administrator and director of nursing to round units and review findings in the morning management meeting. Ongoing education with staff as indicated through rounds.</p> <p>Beginning the week of 11/25/13 center rounds will be conducted 3 times weekly for 4 weeks and monthly for 2 months to ensure that Hoyer lifts are not stored in resident rooms or concentrators stored below fire extinguishers. Results will be discussed at center PI committee meeting for 3 months. The Director of Maintenance shall be responsible for compliance.</p>	12/6/13

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

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OMB NO. 0938-0391

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F 252	<p>Continued From page 22</p> <p>Resident #3's bed, with her call light on the bed within the Hoyer frame. Resident #3 was unable to access her call light or get to her bed. Please refer to F246 as it pertains to call light accessibility.</p> <p>e. On 10/23/13 at 08:50 AM the Hoyer lift was observed by surveyors to be stored in Room #14. It was stored under/over the Resident's bed.</p> <p>f. On 10/23/13 at 10:50 AM and again at 12:05 PM, the Hoyer lift was observed by surveyors to be stored in Room #23. It was stored under/over Resident #3's bed. Resident #3 was not in the room. The Hoyer lift's frame was blocking access to the call light on the bed should she enter the room and need it.</p> <p>g. On 10/24/13 at 3:45 PM the Hoyer lift was observed by surveyors to be stored under/over a bed in room #9. Resident #9 was in the second bed in this room and surveyors were conducting a Resident Interview with the Resident. CNA #7 knocked, entered the room and apologized for the interruption but stated "I need to get the Hoyer to transfer another resident."</p> <p>On 10/23/13 at 2:20 PM CNA #7 was asked by the surveyor where the Hoyer lifts were stored. She stated they were put in empty rooms, or in a resident room. They were put up against the bed with the legs under the bed.</p> <p>2. On 10/21/13 at 2:05 PM during Initial Tour of the facility, the surveyors observed two oxygen concentrators to be stored at the end of B Wing hall by the exit door. They were positioned in front of the Fire Extinguisher, along the wall below the hand rail. Access to the fire extinguisher and</p>	F 252			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 252	Continued From page 23 this portion of the hand rail was obstructed by the 2 oxygen concentrators. On 10/23/13 between 8:50 AM and 2:45 PM surveyors observed the 2 oxygen concentrators remained stored in B Wing hall, with position unchanged. On 10/24/13 at 4:25 PM surveyors observed the 2 oxygen concentrators remained stored at the end of B Wing hall, with position unchanged. On 10/25/13 at 9:20 AM during the facility Environmental Observation, the Administrator was notified by the surveyor of the oxygen concentrators being stored at the end of B Wing hall, and the Hoyer lift storage observations through out the survey. The facility provided no further information.	F 252			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272	Resident # 3 restrictive device evaluation was completed by the Director of Nursing on 10/29/13 for the use of a pommel cushion with no signs or symptoms of pain. The device was evaluated as safe for resident use. The resident's perineal area evaluated by a LN on or before 11/20/13 with no adverse findings noted. A review of other residents utilizing assistive devices was completed by the Director of Nursing on or before 11/29/13 to ensure		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 24</p> <p>Psychosocial well-being; Physical functioning and structural problems; Continenence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a Pommel cushion in a wheelchair was assessed to determine if a resident was safe with use of the cushion. This was true for 1 of 1 sample residents (#3) reviewed for restraints. The failure created the potential for skin breakdown in the resident's perineal area; and, for injury, should the resident attempt to go over the Pommel cushion in an effort to get out of the wheelchair. Findings included:</p> <p>Resident #3 was admitted to the facility on 4/12/07, and readmitted on 1/8/13, with multiple diagnoses which included, hemiplegia affecting</p>	F 272	<p>device evaluation are evaluated for safety. No corrections needed at time of review.</p> <p>The center staff was reeducated by Administrator on or before 11/22/13 to assess residents for safe use of assistive devices as they may be restrictive to resident movement. Director of nursing will bring new physician orders for assistive devices to morning clinical meeting for follow up as indicated by order.</p> <p>Beginning the week of 11/25/13 the Director of Nursing or designee will review 3 charts weekly and then monthly for 2 months to ensure that assistive devices which may be restrictive are assessed for safety and use. The results will be discussed at center PI committee meeting monthly for 3 months. The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 25</p> <p>the non-dominant side related to a stroke (CVA or cerebrovascular accident), unspecified late effects of cerebrovascular disease, and muscular wasting and disuse atrophy (not elsewhere classified).</p> <p>The resident's most recent quarterly MDS assessment, dated 9/1/13 coded, in part:</p> <ul style="list-style-type: none"> * Intact cognition with a BIMS score of 13; * Total assistance of 2 or more persons for transfers; * Extensive assistance of 1 person for ambulation on and off the unit; * Functional limitation in range of motion in 1 upper and 1 lower extremity; * Wheelchair (w/c) use; and, * No restraints. <p>Resident #3's care plan identified "self care deficit" as a focus area in 2009. One intervention for this focus area included the undated handwritten entry, "Pummel [sic] cushion."</p> <p>A Pommel cushion was observed in Resident #3's w/c as follows:</p> <ul style="list-style-type: none"> * 10/21/13 at 2:05 p.m. - the resident slept on the bed and the w/c was next to the bed; * 10/22/13 at 8:15 a.m. - the resident was seated in the w/c during breakfast in the Low-Stim (stimulation) dining room; * 10/22/13 at 9:00 a.m. - during and after CNAs #5 and #6 used a mechanical lift to transfer the resident from the w/c to the bed; * 10/22/13 at 10:45 a.m. - the resident was in the w/c at a table in the main dining room; * 10/22/13 at 12:00 p.m. - the resident was seated in the w/c during the lunch meal in the Low-Stim dining room; * 10/23/13 at 8:40 a.m. - the resident was seated 	F 272			

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

PRINTED: 11/14/2013
FORM APPROVED
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F 272	Continued From page 26 in the w/c during breakfast in the Low-Stim (stimulation) dining room; and, * 10/23/13 at 9:25 a.m. - the resident was awake on the bed, the w/c was next to the bed. Per review of Resident #3's clinical record, an assessment to determine if the resident was safe with the use of the Pommel cushion was not found in the clinical record. On 10/24/13 at 9:30 a.m., the IDON and the RMCO were asked if Resident #3 was assessed to determine if she was safe with the use of the Pommel cushion in her w/c. The RMCO reviewed the resident's clinical record then stated, "I don't see it. I cannot find anything, no." The FIDON joined the interview at 9:45 a.m. The FIDON stated physical therapy added the Pommel cushion "around 8/6/13." The FIDON also reviewed the resident's clinical record and stated that a safety assessment was not completed by the physical therapist either. The RMCO said she would continue to look for a safety assessment. However, no other information or documentation was received from the facility.	F 272			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	Resident #1's plan of care was updated on or before 11/1/13 by Director of Nursing to reflect where the resident eats her meals as indicated by resident's personal preference. Resident # 3's plan of care was updated on		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 27</p> <p>physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility did not ensure resident care plans were periodically reviewed and revised. This was true for 2 of 9 sample residents (#s 1 and 3). The deficient practice created the potential for more than minimal harm when Resident #1's care plan did not include her preference to eat in her room and when Resident #3's care plan for bed mobility did not reflect the resident's current status to ensure the appropriate provision of care. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/21/12, and readmitted on 1/31/13, with multiple diagnoses which included multiple pressure ulcers; diabetic with ophthalmic manifestation type 1 (juvenile type) uncontrolled; left below the knee amputation; bipolar disorder; and dementia with behavioral disturbances.</p> <p>Resident #1's Care Plan focus areas included potential alteration in nutrition. Interventions included, "Meals in the Dining Room," reviewed 5/28/13.</p>	F 280	<p>or before 11/25/13 by Director of Nursing to reflect the date of the pommel cushion and current status of bed mobility of 2 person assist. Resident # 3 was also assessed by manager of clinical operations, RN (MCO) on 11/11/13 for any adverse effects related to assistance of one with bed mobility and none were noted.</p> <p>A review of other residents care plans was conducted by the MDS coordinator (a RN) on 10/31/13 to ensure dates were present for new intervention, bed mobility interventions are correct; where residents dine are reflective of current status.</p> <p>The nursing staff and department managers were reeducated by the Administrator on or before 11/22/13 regarding updating care plans to reflect resident's current health status and individual dining choices as well as dating newly added interventions. Care plans will be reviewed by IDT in morning clinical meeting to ensure updated for changes of condition and resident wishes and each quarter with the assistance of resident and family at quarterly care conference.</p> <p>Beginning the week of 11/25/13 the Director of Nursing or designee will review 5 care plans weekly for 4 weeks and then monthly for 2 months to ensure updates are dated and care plans are reflective of the resident's current status. Results will be discussed at</p>

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

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OMB NO. 0938-0391

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F 280	Continued From page 28 The resident was observed eating meals in her room on 10/22/13 at 8:40 a.m. while in bed with the meal tray in front of her on the over bed table; and, on 10/22/13 at 12:20 p.m., while in her room in her wheelchair with the meal tray in front of her on the over bed table. During an interview on 10/22/13 at 12:05 p.m., Resident #1 stated, "I always eat in my room." On 10/24/13 at 8:30 a.m., the RMCO and IDON were asked about Resident #1's care plan for meals in the dining room. When informed of the observations of the resident eating in her room, the RMCO indicated she did not know where the resident was supposed to eat. The RMCO said she would ask the Registered Dietician where the resident was to eat her meals. On 10/24/13 at about 6:15 p.m., the Administrator, IDON, previous IDON, and RMCO were informed of the care plan issue. On 10/25/13 at about 3:40 p.m., the RMCO provided a revised nutrition care plan for Resident #1 which read, "Resident prefers to eat meals in room." No other information/documentation was received from the facility which resolved the issue. 2. Resident #3 was admitted to the facility on 4/12/07, and readmitted on 1/8/13, with multiple diagnoses which included, hemiplegia affecting the non-dominant side related to a stroke (CVA or cerebrovascular accident), unspecified late effects of cerebrovascular disease, and muscular wasting and disuse atrophy (not elsewhere	F 280	center PI committee meeting for 3 months. The Director of Nursing shall be responsible for compliance.	12/6/13	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 29 classified).</p> <p>The resident's most recent quarterly MDS, dated 9/1/13, coded, in part: * Intact cognition with a BIMS score of 13; and, * Extensive assistance of 2 or more people for bed mobility.</p> <p>One of Resident #3's Care Plan focus areas included risk for self care deficit. Associated interventions included, "Pummel [sic] cushion [no initiation date]" and "[R]equires extensive assist of 1-2 for bed mobility [initiated 8/12/09]." Both were last reviewed 7/24/13.</p> <p>a) A Pommel cushion was observed in Resident #3's wheelchair 7 times during the survey week. (Please refer to F272, Comprehensive Assessments, for the details.)</p> <p>b) On 10/23/13 at about 9:30 a.m., LN #4 informed a surveyor she was going to perform an intermittent catheterization for Resident #3. On the way to the resident's room, the LN asked 2 surveyors if they could assist. When informed no, the LN proceeded with the catheterization without any staff assistance. After the catheterization and without any assistance, LN #4 turned the resident all the way onto her right side. This caused the resident's head and upper torso to be at the very edge of the bed with her left arm over the side of the bed. The LN continued to work alone to change the resident's incontinence brief; then, the LN quickly turned the resident over onto her left side. With the sudden turn to the left, the resident's right leg lifted and her right foot bumped an uncovered container with 425 cc (cubic centimeters) of urine in it that was on the over bed table next to the bed. Urine spilled on</p>	F 280		

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

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F 280	Continued From page 30 the over bed table and onto the floor below (Note: Refer to F441, Infection Control, for more details). Only after that, did the LN use the call light to summons assistance. CNA #6 arrived moments later and assisted the LN to complete the incontinence brief change and to reposition the resident on the bed. On 10/24/13 at 9:30 a.m., the RMCO and the IDON were asked about Resident #3's care plan for the Pommel cushion and bed mobility. At about 9:45 a.m., the FIDON joined the interview. The MCO, IDON, and the FIDON acknowledged the initiation date for the Pommel cushion was not documented and agreed the date should have been included. Regarding bed mobility, the MCO provided the resident's October 2013 ADL Record. The ADL Record documented total dependence of two or more person physical assistance was provided on all shifts from 10/1/13 through the 11-7 shift on 10/24/13. The RMCO stated the bed mobility care plan should have been revised to reflect the resident's current need for assistance by 2 or more people. While LN #4 did follow the care plan that was in place regarding Resident #3's bed mobility, the care plan had not been revised to reflect the resident's current need for assistance by 2 or more people and this resulted in the provision of inadequate assistance as noted above. On 10/24/13 at 6:10 p.m., the Administrator was also informed of the issue. However, no other information/documentation was received from the facility which resolved the issue.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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

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F 281	Continued From page 31 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident interviews, it was determined the facility failed to ensure professional standards of quality were maintained. This was true for 2 of 4 Licensed Nurses (LN #s 2 and 3) and it affected 2 of 10 residents (#s 2 and 11) observed during medication passes and/or blood glucose testing. These failures created the potential for more than minimal harm should Resident #2 not actually receive his antiulcer, non-steroidal, and 2 laxative medications; and, increased tenderness and discomfort when a finger stick was done in the center of Resident #11's fingertip. Findings included: 1. On 10/22/13 at 4:10 p.m., LN #2 was observed as she performed a blood glucose (BG) check for Resident #11. When informed it was time for the BG check, the resident held up his left index finger and the LN stuck the center of that finger tip to obtain a drop of blood for the BG check. Immediately afterward, when asked about the finger stick in the center of Resident #11's finger tip, LN #2 stated, "He prefers it. You get a better drop of blood because frequently there's not much blood when you stick the side of the finger." On 10/22/13 at 4:15 p.m., when asked where he preferred finger sticks to be done, Resident #11 stated, "It don't matter." Then, he held up his right hand, pointed to his right fingers with his left	F 281	Resident # 11 was evaluated for pain by LN related to the finger stick being performed in center of fingertip per resident's choice with no adverse effects stated by resident. The care plan for resident # 11 was updated as to their preference. Resident #2 was evaluated by a licensed nurse on 11/18/13 for any negative outcome related to the nurse pre-signing medication administration record. There were no adverse findings identified. LN #3 was educated by Administrator or designee on or before 11/22/13 on nursing practice of initialing medications after the resident has accepted them. Medication pass competencies were completed by the Director of Nursing or designee on or before 11/26/13 for finger sticks and medication administration to ensure standards of practice were followed. No corrections required at time of review. The licensed nurses were reeducated on finger stick procedure and "5 Rights" of medication administration on or before 11/22/13 by Director of Nursing or designee. Beginning the week of 11/25/13 the Director of Nursing or designee will conduct 3 competencies weekly on finger stick	

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

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F 281	<p>Continued From page 32 index finger, and said, "Not as bad there."</p> <p>Note: Clinical Nursing Skills, 7th edition, 2010, by Perry and Potter, pages 1155 and 1156, stated, in part, "... Choose puncture site. Puncture site should be vascular. In adult, select lateral side of finger; be sure to avoid central tip of finger, which has more dense nerve supply. ..."</p> <p>On 10/25/13 at 1:15 p.m., the Administrator, IDON, RMCO, and Regional Vice President were informed an LN stuck the center of a resident's finger to obtain blood for a BG check.</p> <p>No other information/documentation was received from the facility which resolved the issue.</p> <p>2. On 10/24/13 at 7:50 a.m., LN #3 was observed as she poured omeprazole (antiulcer), acetaminophen, aspirin (non-steroid), Senna and Enulose (both laxatives), then administered the 5 medications to Resident #2. Upon return to the medication cart, LN initialed only the acetaminophen; however, the other 4 medications were already initialed for that date and time. When asked about the LN's initials already in place for 4 of the 5 medications, LN #3 stated, "I initialed them as you walked up [to the medication cart]."</p> <p>Note: The Bureau of Facility Standards Information Letter #97-3, dated 4/16/97 stated, "...Long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually had taken the medication. ... The Board's [of Nursing] expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what</p>	F 281	<p>procedure and medication administration for 4 weeks and then monthly for 2 months. Results will be discussed at center PI committee meeting for 3 months. The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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

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F 281	Continued From page 33 they intend to do."	F 281			
F 309 SS=G	On 10/25/13 at 1:15 p.m., the Administrator, IDON, RMCO, and Regional Vice President were informed that an LN had pre-initialed medications before she administered them. No other information/documentation was received from the facility which resolved the issue. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not thoroughly assess a resident's changing status, notify the physician so a diagnostic work-up could be done and treatment started, or consistently follow residents' care plans. This deficient practice was true for 3 of 9 residents (#s 2, 3, and 4) sampled for quality of care. Resident #4 was harmed when her physician was not notified of her shortness of breath for a period of 6 days, resulting in a delay of treatment. When the physician was finally notified and diagnostic work-up done, Resident #4 was found to be profoundly anemic and in congestive heart failure, requiring a blood transfusion and new	F 309	Resident #4 was assessed by the MD on or before 10/28/13 with new orders received and followed through with no signs or symptoms of acute distress noted at this time. Plan of care was updated by LN on or before 11/22/13 and resident and family informed. Resident was also assessed by LN on or before 11/27/13 related to not transferring according to plan of care without any negative affects noted. Resident #2 received a speech therapy evaluation on or before 10/28/13 with changes made to liquids and equipment use. Resident's respiratory status was assessed by manager of clinical operations on 10/29/13 with no adverse findings at time of		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 34</p> <p>medications. Resident #s 2, 3, and 4 had the potential for more than minimal harm when they did not receive assistance consistent with their plans of care. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 9/19/12 with multiple diagnoses including recurrent persistent hypoglycemia, brittle diabetes mellitus, failure to thrive, hyperlipidemia, severe dementia, chronic anemia, mild hyponatremia, and chronic protein calorie malnutrition.</p> <p>*The Annual MDS assessment dated 9/27/13 documented: -Wants or needs a translator to talk with health care professionals. -Preferred language is Spanish. -Unable to complete the BIMS, assessed by staff with long term and short term memory deficits, rarely or never makes daily decisions. [NOTE: It was determined the facility did not engage a translator for Resident #4's assessments. Please refer to F 154.] -Extensive assist of 2 for transfers. -No shortness of breath.</p> <p>Resident #4's care plan documented: -Under the focus area of "Nutrition", the intervention of, "Observe and report edema." Date Initiated 9/20/12. -Under the focus area of "Risk for Falls", the intervention, "Assist resident getting in and out of bed with 2 assistance using a FWW [front wheeled walked] or [wheelchair] and gait belt." Date initiated 9/19/12. -Under the focus area of "Hydration", the intervention of, "Obtain lab work as per orders. Notify MD of abnormal values."</p>	F 309	<p>assessment.</p> <p>Resident # 3 was evaluated by a licensed nurse on 11/11/13 for not using 2 persons for bed mobility, peri care, and for heels touching bed during an earlier observation without any adverse findings noted. Heels remain intact. No edema noted at time of assessment. Care plan reviewed and updated on or before 11/25/13.</p> <p>A review of other residents residing in the facility were reviewed by manager of clinical operations on 11/8/13 for any noted edema, weight gain, signs or symptoms of respiratory changes, heels floated without touching bed and bed mobility and wheelchairs locked during transfers being assisted per care plan. No corrections were required at time of review.</p> <p>Center staff re-educated by facility Administrator on or before 11/22/13 to ensure that care is being provided per care plan and when floating heels they are not to touch the bed, in addition to promptly notifying MD if a resident shows signs and symptoms of respiratory distress, noted edema, and weight gain. Also to lock wheel chair brakes even if anti-roll backs in place. Director of nursing will bring 24 hour report and physician orders to the clinical meeting to review for clinical changes as well as receiving report from licensed staff on any</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 35</p> <p>a. Resident #4's Physician's Progress Notes documented: -10/16/13. "[Right] upper forehead scrape from scratching - BGs better last [illegible] 89-241 - [weight] up 198 [to] 203 [pounds]." There was no assessment from the physician regarding the root cause of this weight gain. There was no documentation the physician had assessed for edema, listened to the resident's lungs, or obtained her oxygen saturations. There was no new lab work ordered after this visit. See F 325 related to significant weight gain.</p> <p>Resident #4's Nurse's Progress Notes documented: -10/17/13 at 7:00 PM, "Resident having increased restlessness [with] rapid breathing noted and jitteriness when verbally speaking..." -10/17/13 at 8:15 PM, "...labored breathing." There was no documentation of any further assessment regarding Resident #4's rapid or labored breathing, such as listening to her lungs, obtaining oxygen saturations, or assessing for possible edema. There was no documentation the physician was notified.</p> <p>On 10/21/13 at 2:15 PM, Resident #4 was observed sitting in her room, in her wheelchair, which was located next to the left side of her bed, with the resident facing the head of the bed. She was approximately 10 feet from the doorway to the room. As the surveyors entered the room, Resident #4 could be heard with wheezing as she breathed. As the surveyors approached the resident, her ankles were visibly edematous, to the point of her skin appearing taut. As she spoke, her voice sounded forced, as if she was having to exert herself to speak. NOTE: 86.25 hours had elapsed since the facility</p>	F 309	<p>changes noted and reported from shift to shift report. Rounds will be completed with assistance of administrator to ensure other potential care areas are addressed.</p> <p>Beginning the week of 11/25/2013 Director of Nursing or designee will review 5 nursing assessments weekly for 4 weeks then monthly for 2 to verify if noted changes in a residents' clinical condition including weight gain, edema, or change from previous respiratory status if the physician and family has been notified. A review of 5 residents will also be completed to ensure that bed mobility, peri care, heels floated, and brakes are locked during transfers. Results will be discussed by center performance improvement committee for 3 months. The Director of Nursing responsible for compliance.</p>	12/6/13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 36 had first noted rapid breathing.</p> <p>On 10/22/13 at 11:00 AM, the surveyors entered Resident #4's room, along with LN #1, to observe a BG check. Resident #4 was again wheezing, with her ankles visibly swollen as they had been on the surveyor's previous observation above. Resident #4 was wearing blue cotton ankle socks and black shoes, with her skin so taut it was bulging slightly around the top of her socks. When Resident #4 spoke, her voice sounded forced and as if she were having to exert herself. LN #1 did not remark on or assess Resident #4's edema, or her breathing at that time.</p> <p>On 10/23/13 at 3:55 PM, the surveyors reviewed Resident #4's chart. They could find no documentation for follow-up of the rapid or labored breathing noted in the nurse's notes 10/17/13, nor any documentation noting the edema and wheezing observed by the surveyors between 10/21/13 and 10/23/13. The surveyors immediately summoned the former IDON (FIDON) and requested she assess the resident. Along with the surveyors, the FIDON approached Resident #4 in her room. Per request of the surveyors, the FIDON assessed Resident #4's breathing and edema. The FIDON stated the edema in Resident #4's BLEs at that time was "Probably 2 plus pitting edema." The FIDON agreed Resident #4's breathing was "rattly." NOTE: 135 hours had elapsed since the facility first noted rapid breathing.</p> <p>On 10/23/13 at 4:30 PM, FIDON notified the surveyors Resident #4 was, "on her way out to get a chest x-ray. I had the nurse go in and assess her." The FIDON stated Resident #4's physician did not want to give any further orders</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 309	<p>Continued From page 37 or treatment until the x-ray results were obtained.</p> <p>On 10/23/13 at 4:35 PM, a Change of Condition Documentation form in Resident #4's chart documented: -"Resident noted [with] [shortness of breath] respiratory wheezes and increased respirations. Res [with] facial swelling and 2 + pitting edema to BLE. Lower lung sounds clear bilaterally. Res afebrile. MD notified and chest x-ray obtained." NOTE: The resident was sent out of the facility shortly after this time so a chest x-ray could be obtained.</p> <p>On 10/24/13 at 9:30 AM, the facility reported back to the surveyors with the results of the chest x-ray for Resident #4. The report documented, "Mild cardiomegaly. Moderate pulmonary vascular congestion suspected. Diminished lung volumes." The report documented it had been dictated on 10/23/13 at 5:17 PM.</p> <p>On 10/24/13 at 1:50 PM, the surveyor approached LN #1 to inquire about follow-up from the physician regarding the chest x-ray results for Resident #4. LN #1 stated the results had been faxed to the physician, and the physician had requested her medication list. LN #1 stated she had faxed the medication list and was waiting to hear back from the physician.</p> <p>On 10/24/13 at 2:45 PM, the FI DNS provided a copy of a physician's order for Potassium Chloride 10 MEQ ER daily, and Lasix 40 mg one time, then 40 mg daily ongoing for a new diagnosis of Congestive Heart Failure.</p> <p>On 10/24/13 at 3:00, the facility's Regional Medical Director (RMD) met with the surveyors</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 309	<p>Continued From page 38 regarding Resident #4. The RMD stated he had called Resident #4's primary care physician regarding the chest x-ray results, and the Lasix and potassium orders.</p> <p>On 10/24/13 at 3:57 PM, a Preliminary Laboratory Report in Resident #4's record documented: -Hemoglobin of 4.1, identified as critically low. Normal value, 12-16. -Hematocrit of 17, critically low. Normal value 37-47. -Red Blood Cells of 2.89, identified as low. Normal value 4.2-5.4.</p> <p>On 10/24/13 at 4:30 PM, the RMD met again with the surveyors regarding Resident #4. The RMD stated labs had been drawn for Resident #4, and, "We know the cause of the heart failure. She is profoundly anemic, which makes the heart work harder, which put her into heart failure." The RMD stated Resident #4 likely needed to be taken to the hospital for a blood transfusion.</p> <p>On 10/24/13 at 6:15 PM, the IFDON informed the surveyors Resident #4 was being sent to the hospital for a blood transfusion. The surveyors observed Resident #4 being assisted into the facility van at that time.</p> <p>On 10/25/13 at 6:10 AM, the Final Laboratory Report in Resident #4's record documented: -Brain natriuretic peptide (BNP) value of 155.4, high, with normal being 0-100. -Iron value of less than 10, low. Normal value 37-16. -Ferritin level 3.11, low. Normal 13-150. On 10/25/13 at 3:40 PM, the facility provided the surveyors with a copy of the 10/25/13 final laboratory report for Resident #4, with the</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 309	<p>Continued From page 39</p> <p>physician's response written on it. The hand writing on the report documented, "A1C Excellent! 2 u [units] pRBC [packed red blood cells] given 10/24 pm."</p> <p>Resident #4 was harmed when she was noted with rapid or labored breathing, with a delay in treatment of 135 hours before the MD was notified. It was only when the surveyors brought this to the attention of the facility, that the facility began to respond. Even so, there was an additional delay of 21 hours and 28 minutes between the time the facility notified the physician, and the time any treatment was ordered. Ultimately, Resident #4 was found to be "profoundly anemic", to the point of requiring a blood transfusion, as well as a new diagnosis of congestive heart failure requiring medication interventions.</p> <p>On 10/24/13 at 6:15 PM, the Administrator, FIDON, RMCO and IDON were notified of the surveyor's concerns. The facility provided additional information, in terms of the written physician's response on Resident #4's laboratory results, and a physician's progress note dated 10/28/13. However, this information did not resolve the concerns.</p> <p>b. On 10/23/13 at 4:00 PM, the surveyor and the FIDON entered Resident #4's room. CNA #7 was transferring Resident #4 from her bed to her wheelchair. CNA #7 was holding Resident #4 by the right elbow. There was no second person assisting, or gait belt in use, both of which were specified in Resident #4's care plan. The brakes on Resident #4's wheelchair were not locked, and the wheelchair rolled backwards slightly as the resident sat in it.</p> <p>On 10/24/13 at 12:50 PM, the FIDON was asked about the transfer the surveyor had observed. The FIDON stated, "Yep. I saw it too. I was</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 309	Continued From page 40 hoping you didn't." On 10/24/13 at 6:15 PM, the Administrator, IDON, RCMO, and FIDON were informed of the surveyor's findings. The facility offered no further information. 2. Resident #2 was admitted to the facility on 11/17/16 with multiple diagnoses which included dementia, macular degeneration, and celiac disease. Resident #2's most recent MDS assessment, dated 8/20/13, coded: -Unable to complete the BIMS, with no staff assessment of his cognitive abilities. -Totally dependent of 2 for bed mobility, transfers, and dressing. -Totally dependent of 1 for eating. Resident #2's care plan documented, under the Focus area of "Nutrition", the Intervention of, "Adaptive equipment: Plastic tip spoon RNA dining: Cue to take bite, chew, and swallow with meals. (update 4/20/11)" On 10/22/13 at 12:30 PM, Resident #2 was served his meal, which was ground chicken, jello, and pureed peas. [NOTE: Please refer to F 365 as it pertains to appropriate diet texture.] CNA #6 sat down at the table and began to feed Resident #2. The IDON was also sitting at the table, feeding Resident #2's tablemate. CNA #6 was observed to place several bites of food in Resident #2 mouth, without explaining she was about to give him a bite of food, or cueing him to chew or to swallow. After each bite was placed in his mouth, Resident #2's mouth would begin a chewing motion, but he kept chewing for an extended period of time without swallowing. CNA #6 continued to place bites of food into Resident #2's mouth, even with remnants of the previous bite still present. After giving Resident # 2 three bites of chicken, a bite of jello, and a bite of peas,	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 309	<p>Continued From page 41</p> <p>CNA #6 sighed and stated, "[Resident #2] let's have a drink," and offered Resident #6 a drink of water from a glass with a straw. [NOTE: Please see F 369 as it pertains to adaptive equipment with meals.] The mixture of peas, chicken, and jello was overflowing from Resident #2's mouth and onto his chin. CNA #6 wiped the excess food from his chin with a napkin, then without checking to see if his mouth was clear began to place more bites of chicken and peas in his mouth. CNA #6 did not cue Resident #2 about receiving bites of food, chewing, or swallowing. Again the food overflowed from Resident #2's mouth onto his chin. CNA #6 took Resident #2's spoon, wiped the excess food (a mixture of ground chicken and pureed peas) from his chin, and placed the mixture back into his mouth. CNA #6 then offered and assisted Resident #2 with another drink from a glass with a straw, without checking to see if his mouth was clear. Resident #2 sucked some water through the straw, then coughed. CNA #6 waited for Resident #2 to stop coughing, then resumed feeding him as before. This pattern continued throughout the meal. The IDON was also sitting at the table with this resident, but did not intervene with this process.</p> <p>On 10/23/15 at 5:15 PM, the Administrator, FIDON, RDCO, and IDON were informed of the surveyors's observations.</p> <p>On 10/24/13 at 6:15 PM, the Administrator stated, "Thank you for letting us know [Resident #2] was coughing. We didn't know he was doing that. We got a speech therapy evaluation for him." However, the facility offered no further information to resolve the surveyor's concerns.</p> <p>3. Resident #3 was admitted to the facility on 4/12/07, and readmitted on 1/8/13, with multiple diagnoses which included, hemiplegia affecting</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013	
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 309	<p>Continued From page 42</p> <p>the non-dominant side related to a stroke (CVA or cerebrovascular accident), unspecified late effects of cerebrovascular disease, and muscular wasting and disuse atrophy, not elsewhere classified.</p> <p>The resident's most recent quarterly MDS assessment, dated 9/1/13 coded, in part:</p> <ul style="list-style-type: none"> * Intact cognition with a BIMS score of 13; * Total assistance of 2 or more persons for bed mobility; and, * Functional limitation in range of motion in 1 upper and 1 lower extremity. <p>Resident #3's care plan included the focus areas and their associated interventions:</p> <ul style="list-style-type: none"> * Nutrition - "edema checks per nursing r/t [related to] diuretics" - initiated 5/6/12, revised 10/18/12, and reviewed 7/24/13. * At risk for skin alterations - "Elevate heels when in bed..." - initiated 8/12/09 and reviewed 7/24/13. <p>a) The resident's recapitulation of Active Orders from 10/1/13 to 10/31/13 included an order for Demadex, a diuretic, every day.</p> <p>Review of Resident #3's clinical record revealed there were no edema checks documented in the clinical record.</p> <p>On 10/23/13 at about 9:30 a.m., Resident #3 was observed in bed with LN #4 in attendance. At that time, no edema was noted in the resident's lower extremities.</p> <p>b) On 10/23/13 at about 9:45 a.m., Resident #3 was observed supine on her bed with a tan leather, custom-made ankle foot orthosis on her left foot. LN #4, who was in attendance, placed a</p>	F 309		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 309	Continued From page 43 pillow under the resident's lower legs and stated the pillow was used, "to raise the heels." The LN was about to leave the room, when the surveyor pointed out that the resident's left heel orthosis was still in contact with the mattress. LN #4 stated, "Yes it is. That's always how it is." LN #4 then raised the knee of the bed about 5 degrees which raised the resident's left heel off the bed slightly. On 10/24/13 at 9:30 a.m., the RMCO and the IDON were interviewed. When asked about Resident #3's care plan for edema checks and to elevate for the heels when in bed, they agreed the edema checks were not documented and the care plan included to elevate the heels while in bed. At about 9:45 a.m., the former IDON joined the interview and said edema checks were stopped in December 2012 and should have been removed from the resident's care plan. On 10/24/13 at 6:10 p.m., the Administrator, IDON, former IDON, and RMCO were informed of the failure to follow care planned interventions. No other information or documentation was received from the facility which resolved the issue.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	Resident # 2's oral cavity was evaluated by licensed nurse on 10/29/13 to ensure cleanliness and oral cares were completed. Oral cavity was clean at time of evaluation. Resident #2 was assessed by social services consultant on 10/29/13 for any adverse psychosocial effects related to buildup in mouth with no negative findings.		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
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F 312	<p>Continued From page 44</p> <p>by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents received adequate oral care. This was true for 1 of 6 residents (#2) sampled for ADL assistance. The deficient practice had the potential to cause more than minimal harm if residents developed tooth decay from lack of oral care. Findings included:</p> <p>Resident #2 was admitted to the facility on 11/17/06 with multiple diagnoses which included dementia, macular degeneration, and celiac disease. Resident #2's most recent MDS assessment, dated 8/20/13, coded: -Unable to complete the BIMS, with no staff assessment of his cognitive abilities. -Totally dependent on 2 for bed mobility, transfers, and dressing. -Totally dependent on 1 for eating and oral hygiene. On 10/22/13 at 8:24 AM, Resident #2 was served oatmeal, applesauce, and scrambled eggs for breakfast. NOTE: Please see F 365 as it pertains to diet texture. On 10/22/13 at 12:20 PM, Resident #2 was observed sitting at a table in the dining room, waiting for the noon meal to be served. He was sitting with his eyes closed and his mouth open. There were oatmeal flakes visible in, on, and around his lower teeth. On 10/22/13 at 1:15 PM, LN #1 was asked to check Resident #2's mouth for oatmeal flakes. LN #1 examined Resident #2's mouth, and stated, "Oh, my. I'll get the aides right in here." On 10/24/16 at 6:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the</p>	F 312	<p>A review of other residents requiring assistance with oral care was completed by Director of Nursing or designee on or before 11/22/13 to ensure assistance was provided including post meals as needed.</p> <p>The nursing staff was reeducated by Director of Nursing on or before 11/22/13 to ensure oral care is provided daily and as needed and if residents are noted with buildup in their mouth including teeth, to assist residents with oral care at the time of findings. On or before 11/15/13 members of the IDT were assigned a routine schedule by the center administrator for dining room supervision to ensure oral care issues are followed up on.</p> <p>Beginning the week of 11/25/13, a review of 3 residents per week for 4 weeks then monthly for 3 months will be performed by Director of Nursing or designee to ensure that oral care is provided before and after meals. The results will be discussed at monthly PI committee for 3 months. The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 45	F 312		
F 313 SS=D	<p>surveyor's findings. The facility offered no further information.</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents received necessary assistance to obtain new glasses. This was true for 1 of 6 residents (#4) sampled for assistive devices. The deficient practice had the potential to cause more than minimal harm if Resident #4's visual deficits impaired her ability to navigate or interact with her environment. Findings included:</p> <p>Resident #4 was admitted to the facility on 9/19/12 with multiple diagnoses including recurrent persistent hypoglycemia, brittle diabetes mellitus, failure to thrive, hyperlipidemia, severe dementia, chronic anemia, mild hyponatremia, and chronic protein calorie malnutrition (PCM).</p> <p>Resident #4's most recent MDS assessment, dated 9/27/13, coded adequate vision.</p>	F 313	<p>A Spanish speaking staff member informed resident # 4 on or before 11/5/13, of a care conference that was being scheduled to inform her of her current health status in a language that she could understand. On 11/6/13 an RN who speaks Spanish informed resident # 4 of her current health status. A call was also placed to the family to participate in a care conference. Daughter spoke with SSD on or before 11/25/13 and was updated regarding her health status. Daughter will attend care conference in person or via phone at earliest availability to daughter. An appointment for eye glasses made by center transportation and appointment held on 11/22/13 and follow up completed as indicated.</p> <p>A review of other residents with inadequate vision and no use of glasses per most recent MDS were completed by social services designee on or before 11/5/13. Arrangements were made for glasses if residents wished. Care plans were updated where applicable.</p> <p>Center were staff educated by Administrator on or before 11/22/13 if a resident has inadequate vision and glasses are not used; to inform social services for follow up as indicated by resident. New admission charts will be reviewed in morning clinical meeting. Communication will be provided to</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
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F 313	<p>Continued From page 46</p> <p>Resident # 4's MD progress notes, dated 10/4/12, documented, "...complaints: 'I lost my glasses.'...Recommendations...Find eye glasses or have [patient] seen by optometrist for new pair of eye glasses."</p> <p>Resident #4 had falls in the facility, with "Visual Problems" identified as a factor, on 5/17/13 at 3:30 PM, 6/30/13 at 1:30 PM, and 6/30/13 at 7:40 PM.</p> <p>The surveyors observed Resident #4 without eyeglasses on the following occasions: -10/21/13 at 2:15 PM. -10/22/13 between 7:40 AM and 8:15 AM. -10/22/13 at 11:00 AM. -10/22/13 at 12:22 PM. -10/23/13 at 3:55 PM. -10/24/13 at 7:35 AM.</p> <p>On 10/24/13 at 12:52 PM, the FIDON was asked if Resident #4's eyeglasses had been found, or if they had to be replaced. The FIDON stated, "I'm not sure. I don't know that I have ever seen her with glasses. You'll have to ask [the RSS.]"</p> <p>On 10/25/13 at 10:05 AM, the RSS was asked about arranging for replacement eyeglasses for Resident #4. The RSS stated, "Nursing does that." The RSS was asked if helping to arrange that would be something she would do. The RSS stated, "I guess. If I know they're needed. But I didn't know she needed them."</p> <p>On 10/25/13 at 1:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.</p>	F 313	<p>social services if resident's vision or hearing is inadequate for follow up. MDS coordinator will communicate any hearing or vision changes to social services that are coded on the MDS for follow up.</p> <p>Beginning the week of 11/25/13 the Director of Nursing or designee will review 3 charts weekly for 4 weeks and then monthly for 2 months to ensure residents found to have inadequate vision without the use of glasses are referred to social services for follow up. Results to be discussed monthly at the PI committee for 3 months. The Director of Nursing shall be responsible for compliance.</p> <p style="text-align: right;">12/6/13</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 314 F 314 SS=D	Continued From page 47 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a care plan for altered skin integrity was accurate and reflected the resident's actual status. This was true for 1 of 6 sample residents (#1). This failure created the potential for more than minimal harm should the facility fail to implement appropriate preventive measures related to pressure ulcers. Findings included: Resident #1 was admitted to the facility on 3/21/12, and readmitted on 1/31/13, with multiple diagnoses which included multiple pressure ulcers; diabetic, with ophthalmic manifestation type 1 (juvenile type) uncontrolled; left below the knee amputation; bipolar disorder; and dementia with behavioral disturbances. The resident's most recent quarterly MDS assessment, dated 8/7/13, coded, in part: * Intact cognition, with a BIMS score of 15; * Rejection of care occurred daily; * Total assistance required for bed mobility,	F 314 F 314	Resident # 1 care plan was updated to reflect current interventions on or before 11/25/13 by center MDS nurse. On or before 11/26/13 the Director of Nursing or designee completed a review of other residents care plans where Braden scores reviewed and identified those at risk, requiring preventative measures. Updates were made where necessary. The center staff was reeducated by facility Administrator on or before 11/22/13 to ensure skin at risk care plan interventions is current. Care plans will be updated by IDT in morning clinical meeting for changes of condition and wishes and each quarter with the assistance of resident and family at quarterly care conference. Beginning the week of 11/25/13, Director of Nursing or designee will review 3 skin-at-risk care plans weekly for 4 weeks and then monthly for 2 months to ensure interventions are current. Results to be discussed at center PI committee for 3 months. The Director of Nursing shall be responsible for compliance.	12/6/13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 48</p> <p>transfers, and personal hygiene; * At risk for pressure ulcers (PU); * One stage 2 PU; and * Three unstageable PU with suspected deep tissue injury in evolution.</p> <p>Resident #1's Care Plan focus areas included alteration in skin integrity. The interventions included, "Heelift boot to Right foot when in bed," initiated 7/12/13 and revised 7/15/13.</p> <p>On 10/22/13 at 12:05 p.m., 12:20 p.m., 1:00 p.m., and from 2:00 - 2:35 p.m., Resident #1 was observed in her wheelchair with a padded black heelift boot on the right foot.</p> <p>On 10/22/13 at 2:45 p.m., Resident #1 was observed in bed with CNAs #9 & #10 in attendance. At the surveyor's request and with the resident's permission, the heelift boot was temporarily removed which revealed black eschar that covered the end of the right great toe.</p> <p>On 10/24/13 at 8:30 a.m., the RMCO and IDON were asked about the resident's care plan for the heelift boot when in bed. The RMCO reviewed the resident's care plan then stated she would check the care card in the resident's closet. The RMCO left and returned moments later with Resident #1's care card. The RMCO read the care card and stated, "When in bed." The RMCO added, "It needs to be revised because she's wearing it more."</p> <p>No other information was received from the facility which resolved the issue.</p>	F 314			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 49 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure residents maintained acceptable parameters of nutritional status. This was true for 1 of 3 residents (#4) sampled for nutritional issues. Resident #4 was harmed when she experienced a severe weight gain of 53 pounds from 9/20/12 and 10/6/13, but was not assessed by the physician for weight gain based on multiple diagnoses and medications administered. Additionally, the facility did not discuss their concerns regarding weight gain and interventions with Resident #4 in a language she could understand. Findings included: The New England Diet Manual for Extended Care, Revised in 2008, identified by the facility as the diet manual in use, documented under, "Modification in Calories and Carbohydrate, Calorie and Carbohydrate Controlled Diets for Weight Management and Diabetes Mellitus Glycemic Control": -"Description...providing adequate nutrition is the	F 325	Resident #4 was assessed by the MD on or before 10/28/13 with new orders received and nutritional care plan updated on or before 11/22/13 to reflect current needs based on assessment findings. Resident was also evaluated by licensed nurse with assistance of Spanish speaking RN on 11/6/13 with a noted decrease in edema and weight all of which was explained to her in Spanish. A review of other residents that had an unplanned of 5% or 5 pound weight variance in the last 30 days was completed by IDT on or before 11/25/13 to ensure, including but not limited to, that physical assessment (edema), medications and labs are reviewed and/or recommended, and MD and family notified and inclusion in plan of care findings. New orders were processed as indicated from the physician's review. The nursing staff and Registered Dietitian was reeducated by the Director of Nursing or designee on or before 11/22/13 to ensure physicians are notified of weight variances as they occur, for assessment of current clinical condition and to include interdisciplinary team discussions for possible causes and contributing factors. Director of nursing to review weights upon completion and ensure notifications are done as well as IDT note for both gains and losses	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 50</p> <p>primary concern for the resident in long term care facilities if malnutrition is to be prevented or corrected...The Registered Dietician (RD) should be consulted to make appropriate recommendations for each resident. The diet is individualized according to the resident's age, gender, body mass index (BMI), activity level, hypoglycemic regimen, blood glucose levels, and quarterly HgbA1C (glycated hemoglobin) levels." -"Generally, for overweight residents a weight loss diet is not recommended unless obesity impairs activities of daily living and the resident is in agreement with the weight loss plan." -"The diet should be individualized and realistic for the resident."</p> <p>Resident #4 was admitted to the facility on 9/19/12 with multiple diagnoses including recurrent persistent hypoglycemia, brittle diabetes mellitus, failure to thrive, hyperlipidemia, severe dementia, chronic anemia, mild hyponatremia, and chronic protein calorie malnutrition (PCM).</p> <p>Resident #4's admission H&P, dated 9/18/12, documented, "Given the patient's increased risk for metabolic complications including severe hypoglycemia and severe mental status due to it, the patient is being admitted to the telemetry unit."</p> <p>CMS's RAI Version 3.0 Manual, Chapter 3, Section [K], Swallowing/Nutritional Status, item K0310: Weight Gain coding instructions, documented, "Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician."</p>	F 325	<p>and sending the MD a med review for possible contributors including edema.</p> <p>Beginning the week of 11/25/13, 3 residents with weight variances will be reviewed for 4 weeks and then monthly for 2 months to ensure an IDT review has occurred, their note is in medical record and the physician has been notified of resident's current clinical condition. The results will be discussed at center PI committee for 3 months.</p> <p>The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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

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F 325	Continued From page 51 Resident #4's MDS assessments coded: *Admission, 9/26/12: -Wants or needs a translator to talk with health care professionals. -Preferred language is Spanish. -Weight 150 pounds. -Diagnoses of malnutrition, diabetes, and hyperlipidemia. -No diagnosis of anemia. *Quarterly, 12/21/12. -Weight 162 pounds, a 12 pound weight gain. -No significant weight gain. [NOTE: This weight change represented an 8% increase since the previous MDS assessment.] -Diagnosis of malnutrition. *Quarterly MDS, 3/22/13 -Weight of 171 pounds, a 21 pound weight gain since admission. - "2" for significant weight gain, not prescribed by the physician. -Diagnosis of malnutrition was not coded. [NOTE: There was no physician's progress note assessing Resident #4's nutritional status or removing the diagnosis of malnutrition.] *No further MDS data available until 9/27/13. *Annual MDS, 9/27/13: -Wants or needs a translator to talk with health care professionals. -Preferred language is Spanish. -Weight 197 pounds, a 47 pound weight gain since admission. -No significant weight gain. [NOTE: This weight change represented an increase of 15.2% since the MDS 3/22/13.] -No diagnosis of malnutrition. [NOTE: There was still no documentation from the physician regarding the removal of the malnutrition diagnosis.]	F 325		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 325	<p>Continued From page 52</p> <p>Resident #4's Care Plan documented: -Focus area of, "Nutrition Care Plan: Potential alteration in Nutrition Status Diagnosis/disease condition/treatment - DM, severe dementia, anxiety-depression, FTT, PCM, HTN, hyperlipidemia, Inability to verbalize food/fluid needs/desires." Date Initiated 9/20/12. -Goal of, "Will tolerate HCC-small portions. Intakes [greater than] 75%." Date Initiated 9/20/12. [NOTE: The facility did not document Resident #4 was started on small portions until 3/14/13.] -Goal of, "Will not have significant change in weight of 5% in 30 days or 10% in 180 days." Date Initiated 9/20/12. -Intervention of, "Small portions at meals. add snacks tid [three times dily] enc[ourage] dietary compliance. [sic]." Date initiated 11/1/12. [NOTE: The first documentation from the facility that small portions were in fact provided was on 3/14/13.] -Intervention of, "Start small portions-enc[ourage] dietary compliance." Date Initiated 3/14/13. -Intervention of, "Observe for abnormal laboratory data." Date Initiated 9/20/12. -Intervention of, "Observe and report edema." Date Initiated 9/20/12.</p> <p>Resident #4's admission medication orders, dated 9/19/12, documented: Zyprexa 2.5 mg daily at 5:00 PM. This dose was increased to Zyprexa 2.5 mg twice daily on 7/10/13. [NOTE: Please see F 329 as it pertains to Zyprexa use.] -Routine Lantus insulin and sliding scale Novolog insulin for diabetes management. -No concentrated sweets diet. No further dietary restrictions noted.</p> <p>Resident #4's Nursing Assessment forms</p>	F 325		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 53 documented: -9/19/12 *Primary Language, "Spanish." *Weight 150 pounds. *Oxygen saturations (O2 sats) blank. *Edema, "No." *Pedal pulses present on both right and left. -12/27/12 *Primary Language, "Spanish." *Weight 162 pounds (gain of 12 pounds, or 7.4% of initial body weight). *O2 sats, "N/A." *Edema, "Pitting 2 plus." Location as, "BLE" [bilateral lower extremities.] *Pedal pulses present on left and right, "Faint." -3/23/13 *Weight 183 pounds (gain of 33 pounds, or 22% of initial body weight). *O2 sats, "N/A." *Edema, "Pitting 1 - 2 plus." Location as, "BLE." *Pedal pulses present on both right and left. -7/21/13 *Weight 195 pounds (gain of 45 pounds, or 30% of initial body weight). *O2 sats 97% on room air. [NOTE: This is the first and only documentation of Resident #4's O2 sats.] *Edema, "Pitting plus 1." Location as, "BLE." *Pedal pulses present on both right and left. -9/25/13 *Weight 197 pounds (gain of 47 pounds, or 31.3% of initial body weight). *O2 sats blank. *Edema, "Pitting 1 plus." Location as, "BLE." Resident #4's Physician's Progress Notes, dated 11/14/12 - 10/16/13, documented, in their entirety: [NOTE: Please see F 386 as it pertains to the content of the physician's visits.]	F 325			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 54 -11/14/12. "Dementia-short term memory loss - DM II - BG's [increased] [with] UTI? Txed [treated] this wk [week] [with] Augmentin." [NOTE: There was no documentation as to how the physician assessed the degree of her dementia, given the language barrier.] -12/12/12. "DM II [and] BGs somewhat improved - Expect 'loose' controll [sic] [with] her mental deficits." [NOTE: There was no documentation as to how Resident #4's mental deficits were assessed.] -1/9/13. "DM II BGs have improved - PO 100% [with weight increase] 15 [pounds] in 4 months." [NOTE: The physician did not indicate an assessment as to the cause of the weight increase, whether or not the weight increase was a concern, nor whether or not Resident #4's diet should be further restricted, or converse with the resident regarding her weight gain. The physician did not document any awareness of whether or not Resident #4 was experiencing edema at the time of this assessment. The physician did not address adverse reactions to medication as a consideration in Resident #4's weight gain.] [Please see F 329 regarding unnecessary medications.] -2/20/13. "Marked dementia. Short term memory loss. DM II sl [slightly] stabilized." -3/20/13. "BGs vary 180 - 280 - improved stability [and] adequate improvement." -4/17/13. "BGs adequate controll [sic] for her condition. Marked dementia." -5/15/13. "DM II [with] loose but improved BG controll [sic]. Severe Dementia." -6/12/13. "BG controll [sic] adequate. Severe Dementia." -7/10/13. "75 [year old] type II DM [Hispanic] [with] dementia. Reviewing fall rate of falls - 12 documented falls since January. Pt [patient]"	F 325			

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

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F 325	<p>Continued From page 55</p> <p>continues to fall even with 1 on 1 attendant [sic] - will be transferring to [name of town]." [NOTE: On this date, Resident #4's anti-psychotic medication was doubled in dose. Please see F 329.]</p> <p>-8/7/13. "[Decrease] falls - No longer 1 on 1 - BGs remain unstable 70 to 400 - will continue conservative DM II care."</p> <p>-9/18/13. "BGs remain very erratic - range 100-300 [and] making stabilization difficult - but pt doing well [with] no recent falls - smiling [and] content this AM."</p> <p>-10/16/13. "[Right] upper forehead scrape from scratching - BGs better last [illegible] 89-241 - [weight] up 198 [to] 203 [pounds]." [NOTE: Again, the physician noted Resident #4's weight gain, but no further assessment or recommendations were documented.]</p> <p>Resident #4's Medical Nutrition Therapy (MNT) Assessment forms documented:</p> <p>-9/20/12: *Resident Comments, "Spanish speaking." [NOTE: There was no documentation as to how this factor would be addressed as the assessment proceeded. There were no further comments from the resident documented.] *Clinical Conditions, "Severe dementia...DM, hyperlipidemia...chronic PCM...FTT, anemia, acute encephalopathy." *For "Cognitive Status", the boxes for, "Alert", "Oriented", and "Confused" were all marked. *No edema noted. *Medications included Celexa, and both Olanzapine and Zyprexa Zydis (NOTE: Olanzapine is the generic name for Zyprexa). *Diet, "HCC regular" with no MD prescribed weight reduction. *Meal intake 100%.</p>	F 325		

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

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F 325	<p>Continued From page 56</p> <p>*Admission weight, usual weight, and current weight were all documented as, "150 lbs." *The space for BMI documented, "--". *DBW (Desired body weight) goal was documented as, "140 +/- 12 pounds." [NOTE: There was no documentation stating how this goal was arrived at, or that Resident #4's body weight had ever been as low as 140 pounds. There was no documentation the physician had determined the goal to be ideal for this resident. There was no documentation Resident #4, or her family, had been involved in setting this goal.] *Total calories consumed by the resident were documented as 1750 k cal (kilo calories), protein as 68 grams, and fluids as 1750 milliliters. *The Laboratory Data area of the form was blank. *Nutrition and fluid needs were documented as met. *No new labs. *Plan, "maintain current weight - [no significant] changes. Maintain intakes [greater than] 75% - monitor daily. Monitor labs and b.g.s [sic] control regularly as available." [NOTE: There was no plan as to how the facility would monitor Resident #4's status in terms of her PCM or FTT diagnosis, or to resolve her anemia. There was no documentation as to the potential for weight gain related to the use of Zyprexa.]</p> <p>-12/20/12: *Resident comments, "DNR." [NOTE: This was the area of the form for resident participation in the dietary assessment process.] *Diagnoses included severe dementia, DM, PCM, FTT, anemia, and encephalopathy. *For "Cognitive Status", the boxes for, "Alert", "Oriented", and "Confused" were all marked. *Edema, "none noted." *Medications included Lexapro and olanzapine.</p>	F 325		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 57</p> <p>*Diet: HCC regular, with no MD prescribed weight reduction.</p> <p>*Meal intake 100%.</p> <p>*DBW goal, "140 +/- 12 pounds."</p> <p>*The space for BMI documented, "--".</p> <p>*Weight was 162 pounds. 90 days ago had been 150 lbs. The space to document the percentage of this change was blank. [NOTE: Resident #4's weight represented an 8% increase at the time of this assessment.]</p> <p>*No changes in total calories, protein, or fluids consumed by the resident.</p> <p>*The Laboratory Results area of the form was blank.</p> <p>*Nutrition and fluid needs met.</p> <p>*Assessment, "Pt's weight - 162 lbs. - [up] 12 lbs 90 [days]. [Greater than ideal body weight]...[no] new labs..."</p> <p>*Plan as, "Maintain current weight - [no significant] changes. Maintain intakes [greater than] 75% - monitor daily. Monitor labs as available." [NOTE: The assessment did not address Resident #4's 8% weight gain, or the potential for weight gain related to Zyprexa use. There were no laboratory results to address PCM, BG control, or anemia. There was no indication as part of the assessment for this resident that labs would be requested.]</p> <p>-3/14/13:</p> <p>*Resident comments, "DNR."</p> <p>*The diagnoses of PCM, anemia, and FTT are no longer listed. [NOTE: There was no physician's documentation, physician's orders, or laboratory results as to why, how, or when these diagnoses were removed, or how they had been addressed.]</p> <p>*For "Cognitive Status", the boxes for, "Alert", "Oriented", and "Confused" were all marked.</p> <p>*Edema as, "none noted."</p>	F 325		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 325	<p>Continued From page 58</p> <p>*Diet was, "HCC - Regular small portions", with an MD prescribed weight reduction. [NOTE: There was no physician's documentation or order for a weight reduction plan, or assessment as to how weight reduction would safely be accomplished in light of the resident's history of PCM, FTT, and anemia. There was no documentation the resident had been consulted, informed, or involved with this plan, nor that such information had been translated for her into her primary language.]</p> <p>*Usual weight was now listed as, "160's". [NOTE: On the previous assessments, Resident #4's usual weight was documented as 150 lbs. There was no documentation as to how this "new usual weight" or why, if this new figure were considered as her usual body weight, she would need to be on a physician prescribed weight loss plan.]</p> <p>*Weight was 171 lbs., up from 168 lbs. 30 days prior, 162 lbs. 90 days prior, and 150 lbs. 180 days prior. [NOTE: The areas to calculate the percentage of change in her body weight were blank.]</p> <p>*The space for BMI documented, "--".</p> <p>*DBW goal, "140 +/- 12 pounds."</p> <p>*No changes identified in total calories, protein, or fluids consumed by the resident.</p> <p>*The laboratory data area of the form was blank.</p> <p>*Nutrition and fluid needs documented as met.</p> <p>*Assessment, "Pt's weight - 183 lbs. [NOTE: Resident #4's weight was documented as 171 lbs. on the same form.] [Up] 12 lbs. this week- [up] 20 lbs. 90 [days]...Enc[ourage] dietary and snack compliance [NOTE: There was no documentation Resident #4 had not been compliant with dietary and snack restrictions prior. Other than HCC diet, there were no dietary or snack restrictions identified, prior to this time, for Resident #4. There was no assessment from</p>	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 325	<p>Continued From page 59</p> <p>the RD, MD, or nursing staff as to why there had been a 12 pound weight gain in one week's time. There was no documentation of the resolution of the 2 plus pitting edema noted in the nursing assessment from 12/27/12, or if edema had been identified as a potential factor for this sudden weight gain.]</p> <p>Plan was, "Gradual weight loss desired due to weight gain/ [greater than] IBW. Maintain intakes [greater than] 75% - monitor daily. Monitor labs as available. Encourage dietary compliance." [NOTE: There was no indication from this assessment that laboratory studies should be requested, even though the diagnoses of FTT, PCM, and anemia had been removed.]</p> <p>-6/13/13: *Resident Comments, "DNR." *PCM, FTT, and anemia were not listed as diagnoses. *Cognitive status, "Alert," "Oriented," and "Confused." *Edema was, "1-2 [plus] BLE." [NOTE: Even though edema had been documented on the previous 2 quarterly nursing assessments, this was the first notation from the RD indicating an awareness of Resident #4's edema.] *Diet HCC regular with small portions. No physician prescribed weight reduction plan. [NOTE: The 3/14/13 MNT assessment documented a HCC diet with a physician prescribed weight reduction plan. There was no documentation as to when or why that was changed before the 6/13/13 assessment.] *Meal intakes 100%. *Usual weight now 180 lbs. [NOTE: This figure had increased from 150 lbs. on her admission just 9 months prior, and 160 lbs. since the last nutritional assessment 3 months prior.]</p>	F 325		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 60</p> <p>*The space for BMI was blank.</p> <p>*DBW was documented as, "140 lbs. +/- 12 lbs."</p> <p>*Weight was documented as 193 lbs., up from 189 lbs. 30 days prior, 171 lbs. 90 days prior, and 162 lbs. 180 days prior.</p> <p>*The weight percentage of weight change areas of the form were blank.</p> <p>*The Laboratory Data area of the form was blank.</p> <p>*Nutrition and fluid needs were met.</p> <p>*Assessment as, "Pt weight - 193 lbs. - [up] 22 lbs [in 90 days] - [greater than] IBW...[no] new labs...enc[courage] dietary compliance - monitor for trying to eat off others plates." [NOTE: The behavior of eating from other's plates was not documented prior to this note. It was not addressed in this assessment if this had developed as a new behavior after the facility placed Resident #4 on small portions.]</p> <p>*Plan as, "Maintain current weight - [no] continued weight gain. Maintain intakes [greater than] 75% - monitor daily. Encourage dietary compliance. Monitor labs as available." [NOTE: Even though monitoring labs was identified yet again as part of the nutritional plan for Resident #4, there was not a request for labs to be drawn. There was no evidence Resident #4 had been consulted or involved with the facility's concerns regarding her continued weight gain, or the plan to address the weight gain. Edema in Resident #4's lower extremities could have been a factor, but was not addressed in the nutritional assessment or plan.]</p> <p>-9/10/13.</p> <p>*Resident comments, "DNR. POST. [No tube feeding, no IV]."</p> <p>*Diagnoses did not include PCM, FTT, or anemia.</p> <p>*Cognitive Status, "Alert," "Oriented X 2," and "Confused."</p>	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 61</p> <p>*Edema was identified to BLEs.</p> <p>*Medications included Lexapro and Zyprexa. [NOTE: There was no indication on this assessment the doses of either medication had been increased.]</p> <p>*Diet, HCC ground [texture] small portions. "MD Prescribed Weight Reduction" was marked as, "Yes." [NOTE: There was no indication as to when or why the physician had again ordered a new weight reduction program since the previous nutritional assessment 6/13/13, or what new interventions were implemented as a part of this plan. There was no evidence the facility had involved Resident #4, in a language she understood, regarding her input on her continued weight gain, or her willingness to participate in a weight reduction plan.]</p> <p>*Usual weight was documented as, "190 lbs." [NOTE: This the third documented change in Resident #4's usual body weight, with no rationale as to why this change was made.]</p> <p>*BMI was blank.</p> <p>*DBW was, "140 lbs. +/- 12 lbs."</p> <p>*Weight was, 197 lbs.</p> <p>*The percentage in weight change areas of the form were blank.</p> <p>*The Laboratory Data area of the form was blank.</p> <p>*Nutritional and Fluid needs were documented as met.</p> <p>*Assessment as, "Pt.'s weight 197 lbs. [Down] 1 lb. this mo., [up] 4 lbs. in 90 [days]...Was started on smaller portions as previously to prevent further weight gain..."</p> <p>*Plan as, "Gradual weight loss is desired due to obesity. [NOTE: Obesity was not listed by the physician as a diagnosis. Previously, FTT, anemia, and PCM were listed as diagnoses by the physician, with no rationale as to when, how, or why those diagnoses were considered</p>	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 62</p> <p>resolved.] Maintain intakes [greater than] 75%. Monitor daily. Encourage dietary compliance. Monitor labs as available."</p> <p>The RD Interdisciplinary Progress Notes (PNs) documented: 11/1/12, "Pts weight (9/19) 150 lbs. on admit, (10/2) 154 lbs. (10/14) 156 lbs., (10/21) 158 lbs., (10/28) 159 lbs...Pt has been running high b.g.s [sic][with] [increased] insulin...Pt. complains of being hungry [and] seeking food [between] meals. Will change to small portions [at] meals [and] add snacks tid [with] fiber/protein to prevent further weight loss and] promote DM management. Labs (10/19) [glucose] 563 [elevated]. BUN/CR 20 [elevated]. All else WNL incl. protein levels. Will follow for needed interventions." [NOTE: Resident #4 had been identified with a weight gain, not a weight loss. There was no documentation the resident was consulted as to her feelings of hunger, participated in developing interventions to alter that feeling, or guidance to the staff as to how they should proceed when the resident complained of hunger.] -5/7/13. "...Weight [up] 6 lbs. additional this month. Pt. is on HCC-Regular diet and was changed to small portions...will [change] PB & J @ hs [Peanut butter and jelly at bedtime] to 1/2 sand[wich.] Discourage [between] meal snacks, or make healthier options...All staff aware of diet plan." [NOTE: There was no documentation of a communication to Nutrition Services regarding changing the sandwich to a half portion. There was no documentation the resident was aware of and agreement with the diet plan, in addition to the staff.] -10/10/13. "...Weight [up] 6 lbs. additional this month. Was stable last couple months. Pt is on HCC ground diet - small portions...small portions</p>	F 325		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 63</p> <p>were started previously due to weight gain which was successful. She was receiving snacks tid which were changed to HS only. She is busy and sitting in LSDR [low stimulus dining room] most of the time asking for cocoa. Suggest give only 1 glass cocoa [and] then diet beverages to prevent further weight gain..."</p> <p>Resident #4's Interdisciplinary Communication to Nutrition Services forms documented: -9/19/12. New Admission. HCC Regular -11/17/12. "Needs Full PB & J sandwich [at] HS plus extra sandwich avail[able] in fridge for [low] blood sugar." [NOTE: There was no communication to provide small portions as indicated in the RD PN from 11/1/12. The RD PN identified a concern of high blood glucose levels, whereas this communication identified a concern with low blood glucose levels.] -1/9/13. 1500 calorie ADA diet. -3/14/13. HCC Regular texture small portions. 6/18/13. Ground texture, "put food in separate dishes [at] all meals for portioning." [NOTE: There is no indication on this communication as to whether or not Resident #4 should continue on the HCC diet, or the small portions.]</p> <p>Resident #4's Nurse's PNs documented ongoing episodes of restlessness and calling out at night, specifically: -8/29/13 at 4:10 AM, "Res awake most of the NOC [night] shift, yelling, pulling call light cord out of wall...[increased] behaviors, Res denies pain when asked. Res stated, "I'm hungry" several times [and] was given some snacks..." -9/23/13 at 4:10 AM, "Res having issues [with] insomnia, shouting "I'm hungry" during beginning of NOC, waking up roommate who was upset by noise. Res given a sandwich..."</p>	F 325		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 64 Resident #4's PN's also documented: -10/17/13 at 7:00 PM, "Resident having increased restlessness [with] rapid breathing noted and jitteriness when verbally speaking..." -10/17/13 at 8:15 PM, "...labored breathing." On 10/21/13 at 2:15 PM, Resident #4 was observed sitting in her room, in her wheelchair. Her chair was located to the left side of her bed, next to the bed, with the resident facing the head of the bed. She was approximately 10 feet from the doorway to the room. As the surveyors entered the room, Resident #4 could be heard with wheezing as she breathed. As the surveyors approached the resident, her ankles were visibly edematous, to the point of her skin appearing taut. As she spoke, her voice sounded forced, as if she was having to exert herself to speak. On 10/22/13 at 11:00 AM, the surveyors entered Resident #4's room, along with LN #1, to observe a BG check. Resident #4 was again wheezing, with her ankles visibly swollen as they had been on the surveyor's previous observation above. Resident #4 was wearing blue cotton ankle socks and black shoes, with her skin so taut it was bulging slightly around the top of her socks. LN #1 did not remark on or assess Resident #4's edema, or her breathing at that time. [NOTE: The 2014 Nursing Drug Handbook identified, in part, potential adverse reactions to Zyprexa to be insomnia, peripheral edema, dry mouth, increased appetite, thirst, weight gain, hyperglycemia, and abnormal gait. The handbook also lists Zyprexa (Olanzapine) as having a Black Box Warning, "Drug may increase the risk of cardiovascular or infection-related death in elderly	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 65</p> <p>patients with dementia. Olanzapine isn't approved to treat patients with dementia-related psychosis." Please see F 329 related to medication management.]</p> <p>On 10/23/13 at 3:15 PM, the surveyors asked the pharmacist about possible medicines contributing to Resident #4's weight gain. The pharmacist identified Zyprexa as a medication known to cause weight gain, particularly if the dosage had been increased. The pharmacist also stated increased edema and fluctuating BG levels could also be side effects of Zyprexa. The pharmacist stated he did not recall being informed that Resident #4 had weight gain, difficulty with BG management, or edema.</p> <p>On 10/23/13 at 3:55 PM, the surveyors, along with the FIDON, approached Resident #4 in her room. Per request of the surveyors, the FIDON assessed Resident #4's breathing and edema. The FIDON stated the edema in Resident #4's BLEs at that time was "Probably 2 plus pitting edema." The FIDON agreed Resident #4's breathing was "rattly."</p> <p>On 10/23/13 at 4:30 PM, the surveyors were notified Resident #4 was going to be sent out for a chest x-ray.</p> <p>[NOTE: Please see F 309 as it pertains to timely assessment of changing medical status.]</p> <p>On 10/24/13 at 10:30 AM, the RD was asked about the weight gain for Resident #4, as follows: *The RD stated Resident #4 had gained 53 pounds from the time of her admission in September 2012 to the present. The RD stated Resident #4's weight had stabilized between June</p>	F 325		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 325	Continued From page 66 and August of 2013, after the facility implemented healthy low calorie snacks and talked to the activities department about limiting Resident #4's cocoa. *The RD stated Resident #4's weight had shown an increase again in October 2013, but she was not sure why. *When asked about Resident #4's edema, the RD stated Resident #4 had chronic edema, which was, "pretty well controlled." The RD stated she would be informed of changes in Resident #4's edema via the nursing staff. *The RD stated if Resident #4's care plan called for edema checks, she would expect to see them on the MAR. She was unable to state whether or not there were edema checks on the MAR for Resident #4. *When asked how Resident #4's PCM would be monitored, the RD stated she would look at the labs. After reviewing Resident #4's chart, the RD stated, "There are no labs in here. I will check on that." *When asked at what point labs would typically be requested for a resident with a PCM diagnosis, the RD stated, "I would ask. But she eats very well. She consistently eats a well-balanced diet we provide for her." The RD also stated it was likely she had requested labs for Resident #4, but the resident had refused to allow labs to be drawn. The RD was asked to show the surveyors where such requests and refusals would be documented. After reviewing Resident #4's record, the RD stated, "It's not. But her BG's have been stable, not erratic or brittle." *The RD was asked where in Resident #4's nutritional assessments an evaluation of the resident's BGs would be documented. The RD reviewed her assessments for Resident #4, then stated, "If they're not out of the ordinary I don't	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 325	Continued From page 67 mention them." The RD stated she would obtain her information regarding the stability of a resident's BGs from the physician's progress notes, then stated, "What does the physician say about it?" The RD then reviewed the MD progress notes for Resident #4, and stated, "He talks a lot about her BGs and dementia." [NOTE: Resident #4's MD documented either poorly controlled or erratic BGs on 11/24/12, 12/12/12, 8/7/13, and 9/18/13.] *The RD stated the MD would have documented on Resident #4's weight gain. After reviewing Resident #4's record, the RD stated, "He does not talk about nutrition." *The RD was asked how the MD was made aware of her concerns with Resident #4's weight gain. The RD stated, "We would use a condition change form." The RD was asked for this form on Resident #4. The RD initially stated the nursing staff would have filled out the form for Resident #4. She then stated, "I didn't fill one out because the weight gain was never significant." *The RD was asked if Resident #4 was receiving enough calories and nutrients to maintain her weight and good nutritional status on her current diet. The RD stated, "Yes." *The RD was asked how much protein Resident #4 would require on a daily basis, given her diagnosis of PCM. The RD stated, "86 grams." The RD was asked if Resident #4's current diet of HCC small portions provided adequate protein for Resident #4. The RD stated, "I don't know, but I'm sure it does. I'll have to check." The RD was asked if the amount of protein available on a certain diet would a factor for consideration when deciding on the diet, the RD stated, "Yes." The RD then stated it was of primary concern for Resident #4 to lose weight. When asked which would be more important for Resident #4, weight	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 325	Continued From page 68 loss or adequate protein, the RD stated, "Weight, because of mobility and diabetic control." When asked how those conclusions were formulated without laboratory studies, the RD stated she did not know. The RD stated, "I would love for there to be some labs." *The RD stated Resident #4 most recently had labs on 10/19/12. The RD was asked when those labs should be repeated, given Resident #4's diagnoses of PCM, DM, FTT, and anemia, as well as her weight gain. The RD stated, "Every 6 months. Which means 6 months ago." *The RD was asked how factors such as edema, medication side effects, other underlying medical issues had been ruled out as potential causes of her weight gain. The RD said the physician and the pharmacist would make those decisions, but her assessment of Resident #4's weight gain was from the number of calories she had consumed. [NOTE: Please see F 329 as it pertains to unnecessary drugs.] *The RD was asked about documentation that Resident #4 was hungry at times. The RD stated, "She's always hungry. That's why she gained weight." *The RD was asked how many extra calories Resident #4 would have had to consume in order to gain 53 pounds in a year, and if that amount of calories was available to Resident #4 given her current diet in the facility. The RD stated, "Everybody's different. We made some changes, and the weight gain stabilized. Plus she's on some psych meds, which can prevent some people from losing weight. But the pharmacist usually says it is more important to manage behaviors than stabilize weight." The RD stated she could not recall when she had this conversation with the pharmacist regarding Resident #4, and she did not document it.	F 325			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 325	Continued From page 69 *The RD was asked if Resident #4 had ever been notified, in her primary language, of the facility's concerns with her weight gain, or had been if she wanted interventions to alter it. The RD stated, "No. She has dementia." The RD was asked how she knew if it was dementia or a language barrier which was the most challenging for Resident #4's participation in her own plan of care. The RD stated, "I don't." The RD was asked if she had ever requested a translator to interpret a conversation for Resident #4. The RD stated, "No. She has dementia." On 10/24/13, at 4:35 PM, the surveyors interviewed the facility's RMD regarding Resident #4. The RMD was asked about possible causes for Resident #4's weight gain, including edema, side effects her Zyprexa, or other underlying medical issues. The RMD stated, "Those are good questions. I would ask the same thing." When asked about monitoring her PCM, FTT, and anemia, the RMD stated, "Those are all very good questions. I wish I had the answers." On 10/24/13 at 6:00 PM, the Administrator and the IDON were informed of the surveyor's concerns. The facility offered additional information, in terms of laboratory studies, RD assessments, and MD assessments completed after the surveyor's had called the facility's attention to Resident #4's condition. The information provided did not resolve the surveyor's concerns about the deficient practice.	F 325		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	Resident # 4's medication was discontinued on 11/11/13. Resident behavior monitor is still in place to ensure there are no adverse	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 70</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined the facility did not ensure residents were free from unnecessary antipsychotic medications. This was true for 3 of 6 (#s 4, 6, and 8) residents reviewed for antipsychotic medication use. Resident #4 was harmed when she experienced a weight gain of 53 pounds, peripheral edema, recurrent infections, and increased appetite, without those symptoms being ruled out as adverse reactions to Zyprexa use. Additionally, for Residents #s 4, 6, and 8, the physician did not identify specific target behaviors for anti-psychotic use, nor identify why</p>	F 329	<p>effects related to discontinuation of medication. None are noted at this time. The care plan was updated on 11/18/13 by the director of nursing.</p> <p>Resident # 6 was evaluated by a licensed nurse on 11/18/13 for adverse reactions related to medication use with none noted. Care plan updated to reflect Cri Du Chat by SSD on or before 12/5/13. The behavior flow sheet was updated on 11/1/13 by social services designee to include non-pharmacological interventions and side effect monitoring. The family was notified of the black box warning on 11/11/13 and a physician progress note regarding black box warning was received on 11/25/13. The medication was reduced on 11/11/13 by the physician. The care plan was updated on 11/19/13 by the director of nursing.</p> <p>Resident # 8 was evaluated by licensed nurse on or before 11/18/13 for adverse effects related to medication use with none noted including no weight increase. Medication was discontinued on 11/15/13. Behavior monitor is still in place to ensure there are no adverse effects related to medication discontinuation. Care plan updated on or before 12/5/13 by SSD.</p> <p>A review of other residents taking antipsychotic medications were reviewed by social services designee on or before</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 71</p> <p>the potential benefits of the medications outweighed the potential risks per the FDA black box warning. The facility also did not consistently identify and implement non-pharmacological interventions for behaviors, or monitor for adverse reactions. This deficient practice had the potential for harm for Resident #s 6 and 8 should they experience adverse reactions. Findings included:</p> <p>The State Operations Manual, Appendix PP, Guidance to Long Term Care Surveyors, documented under F 329, in part:</p> <p>"Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used...Without adequate monitoring...without adequate indications for use..."</p> <p>"Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility must ensure...behavioral interventions..."</p> <p>"Indications for Use of Medication (including Initiation or Continued Use of Antipsychotic Medication)...An evaluation of the resident helps to identify his/her needs...the evaluation also clarifies...whether other causes for the symptoms (including behavioral distress that could mimic a psychiatric disorder) have been ruled out...Whether non-pharmacological interventions are considered...Whether a particular medication is clinically indicated to manage the symptom or condition...A history of prior and current medications and non-pharmacological interventions."</p> <p>"Monitoring for Efficacy and Adverse Consequences...Incorporate into a comprehensive care plan that reflects appropriate medication related goals...including the likely medication effects and potential for adverse</p>	F 329	<p>11/11/13 to ensure that behavior flow sheets were reflective to residents behaviors and that side effects were being monitored. Additionally, review completed to ensure that families and physicians were aware of black box warning regarding medication use. If a resident is admitted on psychotropic medications, behavior flow sheet and side effect sheets will be reviewed by director of nursing to ensure they are in place with non-pharmacological interventions. Discussions with family will occur with social services to obtain history of behaviors. If residents are exhibiting new behaviors, prior to calling the physician, the licensed staff will have detailed symptom review with director of nursing and discussion of what non-pharmacological interventions have been attempted.</p> <p>Residents medical records were updated as indicated through notifications by the IDT.</p> <p>The social services designee was educated about black box warning notifications, behavior flow sheet specific behaviors and monitoring medication side effects by center Administrator on or before 11/22/13.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will review 3 antipsychotic medications weekly for 4 weeks and then monthly for 2 to ensure that black box warning has been addressed with</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
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F 329	<p>Continued From page 72</p> <p>consequences. Examples of this information may include the FDA boxed warnings or adverse consequences that may be rare, but have sudden onset or that may be irreversible...establish parameters for evaluating the ongoing need for the medication; and verify...the underlying diagnoses or other underlying causes of signs and symptoms..."</p> <p>1. Resident #4 was admitted to the facility on 9/19/12 with multiple diagnoses including recurrent persistent hypoglycemia, brittle diabetes mellitus, failure to thrive, hyperlipidemia, severe dementia, anxiety disorder, depression, chronic anemia, mild hyponatremia, and chronic protein calorie malnutrition.</p> <p>Resident #4's medication list from the acute care hospital, dated 9/18/12, documented Olanzapine (Zyprexa) 2.5 mg each evening at 5:00 PM, and 5 mg twice daily as needed for agitation. The form documented, "This is a new [medication]." [NOTE: The form did not specify a specific behavior related to Resident #4's "agitation."] The form also documented Celexa 10 mg daily for depression, and Ativan 0.5 mg twice daily for anxiety.</p> <p>NOTE: Olanzapine is the generic name for the brand name antipsychotic medication Zyprexa. At various times facility documentation refers to the medication using both of these names.</p> <p>The 2014 Nursing Drug Handbook, pages 1018 and 1019 identified, in part, potential adverse reactions to Zyprexa to be insomnia, peripheral edema, dry mouth, increased appetite, thirst, weight gain, hyperglycemia, and abnormal gait. The handbook also listed Zyprexa as having a</p>	F 329	<p>as well as behavior flow sheets are specific to behaviors and side effects are being monitored and diagnosis warrants use of the medication. The results will be reviewed and discussed by the PI committee for 3 months.</p> <p>The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 329	<p>Continued From page 73</p> <p>Black Box Warning, "Drug may increase the risk of cardiovascular or infection-related death in elderly patients with dementia. Olanzapine isn't approved to treat patients with dementia-related psychosis."</p> <p>*Resident #4's Annual MDS assessment, dated 9/27/13, coded:</p> <ul style="list-style-type: none"> -Wants or needs a translator to talk with health care professionals. -Preferred language is Spanish. -Unable to complete the BIMS, assessed by staff with long term and short term memory deficits, rarely or never makes daily decisions. [NOTE: It was determined the facility did not engage a translator for Resident #4's assessments. Please refer to F 154.] -Unable to participate in the mood interview. Staff assessed no depressive symptoms. -Has delusions. [NOTE: There was no indication how delusions were assessed, given the language barrier.] -No behavioral symptoms, with an improvement since the last assessment. [NOTE: Resident #4's MDS prior to this assessment, dated 3/22/13, also coded no behavioral or depressive symptoms.] <p>Resident #4's Active Orders (Physician's Recapitulation Orders) for October 2013 documented:</p> <ul style="list-style-type: none"> -Lexapro 20 mg daily for depression, order date 4/29/13. -Olanzapine 2.5 mg twice a day for dementia with psychosis, order date 7/10/13. <p>Resident #4's Physician's Progress Notes documented:</p> <ul style="list-style-type: none"> -11/14/12. "Dementia-short term memory loss - 	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 329	Continued From page 74 DM II - BG's [increased] [with] UTI? Txed [treated] this wk [week] [with] Augmentin." [NOTE: There was no documentation as to how the physician assessed the degree of her dementia, given the language barrier.] -12/12/12. "DM II [and] BGs somewhat improved - Expect 'loose' controll [sic] [with] her mental deficits." -1/9/13. "DM II BGs have improved - PO 100% [with weight increase] 15 [pounds] in 4 months." -2/20/13. "Marked dementia. Short term memory loss. DM II sl [slightly] stabilized." -3/20/13. "BGs vary 180 - 280 - improved stability [and] adequate improvement." -4/17/13. "BGs adequate controll [sic] for her condition. Marked dementia." -5/15/13. "DM II [with] loose but improved BG controll [sic]. Severe Dementia." -6/12/13. "BG controll [sic] adequate. Severe Dementia." -7/10/13. "75 [year old] type II DM [Hispanic] [with] dementia. Reviewing fall rate of falls - 12 documented falls since January. Pt [patient] continues to fall even with 1 on 1 attendant [sic] - will be transferring to [name of town]." [NOTE: On this date, Resident #4's anti-psychotic medication was doubled in dose.] -8/7/13. "[Decrease] falls - No longer 1 on 1 - BGs remain unstable 70 to 400 - will continue conservative DM II care." -9/18/13. "BGs remain very erratic - range 100-300 [and] making stabalization difficult - but pt doing well [with] no recent falls - smiling [and] content this AM." -10/16/13. "[Right] upper forehead scrape from scratching - BGs better last [illegible] 89-241 - [weight] up 198 [to] 203 [pounds]." None of the physician's progress noted identified	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 329	<p>Continued From page 75</p> <p>that the resident was on psychotropic medications, or what the target behaviors were. The physician did not document that the benefits of the medications outweighed the risks. The physician did not assess Resident #4's weight gain, erratic blood glucose levels, or falls as a potential adverse reaction of her psychotropic medications. The physician did not document a rationale for doubling the routinely scheduled anti-psychotic dose from 2.5 mg per day to 5 mg per day on 7/10/13.</p> <p>Resident #4's care plan documented: -Focus of, "Exhibits behaviors of agitation AEB (as evidenced by): scratching or striking out at staff with cares related to: Anxiety with paranoid thought, Cognitive impairment Dx Dementia with Psychosis." Date initiated 9/20/12, revision on 9/25/12. *Goal of, "Reduced incidents of agitated behavior." Date initiated 9/20/12. *Interventions included: ~"Becomes delusional and hallucinates with very high blood sugars. Has delusions that caregiver has been 'mean' to her. Reassure her that you are here to help her." Date initiated 10/29/12. [NOTE: The intervention did not direct staff to check and address elevated blood sugars, what would be considered a "very high" blood sugar, or when the physician should be contacted. There was no documentation as to how it was determined her thoughts of caregivers being mean to her were delusions. There was no direction as to what to say to the resident to reassure her, since she was primarily Spanish speaking.] ~"Elicit family input for best approaches to resident." Date initiated 9/20/12. [NOTE: It had been over a year since this intervention had been</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 76</p> <p>added to Resident #4's care plan. However, there was no documentation this had been carried out, or which approaches family had identified.] ~"Give resident item or task in an attempt to distract." Date initiated 9/20/12. [NOTE: There were no suggestions as to which items or tasks were effective for Resident #4, or where those items or tasks could be found.] ~"Monitor for [side effects] of anti-psychotic med: somnolence, dizziness, constipation, dry mouth, weight gain, etc." Date initiated 9/20/12. [NOTE: It was not clear where these items were to be documented. The list of side effects to be monitored did not include peripheral edema, increased appetite, hyperglycemia, insomnia, thirst, or abnormal gait, as identified by the 2014 Drug Handbook.] ~"Res. gets very hungry, offer low cal. snacks." Date initiated 10/11/12. [NOTE: Even though this was identified as a new symptom for Resident #4 22 days after her admission, shortly after Zyprexa was started, there was no documentation the hunger was assessed as a possible adverse drug reaction.]</p> <p>Resident #4's care plan did not document her language barrier, or how it was to be addressed.</p> <p>Resident #4's Behavior Monthly Flow Sheets documented, for Olanzapine and Lexapro: -August 2013. Target behavior, "Throwing Things." No behaviors noted. -September 2013. Target behaviors, "Depressed withdrawn" and "Paranoia delusions." No behaviors noted. -October 2013. Target Behaviors, "Depressed withdrawn" and "Hallucinations/paranoia/delusion". No behaviors noted.</p>	F 329		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 329	<p>Continued From page 77</p> <p>There was no documentation from Resident #4's physician as to what the specific target behavior for Zyprexa was, or why the target behavior changed from August to September. There was no documentation as to what Resident #4 was throwing or why, or whether or not items were thrown in such a way as to cause harm to the resident or others. There was no documentation as to how staff were to assess the presence of hallucinations, delusions, or paranoia, given the language barrier. The interventions on the Behavior Monthly Flow Sheets did not include checking the resident's blood glucose level, which had been identified in the care plan as an antecedent to her delusions.</p> <p>On 9/27/13, Resident #4's Psychotropic Medication Evaluation Form for Olanzapine documented diagnosis of, "Dementia with psychosis." "Behavior warranting use of a medication" was documented as, "Yelling, picking, anger." Adverse reactions, "None apparent."</p> <p>The form identified the evaluation should be done quarterly, although the form was not dated until 9/27/13, more than 12 months after the resident was admitted. The target behavior on the form did not coincide with the behaviors being tracked for September 2013. At the time this form was completed, Resident #4 had gained 47 pounds since admission, was documented by the physician as having "erratic" blood glucose levels, and was noted to complain of feelings of hunger. The form did not assess any of these symptoms as potential adverse reactions to the anti-psychotic use.</p> <p>Resident #4's Initial Psychiatric Evaluation, dated</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 78 10/10/12, documented, "...history of poorly controlled diabetes...[facility name] stated she just appeared very frightened. She is Spanish speaking. One staff member stated she just seemed like she wanted to hide in a corner. The patient and I were able to communicate minimally with my minimal Spanish. The patient told me she was always nervous. When asked, she stated she slept okay. When asked if she wanted to die, she said, 'Yes, would you do something about it? No.' When asked if she felt scared she said, 'Yes.'...In the future, we might consider more focus on the antipsychotic as she appears to be suffering from symptoms of psychosis."</p> <p>There was no documentation as to exploration of underlying causes of Resident #4's fear and nervousness. It is unclear how much of this interaction Resident #4 understood, given the minimal communication with the practitioner's minimal Spanish.</p> <p>Resident #4's Psychiatric Medication Follow Up Evaluations documented: -11/14/12. "[Facility name] staff say [Resident #4] does appear better, much less terrified looking. [Resident #4] reports feeling some better, although she reports still feeling depressed. Still endorsed suicidal ideation, albeit passive. Reported sleeping well at night. [Resident #4] does have a urinary tract infection that she is being treated for. [Resident #4] reports sleeping, 'too much.'...We speak some in my broken Spanish and some in English. She does tell me she is less 'herbiosa' but stated, 'I am too depressed.'...Will also change Celexa 20 mg to Lexapro 20 mg which would be a dose increase. Lexapro 20 mg is equivalent to Celexa 40 mg..."</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
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F 329	Continued From page 79 [NOTE: There was no documentation as to how Resident #4's "terrified" appearance was monitored, how her current infection may be impacting her mood state, or whether or not the presence of the infection or her sleeping patterns may be adverse reactions to her psychotropic medication use.] -1/9/13. "[Facility Name] staff say ever since tapering and discontinuing [Resident #4's] Clonazepam she has showed episodes where she becomes so anxious she yells. [Resident #4] does endorse feeling, 'nerbious.' Otherwise, she is doing fairly well...[Resident #4] is lying in bed sleeping, She is a bit mystified as to who I am. She is gracious about my Spanglish and seems to understand what I say to her...Restart Clonazepam .125 mg twice a day. This was a gradual dose reduction failure...Greater than 50 percent of my time was spent in coordination of care." -2/20/13. "[Facility Name] staff say [Resident #4] has been doing well..." -3/13/13. "[Facility Name] staff say [Resident #4] has been doing quite well..." -4/10/13. "...more isolative [sic] and anxious appearing. She has been doing some picking on her forehead...When I ask how she is replies 'malo' or bad...Will get a UA [urinalysis] and at least temporarily increase Clonazepam..." [NOTE: There was no indication as to the timeframe the "temporary" medication increase was to continue. There was no rationale as to why a psychotropic medication increase was warranted instead of the suspected underlying medical cause being ruled out and treated if indicated.] -5/8/13. "...There has been mention that [Resident #4] has gained weight. I am not sure how much. We will monitor that next appointment." [NOTE: The facility documented	F 329		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 329	Continued From page 80 Resident #4's admission weight in 9/20/12 had been 150 lbs. Resident #4's monthly weight on 5/5/13 was documented as 189 lbs, a gain of 39 lbs. over a period of approximately 8 months. Please see F 325 as it pertains to weight gain. There was no documentation Resident #4's weight gain was assessed as a potential adverse reaction to her Olanzapine.] -6/12/13, "...staff say the patient has been diagnosed with another urinary tract infection, so she is just not doing well..." [NOTE: There was no further mention or evaluation of Resident #4's weight gain. There was no evaluation of another infection being a possible adverse reaction to Resident #4's Olanzapine use.] -7/10/13. "...staff say [Resident #4] probably has a chronic urinary tract infection. They say that she has been extremely restless, very difficult to redirect. They say she has had 12 falls, I believe, in the last two months. They say that she is now on one-to-one staffing...The patient was sleeping soundly...We will just try increasing the Zyprexa to 2.5 mg twice a day. I am not sure if that will help, but we will just see if it is some sort of psychosis [sic]. I believe this patient may be transferred to another facility. If not, I will be happy to follow her in a month." [NOTE: There was no documentation the chronic infection or falls had been assessed as potential adverse medication reactions to the Zyprexa. There was no clear indication of the presence of psychosis, or rationale, besides falls, to increase the Zyprexa dose. There was no further evaluation of Resident #4's weight gain.] -9/11/13. "I reviewed the patient's chart and discussed the patient with caregivers and did a brief mental status exam. Caregivers say [Resident #4] is doing better overall behaviorally. They say they had to do some adjustment of	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 329	<p>Continued From page 81</p> <p>toileting her during the night, which has resulted in things going much more smoothly for everyone..." [NOTE: This was the first mental health visit since the Zyprexa was increased. More than 2 months had passed. There was no documentation as to how, given the language barrier, the mental status exam was conducted, nor of the results. There was no documentation as to how it was determined the resident had improved behaviorally. There was no mention of why a toileting program had not been previously identified or implemented.]</p> <p>-10/9/13. "...The patient's blood sugars have been quite erratic which may contribute at times to her feelings of anxiety. Staff say she has been pretty stable behaviorally. Not as fearful or anxious appearing. Not as attention seeking...I asked her in Spanish how she was feeling and she replied, 'malo.' When I asked why or how she replied, 'I don't know.' She smiled and had good eye contact. Insight and judgement poor. Intelligence less than average. Intelligence is very hard to ascertain, but I am guessing less than average by virtue of dementia..." [NOTE: There was no documentation of Resident #4's erratic blood sugars being ruled out as a potential adverse reaction to her Zyprexa increase. This was the first mention of behavior characterized as, "attention seeking." There was no documentation Resident #4's feelings of, "malo" were further explored by the practitioner who conducted this evaluation, or facility staff notified so they could follow up on those complaints. It is unclear how the practitioner assessed Resident #4's intelligence, or how that data was pertinent to the psychotropic medication evaluation.]</p> <p>Resident #4's Interdisciplinary Progress Notes (PNs), prior to the increase in Zyprexa on 7/10/13</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 329	Continued From page 82 documented: -7/2/13 at 1:00 PM. Cares for 2 falls - both on 6/30/13 - Resident is getting OOB [out of bed] both times. Bed alarms working. Observation has increased Q [every] 15 minutes. Plan to review afternoon activity to provide activity for her. Will review psy [psychotropic] med [due to] [signs and symptoms] of [increased] restlessness in the afternoon" -7/2/13 at 10:10 PM. "...[No] attempts to self-transfer this shift..." -7/3/13 at 4:15 AM. "...Res has been sleeping quietly so far this shift, [without] [negative] behaviors." [NOTE: There was no documentation as to what specific behavior would constitute a "negative" behavior.] -7/7/13 at 3:55 PM. "Resident alarm sounded. When CNA responded found resident sitting on floor in hallway, just outside of resident's room. Resident unable to state what she was trying to do. Res denied need for toileting. Res had been noted sleeping in bed [at 3:45 PM]..." [NOTE: There was no documentation as to whether or not Resident #4 had been offered an afternoon activity, as identified in the note from 7/2/13. There was no documentation of Resident #4's needs being assessed in a language she understood.] -7/8/13 at 7:00 AM. "...[No] neg [negative] behaviors noted this shift. [No] attempts to self-transfer noted..." -7/8/13 at 2:00 PM. "...[No] attempts to self-transfer this shift..." -7/8/13 at 8:15 PM. "...[increased] neg behaviors this shift. Yelling [at] [staff [and] hitting. Res removed from environment [and] calmed. [No] attempts to self-transfer." [NOTE: There was no documentation assessing potential antecedents to Resident #4's behaviors, what environment she	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 83</p> <p>was in when they occurred, or to which environment she was taken to calm her.] -7/9/13 at 3:05 PM. "Discharge when bed available." -7/10/13 at 3:45 PM. "Received [and] processed order to [increase] Zyprexa."</p> <p>Resident #4's PNs after the increase in her Zyprexa documented: -7/12/13. "Late entry for 7/11/13 [night] shift. Res was up [at] start of the shift [and] constantly keep [sic] ringing her call light [and] when asked what she needed she stated she had to use the restroom [and] Res was toileted [4 times] in a 2 hour period only one of the times did Res urinate...Res attempted to get out of bed [more than 7 times]..." -7/18/13 at 9:00 AM. "Resident had 1 episode of yelling in the hallways after breakfast because resident could not get right into bed..." -7/28/13 at 5:00 AM. "Res attempting to self transfer [two times]. Res alarm sounded [and] res found sitting on commode. Res didn't use call light either time." -8/13/13 at 2:00 AM. "[Increased] insomnia, pulling call light cord out of wall constantly, refusing to state what is needed when staff inquires..." -8/29/13 at 4:00 AM. "Res awake most of [night] shift, yelling, pulling call light cord out of the wall... [increased] behaviors, res denies pain when asked. Res stated "I'm hungry" several times [and] was given some snacks, then cont[inue]d to yell "I sleepy" but would not be calmed or redirected when trying to get out of bed..." -9/19/13 at 5:00 PM. "Res has had high BGs this shift ranging 426-478. BG on 9/18/13 [at 4:30 PM] was 478, BG on 9/19/13 [at 7:00 AM] /426, [11:00 AM] /458. Urine dip obtain results as follows.</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 84 Polyuria noted [and] frequently more incontinent..." -9/23/13 at 4:10 AM. "...Res having issues [with] insomnia, shouting "I'm hungry" during beginning of [night]...given sandwich, cont. to yell for some time afterwards...Res also cont. to pull call light cord out of wall [and] wrap it around her neck like a scarf. Res advised not to place cord around neck because of safety issues..." -9/25/13 at 12:40 PM. "Cares - Fall 9/20 [no] injury, attempting to self-transfer - plan to toilet right after each meal..." -10/15/13 at 5:30 AM. "Res const pulling call light cord out of wall [and] pulling on it...got agitated...then took off her attends [and] threw them across the room. Res was yelling loudly each time someone passed the room, would not answer when staff inquired what was needed...Res also pulling pillow case off pillows, removing bedding..." -10/17/13 at 7:00 PM. "Resident having increased restlessness [with] rapid breathing and jitteriness when verbally speaking. Continues to touch forehead [with] bilateral fingertips on her hands. Res is unable to remember that she went to the toilet [every] 5 minutes [four times] [with] no results as far as voiding or bowel movement..." -10/17/13 at 8:15 PM. "LN assisted resident to the restroom [at] this time. LN noted resident ripping the toilet paper off the roll and throwing it onto the floor [three times] during this time. LN noted teeth grinding [with] labored breathing." [NOTE: Each of these entries identified either a symptom which might have indicated Resident #4 was experiencing adverse reactions to her Zyprexa, a physical need which may need to be addressed as a nonpharmalogical intervention, or a potential issue the resident was having difficulty communicating due to her language barrier]	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 85 On 10/21/13 at 2:15 PM, Resident #4 was observed sitting in her room, in her wheelchair, which was located next to the left side of her bed, with the resident facing the head of the bed. She was approximately 10 feet from the doorway to the room. As the surveyors entered the room, Resident #4 could be heard with wheezing as she breathed. As the surveyors approached the resident, her ankles were visibly edematous, to the point of her skin appearing taut. As she spoke, her voice sounded forced, as if she was having to exert herself to speak. On 10/23/13 at 3:40 PM, the Pharmacist was interviewed regarding Resident #4's Zyprexa use and potential adverse reactions. The Pharmacist stated one of the adverse reactions to Zyprexa was weight gain, and if the medication was increased in dose, the rate of weight gain could increase as well. The Pharmacist stated, "Oh, yes. People on Zyprexa usually gain at least 10 pounds, sometimes more, depending on the person." The Pharmacist was asked if Zyprexa could cause elevated blood glucose levels. The Pharmacist stated, "Oh, yes. Probably Zyprexa is the worst for that. I would recommend frequent A1-C's [Hemoglobin A1-C], every 6 months on a resident with stable BGs, every 3 months if the BGs were less stable." The pharmacist was asked if it would be important for him to know if a resident on Zyprexa had edema. The Pharmacist stated, "Of course. The patient's clinical condition is always important." The Pharmacist was asked if the facility had ever informed him Resident #4 had weight gain, unstable BG's, or edema. The Pharmacist stated, "No. I didn't know that." On 10/24/13 at 12:52 PM, the FIDON was	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 86</p> <p>interviewed regarding Resident #4's Zyprexa use. The FIDON stated she was unsure what the specific target behavior was for Resident #4, but she would investigate. The FIDON stated Resident #4 was followed by a mental health nurse practitioner, which should cover those issues for Resident #4. The FIDON was asked how the facility monitored potential adverse reactions or side effects for Resident #4's Zyprexa. The FIDON stated side effects were onitored on the resident's MAR. The surveyors stated they had not seen which side effects, specifically, were to be monitored for Zyprexa. The FIDON stated, "If I was the nurse, and they weren't listed, I would go look them up. That's what I would expect."</p> <p>On 10/24/13 at 3:00 PM, the facility's Regional Medical Director (RMD) was interviewed regarding Resident #4's Zyprexa use. The RMD stated the facility had contacted him in July of 2013 to review Resident #4's chart. The RMD stated he was able to make some recommendations of medication changes to reduce the risk of adverse reactions such as falls and BG levels. The RMD stated he felt Resident #4 was on a very small dose of Zyprexa. The RMD was asked what the target behavior for Resident #4's Zyprexa was. The RMD stated, "That's a good question. I'll have to look into that." The RMD was asked if he was aware of the increase in Resident #4's Zyprexa dose on 7/10/13. The RMD stated, "Right. I just saw that. That was not done from my recommendation, I don't know why." The RMD was asked about unstable BG's, falls, edema, hunger, and weight gain as possible adverse reactions to Zyprexa use. The RMD stated, "Those are all good questions. She's got some heart failure, and I've</p>	F 329		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 87</p> <p>listened to her lungs and talked to her attending physician. We got some Lasix ordered, and we'll see about getting some labs."</p> <p>On 10/25/13 at 10:50 AM, the Resident Services Supervisor (RSS) was asked about target behaviors identified by the physician for anti-psychotic use. The RSS stated typically the target behavior was not identified by the physician, but by the facility. As far as indications for use, the RSS stated, "It is my understanding they have to have some kind of psychosis or psychotic disorder. I sit on the IDT, and I'm responsible to fill out the target behaviors on the behavior monitors, but that's about it."</p> <p>On 10/25/13 at 6:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.</p> <p>Note: Please see F 154 as it pertains to providing information in an understandable fashion, F 309 as it pertains to delay in treatment, and F 325 as it pertains to nutritional status for Resident #4.</p> <p>2. Resident #6 was admitted to the facility on 6/18/13 with multiple diagnoses including cri du chat syndrome with severe developmental delay (see explanation of diagnoses below), and expressive language disorder.</p> <p>Resident #6's most recent Quarterly MDS, dated 9/26/13, coded: -No speech, rarely understood, rarely understands others. -Unable to participate in the BIMS, assessed by staff with long term and short term memory. -Unable to participate in the mood interview,</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 329	<p>Continued From page 88</p> <p>assessed by staff with daily loss of interest in activities, and feeling tired or having little energy daily.</p> <p>-No hallucinations, delusions, or other behaviors.</p> <p>-Resident #6's Active Orders (Physician's Recapitulation Orders) for October 2012 documented Seroquel 75 mg twice daily, starting 9/3/13.</p> <p>Resident #6's record contained no physician's progress notes since her admission. [NOTE: Please see F 387 as it pertains to the frequency of physician's visits.]</p> <p>Resident #6's care plan documented:</p> <p>-Focus area of, "[Diagnosis] of bipolar disorder with occasional loud vocalizations, [history] of slapping at staff, restlessness." Date Initiated: 6/28/13.</p> <p>*Goals of, "No lough [sic] vocalizations or slapping staff," and, "Will be able to sit thru meals and activities." Date initiated 6/26/13.</p> <p>*Interventions included, "Avoid overly stimulating environment," and, "Monitor s/e [side effects] of anti-psychotic medication..." [NOTE: There were no additional non-pharmalogical interventions listed. While there was an intervention to monitor the effects of medication, there was not an intervention to administer the medication.]</p> <p>-Focus area of, "Exhibits inappropriate behavior, resists treatment/care AEB pushing staff away related to: Fear or pain." Date Initiated 6/26/13.</p> <p>-Interventions included, "Administer medication as ordered." "Allow flexibility in ADL routine to accommodate residents mood." "If resident refuses care, leave resident and return in 5-10 minutes." "Praise/Reward resident for demonstrating consistent desired/acceptable</p>	F 329		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 329	<p>Continued From page 89 behavior." Date initiated for all the interventions was 6/26/13.</p> <p>On 10/23/13 at 7:45 AM, the Administrator, FIDON, and IDON were interviewed regarding the anti-psychotic use for Resident #6. The FIDON stated the target behavior for the anti-psychotic medication for this resident was jitteriness or nervousness. When asked if these behaviors would warrant the use of an anti-psychotic medication, the FIDON stated, "It doesn't." The Administrator, IDON, and FIDON were asked about Resident #6's diagnosis of cri du chat, in terms of typical symptoms, treatments, and interventions. The Administrator stated he did not know the answer to that, as he had never seen anyone with that disorder before. The IDON stated she would expect the facility would have found out what causes the syndrome, what can be done about it, and in-serviced the staff. The Administrator, IDON, and FIDON stated to the best of their knowledge, this had not been done, even though Resident #6 had been in the facility for 4 months. The Administrator, IDON, and FIDON were asked how it was determined in Resident #6's care plan her behaviors were "inappropriate", rather than normal and expected due to her disease process. The Administrator stated he did not know, but would check. The Administrator, IDON, and FIDON were asked when and by whom Resident #6 had been diagnosed with bipolar disorder, given Resident #6's communication deficits. The Administrator stated he would check.</p> <p>On 10/23/13 at 9:15 AM, the Administrator provided a document to the surveyor entitled, "Cri Du Chat Syndrome." The document identified it had been obtained from a genetics website on</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 329	<p>Continued From page 90</p> <p>4/24/13. It documented, in part, "The name of the syndrome is French for 'cry of the cat', referring to the distinctive cry of children with this disorder. The cry is caused by abnormal larynx development...Cri-du-chat is caused by a deletion...on the short arm of chromosome 5...often, the larynx doesn't develop correctly, which causes the signature cat-like cry...people with cri-du-chat usually have difficulty walking and talking correctly..." The Administrator also provided a H&P dated 4/22/13, almost 2 months prior to Resident #6's admission to the facility, which documented "bipolar disease" under "Past Medical History." However, there were no further details as to when or how this disorder was diagnosed.</p> <p>On 10/24/13 at 3:00 PM, the RMD was asked about the bipolar diagnosis for Resident #6. The RMD stated he had not been involved in the care for Resident #6, but in his experience it would be very difficult to make that diagnosis in a patient with cri-du-chat syndrome.</p> <p>On 10/24/13 at 6:15 PM, the Administrator, IDON, RDCO, and FIDON were informed of the surveyor's findings. The facility offered no further information.</p> <p>3. Resident #8 was admitted to the facility on 9/30/13 with multiple diagnoses which included dementia, anxiety, and depression.</p> <p>Resident #8's physician's orders documented Seroquel 25 mg daily, for a diagnosis of senile dementia, with an order date of 9/30/13.</p> <p>Resident #8's admission MDS assessment, dated 10/7/13, coded:</p>	F 329			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
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F 329	<p>Continued From page 91</p> <p>-BIMS of 3, indicating severely impaired cognition.</p> <p>-Delusions present.</p> <p>-Wanders daily.</p> <p>On 10/24/13 at approximately 3:30 PM, the surveyors approached Resident #8 in her room. Resident #8 was laying on her bed, pleasantly welcomed the surveyors. Resident #8 stated she had been in the facility, "About a day." When asked why she was there, Resident #8 assumed a confused facial expression and stated pleasantly, "I'm having a little one."</p> <p>On 10/25/13 at 10:05 AM, the RSS was asked what behavior the physician had identified as the target symptoms for the Seroquel use. The RSS stated, "Paranoia and psychosis." The RSS was asked for documentation from the physician stating these were the target symptoms. The RSS stated she would check.</p> <p>On 10/25/13 at 10:45 AM, the RSS returned to the surveyor. The RSS stated she could not find documentation the physician had identified any target behaviors for the Seroquel use. The RSS stated, "I don't know that the doctor has identified any behaviors. We [the facility IDT] identify them. The only thing I know is when she was admitted the diagnosis was identified as dementia with agitation. My understanding is they have to have some kind of psychosis or psychotic disorder."</p> <p>On 10/25/13 at 6:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.</p>	F 329		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR	F 332		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617	
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F 332 SS=D	<p>Continued From page 92 RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate less than 5 percent. This was true for 2 of 27 medications (7.4%) which affected 1 of 9 residents (#13) during medication pass observations. The failure created the potential for less than optimum benefit from prescribed medications when the medications were not administered as ordered. Findings include:</p> <p>On 10/22/13 at 4:00 p.m., LN #2 was observed as she poured, then administered, the following 3 medications for Resident #13: * Ferrous sulfate (an iron supplement) 325 milligrams, 1 tablet by mouth, with water; * Artificial tears, 1 drop in the right eye; and, * Dorzolamide HCL 2%, 1 drop in the right eye.</p> <p>On 10/22/13 at about 4:15 p.m., reconciliation of the aforementioned medications with the resident's recapitulation of Active Orders for 10/1/13 to 10/31/13 revealed the ferrous sulfate was ordered to given with meals and the artificial tears were ordered to be administered in both eyes.</p> <p>Immediately afterward, when asked about the discrepancy regarding the artificial tears, LN #2 stated, "Oh, I always forget the left eye. I'll give it</p>	F 332	<p>Resident # 13 discharged from facility on 11/24/13.</p> <p>LN # 2 was educated by Staff Development Coordinator on or before 11/22/13 regarding the "5 Rights" of medication administration.</p> <p>Medication pass competencies were completed on or before 11/20/13 by Director of Nursing or designee to ensure the LNs are following acceptable practices. No corrections were necessary at the time of review.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will complete 3 medication pass competencies weekly for 4 weeks and then monthly for 2 months. The results will be reported to the PI committee for 3 months. The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 332	Continued From page 93 before 5. It won't be late if I give it before 5."	F 332	Resident # 2 respiratory status evaluated by a licensed nurse on 10/29/13 with no adverse findings noted. A referral was made to speech therapy to evaluate by Director of Nursing on or before 10/28/13 and evaluation was completed prior to 10/28/13.		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure food was prepared in a form to meet individualized needs. This was true for 1 of 6 residents (#2) sampled for dietary issues. The deficient practice had the potential to cause more than minimal harm if Resident #2 choked or aspirated when served and assisted to eat foods inconsistent with the pureed texture ordered by his physician. Findings included: Resident #2 was admitted to the facility on 11/17/06 with multiple diagnoses which included dementia, macular degeneration, and celiac disease. Resident #2's most recent MDS assessment, dated 8/20/13, coded: -Unable to complete the BIMS, with no staff assessment of his cognitive abilities. -Totally dependent of 1 for eating. Resident #2's Active Orders (Recapitulation orders) for October 2013 documented a puree	F 365	On or before 10/30/13 a meal observation was reviewed by a member of the IDT for texture served per tray card and MD orders. No issues noted at time of review. Education was provided to center staff on or before 11/22/13 by the Administrator to ensure diets served are per physician orders. Beginning the week of 11/25/13 the Director of Nursing or designee will review 3 meals weekly for 4 weeks then monthly for 2 months to ensure that individual meals are served at the consistency ordered by the attending physician. The results will be discussed at center PI committee for 3 months. The Director of Nursing shall be responsible for compliance.	12/6/13	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 365	<p>Continued From page 94</p> <p>texture diet, effective 8/7/12.</p> <p>The New England Diet Manual for Extended Care, Revised in 2008, identified by the facility as the diet manual in use, documented, "Puree Texture...chewing to masticate food in the mouth is completely eliminated. All foods are pureed, blenderized or strained to ensure a smooth, cohesive quality without lumps..."</p> <p>On 10/22/13 at 8:35 AM, Resident #2 was observed at breakfast. His meal included oatmeal and scrambled eggs. Neither the oatmeal or the eggs had been pureed. The oatmeal had visible flakes of cooked oats. The eggs had a curd-like texture which would require chewing in order to be swallowed. Resident #2 was being assisted to consume his meal by the SDC. As Resident #2 was given each bite of oatmeal or eggs, he would engage in a chewing motion with his mouth for an extended period of time, still engaging in that motion when presented with another bite. On several occasions throughout the meal, Resident #2 coughed, food particles exited his mouth, and had to be wiped away with a napkin.</p> <p>On 10/22/13 at 12:20 PM, Resident #2 was observed sitting in his wheelchair, at the table for the noon meal. Although several of his lower teeth were missing, whole oatmeal flakes were still visible in/on/around his remaining lower teeth.</p> <p>On 10/22/13 at 12:30 PM, Resident #2 was served his noon meal. CNA #6 and the IDON were sitting at the table to assist the residents to eat. Both CNA #6 and the IDON remained at the table for the duration of the meal. The resident's tray contained ground chicken, jello, and pureed peas. The chicken, although ground, still had the grain of the meat visible in the small pieces. The texture was such as to require chewing before it could be swallowed. The surveyor asked Cook #7 if the chicken was considered pureed. Cook #7</p>	F 365			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 365	<p>Continued From page 95</p> <p>stated, "Yes." CNA #6 then began to assist Resident #2 to consume his meal by placing bites of the chicken in his mouth. Resident #2 engaged in a chewing motion with his mouth, which continued for over a minute. Resident #2 was still chewing, and had not swallowed, when CNA #6 gave him a drink of water. He continued to chew even after the water was given, and was still chewing as bites of jello and peas were placed in his mouth. Eventually, a mixture of chicken, peas, and jello overflowed from Resident #2's mouth onto his chin. This chain of events happened twice, with the mixture wiped from his chin either with a napkin, or the edge of a spoon. Resident #2 was coughing intermittently during this time. On 10/22/13 at 12:25, the surveyor asked the IDON, who was sitting at the table across from Resident #2, if his chicken was pureed. The IDON stated, "It looks more ground to me. It's not pureed." However, the IDON did not respond to replace the ground item with a pureed one specified by Resident #2's physician's orders. The surveyor then informed the IDON of Resident #2's physician's orders for pureed texture, and asked again if his chicken was pureed. The IDON stated, "That looks more ground to me. It's not pureed." Again, the IDON did not respond to obtain pureed chicken for Resident #2, and the chicken remained on the table.</p> <p>On 10/23/13 at approximately 9:30 AM, the Dietary Manager (DM) and the Dietary Consultant (DC) approached the surveyor. They provided copies from their diet manual with the definition for a pureed diet, and stated per that definition, oatmeal and scrambled eggs would have been considered pureed. They were unable to address how oatmeal and scrambled eggs would meet this definition, given the texture and need for mastication (chewing) in order to swallow them.</p>	F 365		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 365	Continued From page 96 The DM stated he felt the chicken which had been served to Resident #2 had been pureed. However, both the DM and the DC stated they did not look at Resident #2's chicken specifically before it was served to Resident #2. On 10/23/13 at 5:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility later provided additional information, but it did not resolve the surveyor's concerns.	F 365			
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure special eating equipment was provided for residents identified as needing it. This was true for 1 of 6 residents (#2) sampled for adaptive equipment. The deficient practice had the potential to cause more than minimal harm if the resident experienced dehydration when not provided a nose cup for his beverages. Findings included: Resident #2 was admitted to the facility on 11/17/06 with multiple diagnoses which included dementia and celiac disease. Resident #2's most recent MDS assessment, dated 8/20/13, coded: -Unable to complete the BIMS, with no staff assessment of his cognitive abilities.	F 369	A referral was made to speech therapy to evaluate resident #2's adaptive equipment needs by the Director of Nursing on or before 10/28/13. The evaluation was completed prior to 10/28/13. The resident is receiving adaptive equipment as ordered; there were no adverse effects post evaluation. A review of other residents utilizing adaptive eating equipment was referenced against the individual dining meal cards on or before 11/22/13 by the IDT to assure that the kitchen staff is aware of equipment needs. The center staff was educated by Administrator on or before 11/22/13 to ensure that adaptive eating equipment as care planned is present at meal time to assist the resident with nutrition and hydration. If items not delivered, staff should seek assistance from kitchen. On or before 11/15/13 members of the IDT were assigned		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617		
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F 369	<p>Continued From page 97</p> <p>-Totally dependent of 1 for eating.</p> <p>Resident #2's care plan documented: -Focus area of "Risk for dehydration." Initiated 12/9/09. -Intervention of "Provide nosey cup adaptive cup." Initiated 12/9/09.</p> <p>On 10/22/13 at 8:35 AM, Resident #2 was observed at the breakfast meal. The SDC was providing assistance to Resident #2 to consume his meal. There was no nosey cup present. Throughout the meal, the SDC offered Resident #2 drinks of his beverages by using a regular glass or cup, and placing a straw in the resident's mouth. Intermittently throughout the meal, Resident #2 was observed to cough.</p> <p>On 10/22/13 at 12:30 PM, Resident #2 was observed at the lunch meal. Resident #2 was being assisted by CNA #6, with the IDON also sitting at the table. Again, there was no nosey cup present, and Resident #2 received his beverages from a regular glass with a straw. Again, intermittent coughing was noted.</p> <p>On 10/23/13 at 7:45 AM, the FIDON was asked about the use of a nosey cup for Resident #2. The FIDON stated she was did not know why a nosey cup wasn't used for Resident #2, but would research and follow up. The FIDON produced no further information for the surveyor.</p> <p>On 10/23/13 at 5:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. On 11/1/13, the facility provided additional information regarding Resident #2's nosey cup. However, the additional information did not resolve the surveyor's</p>	F 369	<p>a routine schedule by the center administrator for dining room supervision to ensure any diet texture issues are followed up on.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will observe 3 meals weekly for 4 weeks and then monthly for 2 months to ensure adaptive equipment is served and present on tray card. The results will be discussed at center PI committee for 3 months.</p> <p>The Director of Nursing shall be responsible for compliance.</p>	12/6/13	

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

PRINTED: 11/14/2013
FORM APPROVED
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F 369 F 386 SS=D	Continued From page 98 concerns. 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure physician's visits included a review of the resident's total status. This was true for 1 of 6 residents (#2) sampled for physician's visits. The deficient practice had the potential for more than minimal harm when it was not documented the residents received a thorough assessment from their physician. Findings included: Resident #2 was admitted to the facility on 11/17/06 with multiple diagnoses including dementia with behavioral disturbances, atherosclerosis, and macular degeneration. Resident #2's Physician's Progress Notes documented, in their entirety: -12/12/12. "Full Care. Severe dementia on Hospice." [NOTE: Facility records indicate Resident #2 was discharged from hospice services on 10/9/12.]	F 369 F 386	Resident # 2 was thoroughly assessed by MD on 11/13/13 for systemic review with detailed progress note placed in medical record. No new orders given at that time. A review of other resident's medical records was completed by a member of the IDT on 11/19/13 to ensure detailed systemic progress notes are in charts. Residents found to be affected were scheduled for MD visits. Education provided to MD by center Administrator and regional medical director on or before 11/22/13 to ensure progress notes reflecting visits are specific to the problems identified with a detailed systems review. Health information manager will review progress notes after visit to ensure notes are detailed. Phone call will be made to the physician for further follow up as indicated through review. Beginning the week of 11/25/13 the Director of Nursing or designee will review 3 charts weekly for 4 weeks and then monthly for 2 months to ensure progress notes specifically reflect residents' condition. The results will be discussed at center PI committee for 3 months. The Director of Nursing shall be responsible for compliance.	12/6/13

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F 386	Continued From page 99 -1/9/13. "Severe dementia. Calm." -2/20/13. "Total care [with] hospice. Stable." -3/20/13. "Remarkable stability. Total care for severe dementia." -4/17/13. "Severe Dementia. Hospice. Stable." -5/15/13. "Severe Parkinson's dementia." -6/12/13. "Total care/Parkinson's/Dementia." -7/10/13. "Beautiful smile. Total care for severe dementia." -8/7/13. "Calm. Severe dementia. Total care. On hospice." -9/18/13. "Nice smile this AM. Appears angelic. Stable severe dementia with total care." -10/10/13. "Smiling and calm. Stable." On 10/23/13 at 7:45 AM, the Administrator and the FIDON were asked about the content of Resident #2's physician's progress notes. The FIDON reviewed the notes and stated, "Oh. Well, we can't always control what the physician writes." The surveyor asked if the facility had involved their medical director to help rectify the situation. The Administrator stated, "Those notes were made by our medical director." On 10/24/13 at 3:00 PM, the facility's RMD was asked about the content of Resident #2's physician's progress noted. The RMD indicated the progress notes were insufficient. On 10/25/13 at 6:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least	F 387	Resident #6 was assessed by their physician on or before 10/28/13.	

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F 387	<p>Continued From page 100</p> <p>once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure residents were seen by their physician's as frequently as required. This was true for 1 of 6 residents (#6) sampled for frequency of physician's visits. The deficient practice had the potential to cause more than minimal harm when Resident #6's multiple medical issues were not monitored by a physician. Findings included:</p> <p>Resident #6 had multiple admissions and discharges from the facility, with her most recent discharge from the facility documented as 5/9/13, and her most recent admission to the facility documented as 6/18/13.</p> <p>There were two documents in Resident #6's record identified as H&Ps. The first H&P, dated 4/22/13, listed multiple diagnoses which included flaccid legs, decreased functional status, and mildly elevated glucose and liver function tests. The second H&P, dated 5/31/13 listed multiple diagnoses which included sepsis secondary to a UTI, acute renal failure, thrombocytopenia, CHF with exacerbation, moderate protein calorie malnutrition, Cri-du-Chat syndrome with developmental delay, right hip pressure wound, and L1 burst fracture with flaccid paralysis.</p>	F 387	<p>A review of residents' records was completed by the manager of clinical operations on 10/29/13 to verify MD appointments are in compliance. Appointments made at time of review as indicated.</p> <p>The nursing staff and department managers were educated by the center Administrator on or before 11/22/13 regarding the frequency of physician visits requirement. Health information manager will track physician visits for ongoing review. Appointments needed will be arranged through either transportation or to MD office for center visit. Required documentation reviewed with MD on or before 11/11/13 by facility Administrator.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will review 3 charts weekly for 4 weeks and then monthly for 2 months to ensure frequency of appointments are compliant. The results to be discussed at center's PI committee meeting for 3 months. The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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F 387	Continued From page 101 When reviewing Resident #6's record, no further physician's visits or progress notes were found. On 10/23/13 at 7:45 AM, the Administrator and IDON were asked about physician visits for Resident #6. The Administrator stated Resident #6 had been to see her physician the day before (10/22/13), but was not sure if she had been seen between the time of her most recent admission and 10/22/13. [NOTE: 125 days had elapsed between the time of Resident #6's admission and her MD visit on 10/22/13. 143 days had elapsed between the date of Resident #6's most recent H&P and her MD visit on 10/22/13.] On 10/24/13 at 6:15 PM, the Administrator, IDON, FIDON, and RDCO were informed of the surveyor's findings. The facility offered no further information.	F 387		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	Residents # 1, 2, 3, 7, and 9 were evaluated by a licensed nurse on or before 11/25/13 for any adverse reaction to 2 licensed nurses not destroying Fentanyl patch without any adverse findings. Resident # 12 for evaluated by a licensed nurse on or before 11/15/13 for adverse reaction related to pharmacy label not matching MAR without any adverse findings noted at time of assessment. Sticker placed	

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F 431	<p>Continued From page 102</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy and procedure (P&P) review, it was determined the facility failed to ensure a process was in place to reconcile loss or diversion of controlled medications, such as used fentanyl patches; pharmacy labels were accurate; an opened vial of Lantus insulin was not available for use more than 28 days; and, medications were stored in locked areas not accessible to residents and unauthorized staff. This was true for 5 of 9 sample residents (#s 1, 2, 3, 7, and 9), and for 1 of 7 residents (#12) during medication pass observations. These failures created the potential for more than minimal harm if Resident #s 1, 2, 3, 7, and 9 did not have their fentanyl patches or the unused portion of the patches was diverted or lost; inadequate pain control for Resident #12 whose pain medication was mislabeled; reduced efficacy of Resident #3's</p>	F 431	<p>on or before 11/27/13 by LN to indicate frequency change.</p> <p>Resident # 3 was evaluated by licensed nurse on 11/15/13 for any adverse reactions related to Lantus being opened for 32 days without any negative findings.</p> <p>Resident # 1 skin was evaluated by licensed nurse on 11/15/13 related to CNAs applying medicated barrier cream without any adverse findings noted. Bedside checked and remains free from any medicated cream.</p> <p>A review of other residents utilizing Fentanyl Patches was reviewed by Director of Nursing on or before 10/29/13 to ensure used patches were destroyed with 2 licensed nurses. No other residents were identified to be using them at time of review.</p> <p>A review of other residents' medication cards and/or containers was reviewed and checked against the physician's order by an LN on or before 11/22/13.</p> <p>A review of opened insulin was completed by Director of Nursing on or before 11/15/13 to ensure they were dated as opened within the previous 28 days. No other insulin was noted to be opened past the specified time frame.</p> <p>A review of other resident rooms was completed by members of the nurse</p>	

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F 431	Continued From page 103 insulin that was in use more than 28 days; and, negative effects for any cognitively impaired and independently mobile resident should they ingest INZO barrier cream stored at Resident #1's bedside. Findings included: 1. Note: The Informational Letter, Reference: S&C: 13-02 NH dated 11/12/12, stated, in part, "Fentanyl transdermal patches are a controlled substance commonly used in nursing homes for pain medication. These patches present a unique situation given the multiple boxed warnings, the potential for abuse, misuse and diversion, and the substantial amount of fentanyl remaining in the patch after use. The facility's policies must address safe and secure storage, limited access and reconciliation of controlled substances in order to minimize loss or diversion, and provide for safe handling, distribution and disposition of the medications. One benefit of the patch is the continuous delivery of fentanyl over 72 hours...One study determined that even after three days of use, 28 to 84.4% of the original fentanyl dose was still present in the patch. The study noted that the dose remaining in the patch was within the limits of a lethal fentanyl dose. The remaining fentanyl in a used patch is a potential vehicle of abuse and accidental overdose and warrants implementation of adequate disposal policies...Staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. ..." On 10/23/13 about 10:15 a.m., the MAR binders	F 431	management staff which included staff development coordinator, MDS nurse, and Director of Nursing on or before 11/22/13 to ensure no medicated barrier creams were found in rooms. Corrections made at time of review as indicated by findings. Licensed nurses were educated by Director of Nursing or Administrator on or before 11/22/13 that 2 licensed staff must witness the destruction of narcotic transdermal patches. A destruction log was placed in the medication room as well as signature lines on the MAR on or before 11/1/13 for 2 licensed nurses to sign off by Director of Nursing. Licensed staff also educated that if a patch is found to be missing at time of removal, Director of Nursing is to be informed so an investigation can be completed. The licensed nursing staff was reeducated by Administrator on or before 11/22/13 that if a medication dose remains the same but a frequency has changed, a sticker is to be placed on the bubble pack that says "see chart". "Directions Changed. Refer to chart." The licensed nursing staff was reeducated by Administrator on or before 11/22/13 that insulin is to be dated when the cap is removed, not taken out of the refrigerator as well as CNAs are not to apply medicated barrier cream and those are to be locked up		

*per phone conversation to
Cameron Prescott
12/13 @ 12:00 noon
N. Sanderson*

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F 431	<p>Continued From page 104</p> <p>and Controlled Substance binders on Medication (Med) Carts 1 and 2 were reviewed for residents for whom fentanyl patches (also known by the brand name Duragesic) were administered. The review revealed fentanyl patches were administered to Resident #s 1, 2, 3, 7, and 9. However, there was no documented evidence, on the residents' individual MARs for October 2013 in the MAR binders or in the Controlled Substance binders, that used fentanyl patches were wasted and witnessed by 2 LNs.</p> <p>a) Resident #1's recapitulation of Active Orders from 10/1/13 to 10/31/13 included the order, "Fentanyl 50 MCG/HR (micrograms per hour) patch 72 Hour Transdermal - Night Shift Every 3 days: check placement q [every] shift." It was started 2/1/13.</p> <p>The resident's October 2013 MAR documented fentanyl 50 micrograms (mcg) was administered on the night shift on 10/2, 10/5, 10/8, 10/9, 10/11, 10/14, 10/17, 10/20, and 10/23. Note: Review of the resident's clinical record revealed there was no documentation regarding why fentanyl was administered 2 days in a row (10/8 and 10/9) and less than 3 days apart (10/9 and 10/11). The MAR also documented "check placement" was done 10/1-10/23/13.</p> <p>b) Resident #2's recapitulation of Active Orders from 10/1/13 to 10/31/13 included the order, "Fentanyl 25 MCG/HR patch 72 Hour Transdermal - Night Shift Every 3 days. Pain Management." It was started 7/9/12.</p> <p>The resident's October 2013 MAR documented fentanyl 25 mcg was administered on the night shift on 10/2, 10/5, 10/8, 10/9, 10/11, 10/14,</p>	F 431	<p>in a med cart or room where only licensed personnel have access to. Director of nursing or designee will complete cart audits each week to verify date of insulin. Only non-medicated barrier cream will be accessible to CNA staff for resident use. The CNAs were educated by the Administrator on or before 11/22/13 that physician ordered, medicated barrier cream must be applied by a licensed nurse and stored in locked area where only licensed staff have access.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will review 3 Fentanyl patch destruction logs per week for 4 weeks and then monthly for 2 months.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will review 5 medication bubble packs weekly for 4 weeks and then monthly for 2 months to ensure the label matches the MAR and the physician order or a sticker has been placed if a dose remains the same but frequency has changed.</p> <p>Beginning the week of 11/25/13 Director of Nursing or designee will review 5 opened insulin vials in medication carts weekly for 4 weeks and then monthly for 2 months to ensure the date on bottle is within the previous 28 days.</p>		

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F 431	<p>Continued From page 105</p> <p>10/17, 10/20, and 10/23. Review of the resident's clinical record revealed there was no documentation regarding why fentanyl was administered 2 days in a row (10/8 and 10/9) and less than 3 days apart (10/9 and 10/11). In addition, the MAR documented "check placement" was done daily, not every shift, on 10/1-10/4 and 10/6-10/23/13.</p> <p>c) Resident #3's recapitulation of Active Orders from 10/1/13 to 10/31/13 included the order, "Fentanyl 50 MCG/HR patch [this would necessitate the use of a 25 mcg patch and a 12 mcg patch] 72 Hour Transdermal - Night Shift Every 3 days: check placement daily chronic pain." It was started 7/23/13.</p> <p>The resident's October 2013 MAR documented fentanyl 37 mcg was administered on the night shift on 10/3, 10/6, 10/9, 10/12, 10/15, and 10/21. The box to document the 10/18 dose was blank; and, review of the resident's clinical record revealed there was no documentation why the 10/18 dose was missed. However, the MAR also documented "check placement" was done daily 10/1-10/23/13.</p> <p>d) Resident #7's "Hospice Facility Doctor Communication Form," dated 10/10/13, documented the order, "fentanyl 12 mcg patch Apply [1] patch q 72 [hours].</p> <p>The resident's October 2013 MAR documented a fentanyl 12 mcg patch was administered on 10/10, 10/13, 10/16, 10/19, and 10/22. The MAR also documented "check placement" was done on the day and night shifts on 10/10-10/21, nights only on 10/22, and day and night on 10/23.</p>	F 431	<p>Beginning the week of 11/25/13 Director of Nursing or designee will review 5 rooms weekly for 4 weeks and then monthly for 2 to ensure there are no medicated barrier creams in resident rooms unlocked. Results of all above mentioned audits will be discussed by center PI committee for 3 months.</p> <p>The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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F 431	<p>Continued From page 106</p> <p>e) Resident #9's October 2013 MAR included the order, "Duragesic-12 (Fentanyl) - Transdermal Dose: 12 MCG/HR Start Date: 9/7/13 Night Shift Every 3 days [for] Pain and documented the fentanyl was administered on the night shift on 10/1, 10/4, 10/7, 10/10, 10/13, 10/16, 10/19, and 10/22. The MAR also documented "check" (of the fentanyl patch) was done daily 10/1-10/4, 10/6-10/9, and 10/11-10/23/13.</p> <p>On 10/23/13 at 11:15 a.m., the facility's pharmacist was asked about used fentanyl patches. The Pharmacist (RPh) stated, "We [facility] talked about that about 3 months ago. I know there's a form. I would expect to see it documented. I haven't checked for that in the last 2 months." When asked how used fentanyl patches could be wasted with 2 witnesses when there was only 1 LN on the night shift, the RPh stated, "They keep the used patch and have the day nurse waste it with them."</p> <p>On 10/23/13 at 2:00 p.m., the Administrator and RMCO were asked to provide documentation that used fentanyl patches were wasted and witnessed by 2 LNs. The RMCO stated, "We have a book. I'll find it."</p> <p>At 2:15 p.m., the RMCO provided a Medication Destruction binder which included Medication Destruction Logs for multiple medications and multiple residents, including 4 of the 5 aforementioned residents (#s 1, 2, 7, and 9). However, only Resident #2's destruction log documented any fentanyl patches were destroyed. In addition, only 2 fentanyl 12 mcg patches were listed for Resident #2; and, the date of the destruction of the 2 patches was not recorded. Note: The 2 fentanyl patches for</p>	F 431			

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F 431	<p>Continued From page 107</p> <p>Resident #2 were dated as received 6/26/12. No other fentanyl patches were listed on the destruction logs for the aforementioned residents.</p> <p>At 2:25 p.m., the RMCO was informed the Medication Destruction Logs did not document any used fentanyl patches were wasted for Resident #s 1, 3, 7, and 9; and, that the date of destruction of 2 fentanyl patches for Resident #2 was not documented. The RMCO stated, "I didn't see it documented either, but I'll have to ask one of the floor nurses." A list of all residents who were prescribed fentanyl patches was requested.</p> <p>On 10/23/13 at 2:30 p.m., LN #1 was interviewed. When asked if she witnessed any fentanyl patches being wasted when she started work at 6:30 a.m. on 10/22/13, LN #1 stated, "No. I haven't seen any fentanyl patches wasted since I've been here, almost 3 months." Note: Fentanyl patches were documented as changed on the night shift on 10/22/13 for Residents #7 and #9.</p> <p>On 10/23/13 at 2:45 p.m., LN #4 was interviewed. The LN stated her shift started at 6:30 a.m. that day. When asked if she witnessed the wasting of any fentanyl patches when she came to work that morning, the LN stated, "No I did not." When asked which LNs were in the building at 6:30 a.m. that day, LN #4 named LN #5 and stated, "[LN#5's name] had an orientee with her the last couple of nights but not last night." Note: Fentanyl patches were documented as changed on the night shift on 10/23/13 for Residents #1 and #2.</p> <p>At 2:50 p.m., the RMCO provided 2 lists, with a total of 5 residents, with orders for fentanyl patches. This list included Resident #s 1, 2, 3, 7, and 9. The RMCO stated, "I think they [LNs] they</p>	F 431			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2013
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F 431	<p>Continued From page 108</p> <p>are documenting when they have to return them [medications] but maybe not when they're wasting the used [fentanyl] patches." All P&P regarding wasting used fentanyl patches was requested. The RMCO stated, "I'm not sure we have one. I'll talk to the pharmacist."</p> <p>At 3:20 p.m., the RPh was again interviewed. When asked if the facility had a policy regarding wasting used fentanyl patches, the RPh stated, "I don't recall approving a process. I remember talking to the [previous DON's name] and I assumed they had one, but I was wrong."</p> <p>At 4:30 p.m., the Administrator provided an undated "Disposal of Used Fentanyl Patches" P&P. It documented, "...Fentanyl patches shall be disposed in a way to minimize access by unauthorized staff, residents, and visitors. ... 1. Removal of used fentanyl patches should may [sic] be documented on the...(MAR) at the time of removal by the nurse administering medications. 2. Before disposal, the patch should be made unusable by folding the adhesive sides of the patch together... 3. Used patches should be placed in a clear plastic bag. 4. At the conclusion of the medication pass, using an indelible marker, the nurse should mark the date, time, number of used patches and his/her initials on the outside of the bag[.] 4.1 The used patches should be counted by a second nurse who also marks the date, time, number of used patches and his/her initials on the outside of the bag. 5. As soon as all tasks associated with [med] administration are completed, the [med] nurse delivers the plastic bag of used patches to the [DON] or designee for disposal. 6. Disposal is witnessed and documented per facility policy or applicable law: 6.1 Flushing (if allowable) or 6.2 Reverse</p>	F 431		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 109</p> <p>distributor or 6.3 Medication disposal kit[.] 7. Facility staff should regularly reconcile the number of patches disposed to the number of used fentanyl patches recorded as removed on the MAR.</p> <p>On 10/24/13 at 8:00 a.m., LN #3 was interviewed. The LN stated she had worked full time on the night shift since September; and, when she worked, except during shift change, she was the only LN in the building. When asked about wasting used fentanyl patches, LN #3 stated, "Prior to the in-service yesterday, I disposed of them in the sharps container." When asked if another LN witnessed when she wasted fentanyl patches, the LN stated, "No." When asked if she documented that fentanyl patches were wasted, the LN stated, "No."</p> <p>The facility failed to ensure a process was in place to reconcile loss or diversion of controlled medications as 2 LNs did not witness or document when used fentanyl patches were wasted.</p> <p>On 10/24/13 at 6:10 p.m., the Administrator, IDON, former IDON, and RMCO were informed of the issue. No other information/documentation was received regarding the issue.</p> <p>2. On 10/22/13 at 7:45 a.m., LN #1 was observed as she poured, then administered one Norco 5/325 milligram [mg] tablet to Resident #12. The pharmacy label instructions on the bubble pack of Norco read, "Give 1 tab[let] by mouth four times daily and give 1 tab by mouth every 6 hours as needed for breakthrough pain..."</p> <p>On 10/22/13 at about 2:30 p.m., a discrepancy</p>	F 431		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 431	<p>Continued From page 110</p> <p>was noted when Resident #12's Norco was compared to his All Active & Discontinued Orders for October 2013, which included:</p> <p>* "Hydrocodone-Acetaminophen 5-325 MG [milligrams] Tablet By mouth (Oral) - PRN [as needed]...: 1 tab[let] q [every] 6 hours... D/C [discontinue] Date: 10/18/13...";</p> <p>* "Hydrocodone-Acetaminophen 5-325 MG Tablet By mouth... - Twice a Day Everyday...D/C Date: 10/18/13...";</p> <p>* "Hydrocodone-Acetaminophen 5-325 MG Tablet By mouth (Oral) - Daily Everyday: Give q hs [bedtime]" which was ordered and started 10/18/13; and,</p> <p>* "Hydrocodone-Acetaminophen 5-325 MG Tablet By mouth (Oral) - PRN...: 1 tab q 4 hours..." which was ordered and started 10/18/13.</p> <p>Note: Hydrocodone-Acetaminophen is the generic name for Norco.</p> <p>On 10/23/13 at 1:50 p.m., LN #1 was asked about the discrepancy between the pharmacy label on Resident #12's Norco and his physician orders. The LN confirmed the label did not match the order. She stated, "I checked to be sure it was the right dose but I didn't read the label to compare it. We usually try to use up the medication because you can't return narcotics to the pharmacy."</p> <p>On 10/24/13 at 6:10 p.m., the Administrator, IDON, former IDON, and RMCO were informed of the issue. No other information or documentation was received from the facility.</p> <p>3. On 10/25/13 at 9:15 a.m., during inspection of Medication (med) Cart 2 with LN #2 in attendance, an open vial of Lantus insulin, prescribed for Resident #3, was observed with an</p>	F 431			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 111</p> <p>open date of 9/23/13. LN #2 acknowledged the open date and stated, "Four days more than it should be." The LN removed the vial of insulin and said she would get a new vial for the resident.</p> <p>On 10/25/13 at 1:15 p.m., the Administrator, IDON, and RMCO were informed of the issue. No other information/documentation was received from the facility regarding the issue.</p> <p>4. On 10/22/13 at 2:35 p.m., CNA #9 and CNA #10 were observed as they transferred Resident #1 from her wheelchair to her bed. After the transfer, the CNAs provided peri-care. Then, CNA #9 removed a tube of INZO Barrier Cream with 5% dimethicone and zinc oxide from a drawer in the resident's bedside table. CNA #9 handed the tube of INZO to CNA #10 who applied the barrier cream to the resident's peri-rectal area and buttocks.</p> <p>On 10/23/13 at 10:45 a.m., when informed a tube of INZO cream was observed stored in Resident #1's bedside table and applied by a CNA, LN #4 stated, "Oh no, that's not right." The LN immediately went to the resident's room and removed the tube of INZO cream from the resident's room.</p> <p>The facility did not ensure all medications were stored in locked areas and not accessible to residents and unauthorized staff.</p> <p>On 10/24/13 at 6:10 p.m., the Administrator, IDON, former IDON, and RMCO were informed of the issue. No other information or documentation was received from the facility.</p>	F 431		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 441 F 441 SS=E	Continued From page 112 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	Resident # 13 discharged from facility on 11/24/13. Resident # 7 was observed by licensed nurse on 11/18/13 for adverse reaction post incident related to hand hygiene after insulin injection with no adverse findings noted. Pages of MAR were replaced on 11/1/13. LN # 1 was educated by Administrator on or before 11/22/13 to perform hand hygiene after giving medications and prior to leaving resident rooms. Resident # 1 was evaluated by licensed nurse on 11/15/13 for any adverse reaction post incident related to hand hygiene with no adverse findings noted. CNAs # 9 and 10 were educated by center Administrator on or before 11/22/13 to change gloves and perform hand hygiene after peri care and prior to leaving resident rooms. LN # 4 was educated by center Administrator on or before 11/22/13 when spills happen in rooms to check surrounding environment to ensure all areas are cleansed and disinfected. Resident # 15 was discharged from facility on 7/14/13. Resident # 16 was discharged from facility on 10/1/13.		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 113 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and review of the infection control surveillance program records, it was determined the facility failed to ensure staff adhered to standard hand hygiene measures to prevent infection and the spread of infections; residents without signs and symptoms of urinary tract infection (UTI) were not treated with antibiotics and that antibiotic use was consistently reviewed for appropriateness. This was true for 3 of 9 sample residents (#s 1, 3, and 7) observed during the provision of cares; 1 of 9 residents (#13) observed during medication passes; and, 6 of 8 residents (#s 12, 15, 16, 17, 18, and 19) reviewed for UTI and antibiotic use related to UTI. These failures placed residents at risk to acquire infections, for unnecessary antibiotics and negative effects related to those antibiotics, and possibly for ineffective treatment of UTI. Findings included: The facility's policy, IC203 Hand Hygiene, revised 10/1/13, included the following: * "Wash hands with soap and water in the following situations: After removing gloves...; Before and after direct patient care;..." * "Decontaminate hands using an alcohol based hand rub OR wash hands with soap and water in the following clinical situations: ...After contact with patient's intact skin;...After removing gloves..." 1. On 10/22/13 at 4:00 p.m., LN #2 was observed as she administered 2 eye medications to Resident #13, removed her gloves, then left the	F 441	Resident # 17 was discharged from facility on 9/9/13. Residents # 12, 18, and 19 were evaluated by licensed nurse on 11/15/13 for any noted adverse reactions to previous antibiotic use. No adverse findings noted at time of assessments. The center staff re-educated by infection control nurse or designee on or before 11/22/13 to ensure hand hygiene is performed before and after care and upon leaving a resident room. Staff also educated on antibiotic use without signs and symptoms. If symptoms are noted, they are to be documented in the medical record for justification of antibiotic use. Also to inform the physician of lab results indication if organism is resistant to the antibiotic ordered. When antibiotic is started, Infection control nurse will verify why it was ordered and for documentation leading up to the order. The infection control nurse to verify with floor staff the reason a test was ordered and document that in the medical record as well as educating LNs to document why they are performing a certain test. Ongoing infection control practice competencies will be completed by infection control nurse each month to ensure infection control practices are maintained.	

Beginning the week 11/25/13 Director of

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 441	<p>Continued From page 114</p> <p>resident's room. However, the LN did not perform any type of hand hygiene before she left the room and returned to the medication (med) cart.</p> <p>Upon return to the medication cart, the LN initialed the eye medications on Resident #13's MAR. When asked about the lack of hand hygiene following the medication administration, the LN acknowledged she had not cleansed her hands. She sanitized her hands at that time.</p> <p>2. On 10/22/13 at 8:00 a.m., LN #1 was observed as she injected an insulin medication into Resident #7's abdomen and applied an Exelon patch to the residents left anterior chest. After that, the LN removed her gloves and left the resident's room. However, the LN did not perform any type of hand hygiene before she left the room and returned to the medication (med) cart.</p> <p>Upon return to the medication (med) cart, the LN initialed the aforementioned medications on Resident #7's MAR, then she handled other MAR pages in the MAR binder on the med cart.</p> <p>On 10/24/13 at 6:10 p.m., the Administrator, IDON, former IDON, and RMCO were informed of the infection control issue. No other information was received from the facility which resolved the issue.</p> <p>3. On 10/22/13 at about 2:40 p.m., CNA #9 and CNA #10 were observed at they provided care for Resident #1. The CNAs transferred the resident into bed with a mechanical lift then performed peri-care and changed the resident's incontinence brief. The CNAs did not remove their gloves and perform hand hygiene before they repositioned the resident in bed and placed</p>	F 441	<p>Nursing or designee will review 5 observations of medication administration, 2 reviews of catheterizations, 2 wound treatments, and 5 CNA cares to ensure infection control practices are maintained. A review of 3 antibiotic orders will also be reviewed for documentation of symptoms and susceptibility to antibiotic and follow ups are made as indicated. Observations and reviews will occur weekly for 4 weeks and then monthly for 2 months. The results will be discussed with the PI committee for 3 months.</p> <p>The Director of Nursing responsible for compliance.</p>	12/6/13	

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

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OMB NO. 0938-0391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 115</p> <p>pillows per the resident's directions. After that, CNA #10 removed her gloves and washed her hands. However, CNA #9 gathered the soiled clothes into a bag and removed a bag of trash from the trash can, then removed her gloves and left the resident's room. CNA #9 did not perform any hygiene after resident contact and glove removal.</p> <p>Moments later, CNA #9 returned to the hallway near Resident #1's room. The CNA asked the surveyor, "How'd we do?" When informed about the lack of hand hygiene after glove removal following resident contact, the CNA stated she thought she needed to deposit the bags of clothing and trash first.</p> <p>4. On 10/23/13 at about 9:30 a.m., LN #4 was observed as she performed an intermittent catheterization for Resident #3. After that, the LN repositioned the resident in bed. When the LN turned the resident to the left, the resident's foot bumped an uncovered container of urine on the over bed table by the bed. Urine spilled onto the over bed table and the floor below the over bed table. The LN completed caring for the resident, then removed the container of urine from the over bed table. The LN said she needed to get supplies to clean the over bed table and left the room.</p> <p>Moments later, the LN returned to Resident #3's room, wiped the urine off the over bed table with paper towels, then sanitized the over bed table with bleach wipes. The LN remained in the resident's room for 5 minutes while she waited for the over bed table to dry. However, during that time, the LN did not check the floor for urine spillage. Once the over bed table dried, the LN</p>	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 116</p> <p>placed the resident's items on it, turned off the light, and was headed out the door when the surveyor called her attention to the urine on the floor next to the bed. The LN saw the urine on the floor and stated, "Oh, I didn't see that." The LN immediately left the room for more supplies. She returned moments later, wiped the urine off the floor with paper towels then used bleach wipes to sanitize the area.</p> <p>On 10/24/13 at 6:10 p.m., the Administrator, IDON, former IDON, and RMCO were informed of the infection control issues. No other information was received from the facility which resolved the issues.</p> <p>5. On 10/25/13 at 9:55 a.m., the Infection Preventionist (IP) was interviewed and Infection Control Program records were reviewed.</p> <p>Review of Infection Control Data Logs for July and August 2013, Resident Infection Reports (RIR), urinalysis and urine culture and sensitivity (C&S) reports, physician orders, MARs, and Interdisciplinary Progress Notes (IPN) revealed there were no documented signs or symptoms (S&S) of UTI for all the residents who were treated with antibiotics and/or the infection causing pathogen was not sensitive to the antibiotic prescribed and administered.</p> <p>The RIR included areas to document, "UTI in resident WITHOUT CATHETER" or "UTI in resident with CATHETER." Under UTI without catheter was documented, "MUST HAVE at least 3 of the following: fever over 100 degrees F [Fahrenheit] or chills; Burning pain on urination or frequency/urgency in resident; Flank or suprapubic pain or tenderness; Change in</p>	F 441		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 117</p> <p>character of urine; and/or, Worsening of mental or functional status." Under UTI with catheter was documented, "MUST HAVE at least 2 of the following: fever over 100 degrees F or chills; Flank or suprapubic pain or tenderness; Change in character of urine; and/or, Worsening of mental or functional status."</p> <p>Residents treated with antibiotics for UTI in July 2013 without documented S&S of UTI and/or the pathogen was resistant to the antibiotic administered included:</p> <p>* Resident #15's RIR, dated 7/1/13, documented UTI in resident without catheter with worsening of mental or functional status as the only symptom. Levaquin, an antibiotic, was ordered daily for 7 days. However, a urine culture, dated 7/1/13, revealed the pathogen, morganella, was resistant to Levaquin.</p> <p>* Resident #16's RIR, dated 7/19/13, documented UTI in a resident without catheter. None of the "MUST HAVE" S&S were checked and in the area to document when a culture was done documented, "N/A (not applicable)." Bactrim DS was ordered twice a day for 5 days. Review of IPN dated, 6/10/13 through 7/26/13, revealed there were no documented S&S of UTI before the antibiotic was administered.</p> <p>* Resident #18's RIR, dated 7/23/13, documented a UTI. Neither "Without Catheter" or "With Catheter" was marked and none of the "MUST HAVE" symptoms were checked under either. Review of IPN, dated 7/22/13 through 8/6/13, revealed no documented S&S of UTI. Nonetheless, Levaquin was ordered and administered daily for 7 days. A urine culture report, dated 7/25/13, documented "mixed flora" and, "Clinical Laboratory Standards do not indicate susceptibilities for this organism."</p>	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2013
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F 441	Continued From page 118 Residents who were treated with antibiotics for UTI in August 2013 without documented S&S of UTI included: * Resident #12's RIR, dated 8/22/13, documented UTI in a resident without a catheter. The only "MUST HAVE" symptom checked was, "Change in character of urine." Review of the IPN, dated 7/22/13 through 10/13/13, revealed there were no documented S&S of UTI before the antibiotics were administered. A urine culture report, dated 8/22/13, identified proteus mirabilis as the pathogen. Cipro (antibiotic) was ordered and administered for 2 days before it was changed to Rocephin (different antibiotic) for 3 days." * Resident #17's RIR, dated 8/23/13, documented a UTI. Neither "Without Catheter" or "With Catheter" was marked and none of the "MUST HAVE" symptoms were checked under either. A urine culture report, dated 8/22/13, identified klebsiella pneumoniae as the pathogen. Ceftin (antibiotic) was ordered and administered twice daily for 7 days. Review of the IPN dated 8/17/13 through 9/4/13 revealed there were no documented S&S of UTI before the antibiotics were administered. * Resident #19's RIR, dated 8/10/13, documented UTI in a resident with a catheter. None of the "MUST HAVE" symptoms were checked. And, review of the IPN dated 7/28 through 8/19/13 revealed there were no documented S&S of UTI. Nonetheless, Augmentin (antibiotic) was ordered and administered twice a day for 10 days. When asked about antibiotics ordered for UTI for the aforementioned residents, the IP confirmed there were none, or only 1, S&S documented for those residents. When asked about antibiotic review, the IP acknowledged the organism that	F 441			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 119 caused Resident #15's UTI was resistant to the antibiotic administered. The IP expressed appreciation for review of the program. The facility failed to consistently implement an Infection Control Program to ensure staff consistently adhered to hand hygiene measures, only those residents with documented S&S of UTI were administered antibiotics for UTI, and antibiotics prescribed for UTI were appropriate. On 10/25/13 at 1:15 p.m., the Administrator, IDON, RMCO, and RVP were informed of the infection control issues. However, no other information or documentation was received which resolved the issues.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain	F 514	Resident #1's labs were placed in resident's medical record on or before 10/28/13. Resident # 7 hospice care plan was placed in the medical record on or before 10/28/13 Resident # 2 previous POST removed from medical record by social services designee on or before 11/22/13. A review of the last 30 days of laboratory orders was reviewed by manager of clinical operations on or before 11/19/13 to ensure labs were placed in medical record. A review of hospice care plans was reviewed by manager of clinical operations on or before 11/15/13 to ensure they were present in the medical record. Corrections noted and updated on or before 11/22/13 by the MDS nurse. A review of other residents POST forms was reviewed by the social services designee on		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 120</p> <p>clinical records for each resident in accordance with accepted professional standards and practices to ensure the records were complete and accurate. This was true for 3 of 9 sample residents (#s 1, 2, and 7) when Resident #1's laboratory results and Resident #7's facility care plan for hospice care were not in their respective records; and, when Resident #2's advanced directives contained conflicted information. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 3/21/12, and readmitted on 1/31/13, with multiple diagnoses which included multiple pressure ulcers; diabetic, with ophthalmic manifestation type 1 (juvenile type) uncontrolled; left below the knee amputation; bipolar disorder; and dementia with behavioral disturbances.</p> <p>Resident #1's Physician Orders included orders for the following lab [laboratory] tests: * 10/3/13 - "Iron level, vit[amin] D 25-OH level [the most accurate way to measure how much vitamin D is in the body]... - One Time Only;" and, * 10/14/13 - "CBC [complete blood count]...A1C [blood test that provides information about average levels of blood glucose, or blood sugar, over the past 3 months].... - One Time Only."</p> <p>Per review of the Resident #1's clinical record, the lab report for the vitamin D 25-OH level drawn 10/4/13 was canceled and the A1C drawn 10/14/13 was "pending."</p> <p>On 10/24/13 at 8:30 a.m., the RMCO and IDON</p>	F 514	<p>or before 11/22/13 to ensure only the most recent copy was in the medical record. Corrections were made at time of review if indicated.</p> <p>The staff who access clinical records was reeducated by center Administrator that medical records are to be complete and accurate on or before 11/22/13 including but not limited to laboratory results placed in medical record. If not received from lab, a phone call is to be made requesting copy, hospice care plans are to be present in medical record if a resident utilizes hospice services, and when a POST form is updated, the previous version is to be sent to medical records and placed in the over flow record. Residents residing in center with new hospice orders as well as new admissions on hospice; record will be reviewed in morning clinical meeting to verify care plan present for coordination of care. Changes in the POST will be added to 24 hour report for an IDT review of the medical record.</p> <p>Beginning the week of 11/25/13 Health Information Manager or designee will review 5 charts weekly for 4 weeks and monthly for 2 to ensure that ordered test results are present in medical record as well as hospice care plans and most current version of POST. The Results will be reviewed by center PI committee for 3 months.</p>	

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

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F 514	<p>Continued From page 121</p> <p>were asked about the vitamin D 25-OH level and the A1C for Resident #1. The RMCO reviewed the resident's clinical record and acknowledged the A1C result was pending and the vitamin D 25-OH test had been canceled. Regarding the A1C, the RMCO stated, "I don't see it. I'll have to check on that, call the lab." Regarding the vitamin D 25-OH test, the RMCO stated, "It was done but it was canceled." The RMCO stated she would check in to it and get back with the surveyor.</p> <p>On 10/24/13 at about 6:15 p.m., the Administrator was also informed of the issue. The RMCO was also present and she provided 3 facsimile [fax] pages from the laboratory.</p> <p>The faxed pages included a cover sheet, the vitamin D 25-OH results, dated 10/5/13, and the A1C results, dated 10/15/13. The RMCO pointed out that the laboratory's fax cover sheet included the statement, "...It is our policy that the ordering physician is the priority fax, and the facility is secondary..." The RMCO agreed the lab results should have been in the resident's clinical record.</p> <p>No other information or documentation was received from the facility regarding the issue.</p> <p>2. Resident #7 was admitted to the facility on 8/23/13 with multiple diagnoses which included cellulitis/abscess of the buttock and leg; malignant neoplasm (cancer) of the liver, primary; diabetes, lower limb amputation, and personal history of falls. Hospice care started on 9/10/13 related to the liver cancer.</p> <p>Review of Resident #7's clinical record revealed the the facility's care plan did not include anything about hospice care.</p>	F 514	<p>The Director of Nursing shall be responsible for compliance.</p>	12/6/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 122</p> <p>On 10/24/13 at 4:50 p.m., the Administrator, RMCO, and the FIDON were asked about the facility's care plan for Resident #7's hospice care. The RMCO reviewed the resident's care plan then stated, "I didn't see anything."</p> <p>On 10/24/13 at 5:20 p.m., the Administrator provided a facility care plan for Resident #7's hospice care. The Administrator indicated the care plan was in the computer all along and, "I just didn't print it out." When asked how staff would know about hospice services for the resident, the Administrator stated, "Because of the hospice binder on the top rack where the medical records and charts are kept." The Administrator agreed the facility care plan for hospice care should have been in Resident #7's clinical record.</p> <p>No other information or documentation was received from the facility regarding the issue.</p> <p>3. Resident #2 was admitted to the facility on 11/17/06 with multiple diagnoses which included dementia and celiac disease.</p> <p>Resident #2's most recent MDS assessment, dated 8/20/13, coded the resident was unable to complete the BIMS, with no staff assessment of his cognitive abilities.</p> <p>Resident #2's record included 3 documents in the advanced directives section: -A Living Will and Durable Power of Attorney for Health Care (LW/DPOAHC), dated 2/3/1997, signed by Resident #2, which documented the resident would like life-sustaining procedures to be withheld or withdrawn except for the</p>	F 514			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 123</p> <p>administration of nutrition and hydration. The document identified an individual to make decisions on Resident #2's behalf, if he were unable to make decisions on his own.</p> <p>-A Physician's Orders for Scope of Treatment (POST) form, dated 9/10/10, signed by the person designated as DPOAHC for Resident #2. The POST form documented Resident #2's Cardiopulmonary Resuscitation (CPR) status as, "Do Not Resuscitate" (DNR), but a feeding tube and intravenous (IV) fluids should be used. The form documented Resident #2's LW/DPOAHC were used as the basis for the contents of the POST form.</p> <p>-A second POST form, dated 3/14/13, which documented a DNR code status, with no IV fluids and no feeding tube. The form documented, "Patient's best interest" as the basis for the contents of the second POST form.</p> <p>On 10/23/13 at 7:45 AM, the Administrator was asked about the conflicting advanced directives in Resident #2's chart. The Administrator stated all of the documents pre-dated his employment in the facility, so he would have to research further.</p> <p>On 10/23/13 at 11:05 AM, the Administrator and SSD approached the surveyor. The SSD stated the contents of the POST had been changed per an e-mail request from the DPOAHC. The Administrator stated, "The old ones should have been thinned, that's for sure," but further stated the expectation of the facility would be for the staff to honor the most recently dated advanced directive.</p>	F 514			

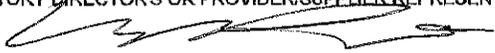
Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual State relicensure survey of your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, team coordinator; Nina Sanderson, LSW; and, Susan Gollobit, RN.</p> <p>The survey team entered the facility on Monday, 10/21/13, and exited the facility on Friday, 10/25/13.</p> <p>Survey Definitions:</p> <p>FSD/FSS = Food Services Director/Food Services Supervisor IDON/IDNS = Interim Director of Nursing Services RMCO = Regional Manager of Clinical Operations</p>	C 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Care and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
C 117	<p>02.100,03,c,i Fully Informed of Rights</p> <p>i. Is fully informed, as evidenced by the patient's/resident's written acknowledgement, prior to or at the time of admission and during his stay, of these rights and of all rules, regulations and minimum standards governing patient/resident conduct and responsibilities. Should the patient/resident be medically or legally unable to understand these rights, the patient's/resident's guardian or responsible person (not an</p>	C 117	<p>Refer to F152</p> <p>RECEIVED NOV 27 2013 FACILITY STANDARDS</p>	12/6/13

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



TITLE

Administrator

(X6) DATE

11/26/13

Bureau of Facility Standards

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C 117	Continued From page 1 employee of the facility) has been informed on the patient's/resident's behalf; This Rule is not met as evidenced by: Please see F 152 as it pertains to guardianship.	C 117		
C 119	02.100,03,c,iii Informed of Medical Condition by Physician iii. Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research; This Rule is not met as evidenced by: Please see F 154 as it pertains to resident involvement in decisions.	C 119	Refer to F154	12/6/13
C 120	02.100,03,c,iv Appropriate Cause for Transfer/Discharge iv. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients/residents, or for nonpayment for his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record; This Rule is not met as evidenced by: Refer to F204 as it related to residents discharged with orders for home therapy and equipment.	C 120	Refer to F204	12/6/13

Bureau of Facility Standards

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C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please see F 241 as it pertains to resident dignity.	C 125	Refer to F241	12/6/13
C 147	02.100,05,g Prohibited Uses of Chemical Restraints g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please see F 329 as it pertains to antipsychotic use.	C 147	Refer to F329	12/6/13
C 268	02.107,01 DIETARY SERVICE 107. DIETARY SERVICE. 01. Dietary Supervision. A qualified food service supervisor shall be designated by the administrator to be in charge of the dietary department. This person shall: This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the person in charge of Dietary	C 268	C268 No residents were identified as being affected by this deficiency. The Food Service Director completed his state approved Food Service Supervisor's	

Bureau of Facility Standards

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C 268	<p>Continued From page 3</p> <p>Services, the Food Services Director (FSD) had not completed an approved program for Food Service Supervision. This had the potential for a negative affect for 9 of 9 sample residents (#s 1-9) and all other residents who dined in the facility. Findings included:</p> <p>Note: Idaho Administrative Code, Department of Health and Welfare, IDAPA (Idaho Administrative Procedures Act) 16.03.02 - Rules and Minimum Standards for Skilled Nursing & Intermediate Care Facilities, sub-section 002.13.a,b,c, & d, defines a Food Service Supervisor as a person who:</p> <p>"a. Is a qualified dietitian; or b. Has a baccalaureate degree with major studies in food and nutrition or food service management; or c. Is a graduate of a state approved Food Service Supervisor's (Dietetic Assistant) course, classroom or correspondence; or d. Has training and experience in food service management in military service equivalent in content to program in paragraph c."</p> <p>On 10/21/13 at about 10: 30 a.m., the FSD stated, "I am currently in school and my last module is due 10/27/13."</p> <p>On 10/23/13 at 12:55 p.m., when asked if he met any of the aforementioned Food Service Supervisor qualifications, the FSD stated "No" to all of them. The Regional Registered Dietician was present during the interview.</p> <p>On 10/24/13 at 6:20 p.m., the Administrator, IDON, FIDON, and MCO were informed of the finding. The facility did not provide any additional information.</p>	C 268	<p>(Dietetic Assistant) course on 10/27/13.</p> <p>The kitchen was inspected on or before 11/27/13 by regional registered dietician/food services director and no issues identified.</p> <p>The Food Service Director completed his approved Food Service Supervisor's course on 10/27/13 and received his certificate of completion. He will complete his test before January 15, 2014.</p> <p>Beginning the week of 11/25/13 the administrator will do an audit of the FSD certification weekly for four weeks and monthly for two months. Results will be reviewed by the Performance Improvement Committee for three months. Administrator responsible for follow up.</p>	12/6/13

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C 314	Continued From page 4	C 314		
C 314	02.107,07,c Dietary Services c. Foods shall be served in a form to meet individual patient's/resident's needs: This Rule is not met as evidenced by: Please see F 365 as it pertains to diet texture.	C 314	Refer to 365	12/6/13
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Please see F 252 as it pertains to storage of medical equipment.	C 361	Refer to F252	12/6/13
C 644	02.150,01,a,i Handwashing Techniques a. Methods of maintaining sanitary conditions in the facility such as: i. Handwashing techniques. This Rule is not met as evidenced by: Please see F 441 as it pertains to handwashing.	C 644	Refer to F441 C664 No residents were directly affected.	12/6/13
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping	C 664	No residents were directly affected. Infection control committee will be scheduled on a routine day each month, if possible, to facilitate	

Bureau of Facility Standards

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C 664	<p>Continued From page 5</p> <p>services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure ICC members participated in ICC meetings. The Pharmacist did not participate in any of the meetings. And, a representative from the housekeeping department and a representative from the maintenance department did not participate in the meetings on a regular basis. The failure of ICC members to participate in Infection Control, as evidenced by their absence at committee meetings, created the potential for a negative affect for 9 of 9 sample residents (#s 1-9) as well as for all other residents, staff and visitors in the facility. Findings included:</p> <p>On 10/25/13 at 9:55 a.m., the Infection Preventionist (IP) was interviewed and the Infection Control Program records were reviewed with the IP. The IP stated she assumed the IP position in January 2013. When asked about ICC meetings, the IP stated the ICC "usually" met monthly during Performance Improvement meetings. The IP said the ICC members included the administrator, nursing, maintenance, dietary, housekeeping, social services, activities, and the medical director. When asked if a pharmacist attended ICC meetings, the IP stated, "No." The ICC meeting minutes and attendance records for the past 7 months were requested.</p> <p>That afternoon, the IP provided the ICC meeting minutes and attendance records for March 20, 2013; April 17, 2013; June 12, 2013; July 10, 2013; and, September 25, 2013.</p>	C 664	<p>notification to the pharmacist to ensure his attendance. Administrator will ensure pharmacist is notified of the meeting each month.</p> <p>Beginning in December 2013 advanced notification and follow up will be directed to the pharmacist. An ongoing audit will be provided by the administrator to the Performance improvement committee each month for 3 months.</p>	12/6/13

Bureau of Facility Standards

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C 664	Continued From page 6 The aforementioned ICC meeting minutes and attendance records revealed the following ICC members did not attend/participate in the meetings as follows: * Pharmacist - did not attend any of the meetings; * Housekeeping representative - did not attend the March, April, June, or July meeting; and, * Maintenance representative - did not attend the April, June, or July meeting. On 10/25/13 at 1:30 p.m., the Administrator, IDON, and MCO were informed of the findings. No other information was received from the facility which resolved the issue.	C 664		
C 696	02.152 SOCIAL SERVICES 152. SOCIAL SERVICES. The facility shall provide for the identification of the social and emotional needs of the patients/residents either directly or through arrangements with an outside resource and shall provide means to meet the needs identified. The program shall be accomplished by: This Rule is not met as evidenced by: Please see F 250 as it pertains to provision of medically related social services.	C 696	Refer to F250	12/6/13
C 733	02.154,02,b Frequency of Physician Visits b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on	C 733	Refer to F387	12/6/13

Bureau of Facility Standards

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C 733	Continued From page 7 physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Please see F 387 as it pertains to frequency of physician's visits.	C 733		
C 735	02.154,02,d Current History and Physical and Findings d. The physician shall provide the facility with medical information necessary to care for the patient/ resident which includes at least a current history and physical or medical findings completed made no longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information shall include diagnosis, medical findings, activity limitations, and rehabilitation potential. This Rule is not met as evidenced by: Based on closed record review and staff interview, it was determined the facility did not ensure a history and physical (H&P) for 1 of 10 sample residents (#10) was completed no more than five days prior to admission and no later than 48 hours after admission. Failure to have a current H&P created the potential for the resident's care to be less than optimal. Findings included: Resident #10 was admitted to the facility on	C 735	C735 Resident #10 discharged on 9/24/13. Administrator to do a review of the last 30 days of admissions on or before 11/25/13 to ensure new admissions have a history and physical completed within 5 days prior to admission or within 48 hours after admission. Health Information Manager educated on or before 11/25/13 by Administrator of receiving a current history and physical for each admission. New admission charts will be brought to morning clinical	

Bureau of Facility Standards

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C 735	<p>Continued From page 8</p> <p>9/18/13 with multiple diagnoses which included urinary tract infection, unspecified essential hypertension, personal history of falls, personal history of malignant neoplasm (cancer) of the bladder, chronic kidney disease stage I, and dementia.</p> <p>Review of the resident's closed clinical record revealed the only H&P in the record was dated 9/9/13, which was 9 days before the resident's admission to the facility.</p> <p>On 10/24/13 at 2:15 p.m., the Resident Services Director (RSD) was interviewed and asked to provide the resident's current H&P. The RSD reviewed the resident's clinical record then confirmed that a current H&P was not there.</p> <p>On 10/24/11 at about 6:15 p.m., the Administrator was informed of the issue. The facility did not provide any additional information regarding the issue.</p>	C 735	<p>meeting with IDT to ensure history and physical is present.</p> <p>Beginning the week of 11/25/13 the center Administrator will complete record reviews of new admission charts for current history and physical weekly for four weeks and monthly for two months. Results will be reviewed in Performance Improvement meeting monthly for three months. Administrator responsible for follow up.</p>	12/6/13
C 745	<p>02.200,01,c Develop/Maintain Goals/Objectives</p> <p>c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please see F 281 as it pertains to the manner in which medications were administered.</p>	C 745	Refer to F281	12/6/13
C 747	<p>02.200,01,e Individualized Resident Care Plan</p> <p>e. Observing and evaluating the condition of each patient/resident and developing a written, individualized</p>	C 747	Refer to F314	12/6/13

Bureau of Facility Standards

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C 747	Continued From page 9 patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; This Rule is not met as evidenced by: Refer to F314 as it related to altered skin integrity/pressure ulcer care plans.	C 747		
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please see F 272 as it pertains to nursing assessments for equipment use.	C 779	Refer to F272	12/6/13
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	Refer to F280	12/6/13
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by:	C 784	Refer to F246	12/6/13

Bureau of Facility Standards

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C 784	Continued From page 10 Please see F 246 as it pertains to accommodation of resident needs, assessing and addressing visual needs, and delay in treatment.	C 784		
C 787	02.200,03,b,iii Fluid/Nutritional Intake iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Please see F 369 as it pertains to weight gain and adaptive equipment at meals.	C 787	Refer to F369	12/6/13
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please see F 314 as it pertains to pressure ulcer prevention.	C 789	Refer to F314	12/6/13
C 791	02.200,03,b,vii ORAL HYGIENE vii. Oral hygiene; This Rule is not met as evidenced by: Please see F 312 as it pertains to oral hygiene.	C 791	Refer to F312	12/6/13
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and	C 881	Refer to F514	12/6/13

Bureau of Facility Standards

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C 881	Continued From page 11 signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Please see F 514 as it pertains to medical records.	C 881		