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 3981

January 31, 2014

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

Provider #: 135095

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

Dear Mr. Prescott:

On **January 24, 2014**, a Facility Fire Safety and Construction survey was conducted at **Cherry Ridge Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 13, 2014**. Failure to submit an acceptable PoC by **February 13, 2014**, may result in the imposition of civil monetary penalties by **March 5, 2014**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 28, 2014**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 28, 2014**. A change in the seriousness of the deficiencies on **February 28, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 28, 2014**, includes the following:

Denial of payment for new admissions effective **April 24, 2014**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifyimg noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 24, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 24, 2014**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

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

This request must be received by **February 13, 2014**. If your request for informal dispute resolution is received after **February 13, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	135095		01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY RIDGE CENTER	501 WEST IDAHO BOULEVARD EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type V (000) building, constructed in 1959. The structure has a private well and storage tank as a sole source to supply the automatic sprinkler extinguishment system which has quick response sprinkler heads in habitable spaces. There are five exits at grade level. Currently the facility is licensed for 40 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on January 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, and 42 CFR 483.70. The survey was conducted by: Tom Mroz, CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program	K 000	RECEIVED FEB 12 2014 FACILITY STANDARDS "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."	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to document one of twelve required fire	K 050	The facility maintenance director completed fire drills on each shift at unexpected times during quarter four of 2013. An initial audit of fire drills was completed by the facility administrator on or before 2/14/14 to ensure that fire drills are occurring quarterly on each shift.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/11/14

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

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K 050	Continued From page 1 drills. The deficient practice affected three of three smoke compartments, staff, and 29 residents. The facility has the capacity for 40 beds with a census of 43 the day of survey. Findings include: During a review of the facility's fire drill reports for the 12 month period prior to the day of survey on January 24, 2014 at 11:00 a.m., the facility was unable to provide a documented fire drill for the third shift of the third quarter of 2013. Interview with the maintenance supervisor revealed that the facility was aware of the missing fire drill and was hoping 4 drills in the 4th quarter would make up for the missed drill in the 3rd quarter. Actual NFPA Standard: NFPA 101, 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions to simulate the unusual conditions occurring in case of fire.	K 050	The facility maintenance director was educated by the facility administrator on or before 2/7/14 that fire drills must be conducted at lease quarterly on each shift at unexpected times. Beginning the week of 2/17/14 the facility administrator will do an audit each month for three months of the fire drill log to ensure that quarterly fire drills are being completed on each shift. The results will be discussed in the Performance Improvement committee meeting monthly for three months. The maintenance director is responsible for compliance.	2/28/14
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to prohibit the use of egress corridors as return air plenums and to maintain a balanced engineered return air supply system. The deficient practice affected three of three smoke	K 067	The facility will have an air balance study done by March 31, 2014. The facility will have in-duct smoke detectors installed into the cold air return by March 31, 2014. The in-duct smoke detectors will communicate with the fire panel and HVAC unit. Upon smoke detection or the fire alarm being triggered from a pull station, the HVAC unit will power off,	

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K 067	Continued From page 2 compartments, staff and all residents. The facility has the capacity for 40 beds with a census of 29 on the days of survey. Findings Include: Observation on January 24, 2014 at 1:00 p.m. revealed that the facility was using the egress corridors for return air plenums. The resident rooms had ducted supply registers and no return air supply registers. The facility was using the corridors as the return pathway to the heating, ventilating and air conditioning (HVAC) units for air from the resident rooms. The facility was unable to provide evidence of a balanced engineered HVAC system without using the egress corridors for a return air plenum. Interview with the Maintenance Supervisor revealed that the facility was not aware of the requirement to prohibit the use of egress corridors as return air plenums. Actual NFPA Standard: NFPA 101, 9.2 HEATING, VENTILATING, AND AIR CONDITIONING 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 90A, 2-3.11 Corridor Air Systems. 2-3.11.1. Egress corridors in health care,	K 067	ceasing the air flow. The facility will also request K067 waiver. The facility administrator and maintenance director will monitor the progress of the air balance study as well as the progress of the installation of in-duct smoke detectors to ensure the projects are completed by March 31, 2014.	2/28/14

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K 067	Continued From page 3 detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridor. Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of an engineered smoke-control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g., grating doors or grating partitions).	K 067		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to inspect and load test the Emergency Power Supply System (EPSS). This potentially exposed residents to loss of illumination of exit egress, fire and smoke alarms,	K 144	The facility maintenance director performed a load test on the generator for a full 30 minutes on December 17, 2013. Weekly inspections of the generator were performed the first week of August 2013. An initial audit of weekly and monthly generator load tests was completed by the facility administrator on or before 2/14/14. The facility maintenance director was educated by the facility administrator on or before 2/7/14 to perform load	

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K 144	Continued From page 4 and life support equipment during power outage. The deficient practice affected three of three smoke compartments, staff, and 29 residents. The facility has the capacity for 40 beds and at the time of the survey, the census was 29. Findings include: 1.) Observation during record review on January 24, 2014 at 11:26 a.m. of the facility's generator inspection logs for the calendar year prior to the survey indicated that the generator was not being tested under load on a monthly basis for a minimum of 30 minutes as required. There was no documented 30 minute load test performed in July and August 2013. Load tests were not performed for a full thirty minutes during the following months: September 2013 - 10 minutes October 2013 - 25 minutes November 2013 - 15 minutes 2.) Observation during record review on January 24, 2014 at 11:46 a.m. of the facility's generator inspection logs for the calendar year prior to the survey indicated that the generator was not being inspected weekly. Weekly inspections were not performed for the 4th and 5th week in July 2013. Interview with the Maintenance Engineer on January 24, 2014 at 11:50 a.m., revealed that the he started working for the facility in July 2013 and the transition resulted in inspections and testing being missed.. Actual NFPA Standards: NFPA 110, 6-4 Operational Inspection and Testing.	K 144	tests on the generator for a full 30 minutes each month as well as performing weekly inspections on the generator. Beginning the week of 2/17/14 the facility administrator will audit the monthly generator load tests monthly for 3 months. The facility administrator will audit the weekly generator inspection logs weekly for 4 weeks and monthly for 2 months. Results will be reviewed by the Performance Improvement committee monthly for 3 months. The facility maintenance director is responsible for follow up.	2/28/14

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K 144	Continued From page 5 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		

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C 000	16.03.02 INITIAL COMMENTS 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. The facility is a single story, Type V (000) building, constructed in 1959. The structure has a private well and storage tank as a sole source to supply the automatic sprinkler extinguishment system which has quick response sprinkler heads in habitable spaces. There are five exits at grade level. Currently the facility is licensed for 40 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on January 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Tom Mroz, CFI-II Health Facility Surveyor Facility Fire/Life Safety & Construction Program	C 000	"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." RECEIVED FEB 12 2014 FACILITY STANDARDS	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tag on the CMS - 2567:	C 226	Refer to K050, K067, and K144	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	2/11/14

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C 226	Continued From Page 1 K050 Fire drills K067 Corridor used as plenum K144 Generator inspections	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.