



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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 1956

January 2, 2014

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

Provider #: 135095

Dear Mr. Prescott:

On **December 18, 2013**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 6, 2013**. However, based on our on-site follow-up revisit conducted **December 18, 2013**, we found that your facility is not in substantial compliance with the following participation requirements:

F241 -- S/S: D -- 42 CFR §483.15(a) -- Dignity and Respect of Individuality

F312 -- S/S: D -- 42 CFR §483.25(a)(3) -- ADL Care Provided for dependent residents

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 (Complete Date), to signify when you allege that each tag will be back in compliance.** 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 copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that

have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 15, 2014**.

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.

- 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.

Cameron Prescott, Administrator
January 2, 2014
Page 3 of 4

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

As noted in the letter of **November 14, 2013**, following the **Recertification and State Licensure** survey of **October 25, 2013**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement 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.

STATE ACTIONS effective with the date of this letter (**January 2, 2014**): None

If you believe the 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, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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](#)

Cameron Prescott, Administrator
January 2, 2014
Page 4 of 4

This request must be received by **January 15, 2014**. If your request for informal dispute resolution is received after **January 15, 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 on-site follow-up revisit. If you have any questions or concerns, please contact this office at (208) 334-6626.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Todd".

LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

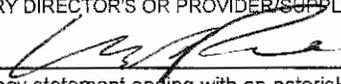
PRINTED: 12/31/2013
FORM APPROVED
OMB NO. 0938-0391

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 R 12/18/2013
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 follow-up survey to the recertification of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling RN, QMRP Rebecca Thomas, RN</p> <p>The survey team entered and exited the facility on 12/18/13.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing MDS = Minimum Data Set assessment RNA = Restorative Nurse Aide</p> <p>{F 241} 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY SS=D</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility had failed to ensure that Resident #3 was addressed in a dignified way during meals. This was true for 1 of 6 (#3) sampled residents during the follow-up survey. There was a potential for psychological harm when the resident was treated in an undignified manner by staff giving</p>	{F 000}	<p>RECEIVED JAN - 8 2014 FACILITY STANDARDS</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>Resident #3 was evaluated by the Director of Nursing on 12/19/13 for psychosocial effects related to cited incident with no complaints of or signs and symptoms of adverse effects noted at the time of evaluation.</p> <p>A review of other residents requiring verbal cueing at meals was completed by the director of nursing on 12/20/13 during meal time to ensure residents were cued with proper cueing techniques per plan of care while maintaining dignity. No incidents noted during time of review.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

1/7/14

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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{F 241}	Continued From page 1 verbal cues from 8 feet away. Findings include: Resident #3 was admitted to the facility 4/12/07 with diagnoses of diabetes mellitus and hemiplegia affect - non dominant side due to cerebrovascular disease. The most recent quarterly MDS, dated 11/24/13 documented the resident was cognitively intact with a BIMS of 13, required supervision and setup help for eating. On 12/18/13 at 12:23 p.m. Resident #3 was in the "Low Stimulation" dining room. The resident was seated at the end of the dining table in the room. The table was about eight feet long and it had five residents seated at it. At the opposite end of the table was a resident who was seated in a wheelchair and CNA #1 was feeding the resident a pureed diet. During the meal, Resident #3 was observed to feed herself. At 12:35 p.m. CNA #1 told Resident #3, from across the length of the table, loud enough so the resident and every one else in the room could hear, "[Name] small bites." The aide then returned to feeding the residents.	{F 241}	The Director of Nursing educated nursing staff on or before 12/24/13 on techniques to ensure that residents are being cued per plan of care while maintaining dignity. Identified CNA was included in education. Beginning the week of 12/30/13 The Director of Nursing or designee will review 5 meals weekly for 4 weeks and then monthly for 2 to ensure that residents who require cueing are being cued while maintaining dignity. Results and corrections if applicable will be reviewed by the center performance improvement committee monthly for 3 months. The Director of Nursing will be responsible for follow up.	12/24/13	
{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.	{F 312}	Resident # 4 was evaluated by social services designee on 12/23/13 for any signs and symptoms of adverse psychosocial effects related to cited incident with none noted at time of evaluation. Resident also assessed by licensed nurse on 12/20/13 for any adverse effects with none noted. Plan of care was updated on by 12/20/13 by director of nursing to reflect current interventions.		

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{F 312}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure that a resident who required extensive assistance related to swallowing difficulties received care planned interventions to prevent the "gobbling" of food. This was true for 1 of 6 (#4) sampled residents and placed the resident at risk for choking. Findings include: Resident #4 was admitted to the facility on 9/19/12 with diagnoses of dementia with behavior disturbances, dysphagia oropharyngeal stage and depressive disorder. The most recent significant change MDS assessment, dated 10/30/13, documented the resident was severely cognitively impaired with a BIMS of 1 and required extensive assistance of one person for eating. The resident had a history of choking. The resident's care plan had a focus area, dated 7/31/13, that documented, "RNA Requires assistance with eating related to: history of swallowing difficulty (Restorative Program). The interventions were: "- [Resident name] tends to gobble her food down with large bites. Cue to eat slower, provide food in individual dishes and giver [sic] her only 1 - 2 at a time. - Alternate bites of food and fluids. - Verbal cues as needed for chin tuck and double swallow." On 12/18/13 at 12:20 p.m. the resident was observed in the "Low Stimulus" dining area.	{F 312}	A review of other residents that require assist with meals was completed by the director of nursing on 12/20/13 during meal time to ensure assistance provided per plan of care. No corrections needed at time of review. Director of Nursing educated nursing staff on or before 12/24/13 to ensure that residents are receiving assistance and cueing techniques at meals per plan of care. Identified CNA was included in education. Beginning the week of 12/30/13 Director of nursing or designee will review 5 meals weekly for 4 weeks and then monthly for 2 to ensure that residents' assistance is provided per care plan. Results and corrections if applicable to be reviewed by center performance improvement committee monthly for 3 months. Director of nursing responsible for compliance. 12/24/13		

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{F 312}	<p>Continued From page 3</p> <p>There were 5 residents and CNA #1 and a speech therapist in the room. Resident #4 was ordered to have a ground diet because of a history of dysphagia. At 12:23 p.m. Resident #4's meal arrived in 4 bowls. The bowls contained ground pork, soft boiled potatoes, spinach, and fruit cocktail. The aide set the first bowl of meat in front of the resident and put a spoon in it. The resident had a clothing protector on and a napkin draped across her lap. The aide assisted with setting up the other 4 residents at the table. The aide then sat down and started feeding a resident at the far end of the table a pureed diet. The speech therapist was in the corner observing the meal. Resident #4 started to eat the contents of the bowl. The resident used her spoon and fingers to eat the contents. The resident spilled food on the table, clothing protector and napkin. When the bowl was empty, the resident picked food up off the table and clothing protector and ate it also. The aide never redirected the resident, nor cued the resident to take alternating drinks of fluids with bites of food as was care planned.</p> <p>At 12:30 p.m. CNA#1 got up and changed out the bowl of meat with a bowl of potatoes. The aide returned to feeding the resident at the end of the table. Resident #4's first scoop of potatoes was a heaping spoonful and she spilled it on the clothing protector. The resident finished the rest of the bowl in three scoops, then she used her fingers to eat the spillage. The resident was finished with the potatoes in less than a minute. Staff did not intervene to slow the resident down, provide liquid between bites, etc. The resident then sat back in the chair with her fingers crossed next to her chest and waited for the next bowl of food.</p> <p>At 12:35 p.m. CNA#1 got up and changed out the</p>	{F 312}		

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{F 312}	Continued From page 4 potatoes to spinach. The resident continued to sit with her hands folded across her chest and looking down at the table. No one encouraged her to eat.	{F 312}			
	<p>At 12:40 p.m. the resident picked up the bowl of fruit cocktail and drank from the bowl. CNA#1 got up after the resident took a drink from the bowl. The aide went around the table to the resident and put a spoon in the bowl and told the resident to use the spoon. The aide went back to feeding the resident at the end of the table. The resident picked the bowl up with the spoon in it and took another drink of the contents. She did not use the spoon. The spoon fell out of the bowl into her lap. At that time, the speech therapist got up and went over to the resident, picked up the spoon, put it in the bowl, and used hand over hand assistance with the resident to take a spoonful of fruit cocktail. The resident took a bite then used her fingers to eat some of what was left. The resident then sat back in her chair crossed her fingers and put them across her chest.</p> <p>On 12/18/13 at 2:00 p.m. CNA #1 and the DON were interviewed about the resident being in the "Low Stim" room. They stated the resident needs to eat in an area that has low stimulation as she is easily distracted. The resident eats one item at a time and staff are to keep an eye on her because she feeds herself. No further information was provided.</p> <p>The Administrator, DON and corporate staff were informed on 12/18/13 at 4:30 p.m. The facility submitted additional information but there was nothing about following the resident's care plan or assisting the resident as needed in the submitted information.</p>				

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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001270	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2013
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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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{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 following deficiencies were cited during a follow-up survey to the annual recertification at your facility. The surveyors conducting the survey were: Arnold Rosling RN, QMRP Rebecca Thomas, RN	{C 000}	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." Refer to F 241	
{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: Refer to F 241 as it relates to dignity.	{C 125}		12/24/13
{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: Refer to F 312 as it relates to assisting residents.	{C 784}		Refer to F 312

RECEIVED
JAN - 8 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE 1/6/14
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