



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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May 1, 2016

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

Provider #: 135095

Dear Mr. Prescott:

On **April 14, 2016**, a survey was conducted at Cherry Ridge Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found that the most serious deficiency in your facility to be isolated in nature. The deficiency cited reflects actual harm that is not Immediate Jeopardy (Severity/Scope = G)

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid 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 (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 11, 2016**. Failure to submit an acceptable PoC by **May 11, 2016**, may result in the imposition of civil monetary penalties by **June 5, 2016**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

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

Civil money penalty

Denial of Payment for New Admission made on or after July 14, 2016.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 14, 2016**, if substantial compliance is not achieved by that time.

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

Cameron Prescott, Administrator
May 1, 2016
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If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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 **May 11, 2016**. If your request for informal dispute resolution is received after **May 11, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

Cameron Prescott, Administrator

May 1, 2016

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

PRINTED: 09/26/2016
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 04/14/2016
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 recertification and complaint investigation survey of your facility.</p> <p>The surveyors conducting the survey were: Evelyn Floyd, JD, MS, RN -Team Coordinator Amy Youngman, RN</p> <p>The survey team entered the facility on 4/11/16 and exited on 4/14/16.</p> <p>Acronyms used in this report include:: ABHR Cream= Lorazepam, Diphenhydramine, Haloperidol and Metoclopramide ADL= Activities of Daily Living BIMS= Brief Interview for Mental Status BUN= Blood Urea Nitrogen cm= Centimeters CNA= Certified Nurse Aide DM= Dietary Manager DON= Director of Nursing GDR= Gradual Dose Reduction IDT=Interdisciplinary Team K/ul= Kilo per microliter LN= Licensed Nurse MCO=Manager of Clinical Operations MDS= Minimum Data Set Assessment MS=Morphine Sulfate mEq= milliEquivalent mg= milligram mg/L= milligrams per liter mg/dL= milligrams per deciliter MAR=Medication Administration Record MD= Medical Doctor NP= Nurse Practitioner NS= Normal Saline OT= Occupational Therapy</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

05/11/2016

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 PASRR= Preadmission Screening and Resident Review POST= Physician Orders for Scope of Treatment PRN= as needed q= every SBAR=Situation, Background, Assessment and Recommendation SSD= Social Services Director TAR= Treatment Administration Record WBC= White Blood Cell	F 000			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278		6/14/16	

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F 278	<p>Continued From page 2</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure MDS assessments accurately documented the status of 1 of 13 sampled residents (#6). As a result, an antipsychotic medication was omitted from a resident's MDS assessments. Findings include:</p> <p>Resident #6 was admitted on 12/5/13 and re-admitted on 10/23/15 with diagnoses which included major depression.</p> <p>Review of Psychiatric Progress Notes dated 1/5/15, 3/2/15, 5/11/15, 8/10/15, and 2/5/16 documented Resident #6 was on Apripiprazole (Abilify), an antipsychotic medication.</p> <p>Review of Medication Administration Records documented Resident #6 received Apripiprazole (Abilify), in February, March, and April of 2016.</p> <p>Resident #6's Admission MDS assessment, dated 10/23/15, and the resident's Quarterly MDS assessment, dated 1/15/16, did not document the resident as receiving antipsychotic medications.</p> <p>On 4/13/16 at 11 am, the Social Services Director stated Resident #6 was not bi-polar, but had major depression and was taking Abilify. She stated each area completes their own assessments and the a corporate MDS Coordinator came in to put the assessment</p>	F 278	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident #6 Minimum Data Set (MDS) medication section was modified by regional Clinical Reimbursement Coordinator (CRC) on or before 5/24/16.</p> <p>A review of the last 90 days of current residents' most recent MDS was completed on or before 5/24/16 by the Center Nurse Executive (CNE) or designee to ensure that the medications are accurately reflected on the MDS. Corrections made as indicated at the time of review.</p> <p>Systematic Change: Prior to the submission of the MDS, the CNE or designee will verify medications are correctly coded on the MDS.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 278	Continued From page 3 together. On 4/13/16 at 4:30 pm, the DON and MCO indicated the assessments were incorrect.	F 278	The CNE completed an education with the CRC on or before 5/24/16 to ensure that medications are coded. Beginning the week of 5/30/16 the CNE or designee will review medications on MDS <input type="checkbox"/> for that week. This review will be completed weekly for 4 weeks and monthly for 2 months. Results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		6/14/16	

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure the care plans for 2 of 12 residents (#2 and #12) whose comprehensive care plans were reviewed, included interventions and equipment necessary to meet their needs. This created the potential for harm to the two residents if they did not receive needed services. As a result, Resident #2's care plan did not include milk shakes daily to prevent further weight loss and the use of a Hoyer lift for transfers; and Resident #12's care plan did not address her refusal of the use of a gait belt during transfers. Findings include: 1. According to Resident #2's "Admission Record" the resident was admitted to the facility on 7/20/13, with diagnoses including: dementia with behaviors, dysphagia (difficulty swallowing), depression, weakness, and significant weight loss. Resident #2's most recent MDS Significant Change of Status assessment, dated 1/24/2016, indicated Resident #2 had recently experienced a weight loss greater than 5% of her body weight and that this weight loss was not the result of a physician prescribed weight loss plan. In addition, the MDS indicated the resident required the use of a wheelchair for ambulation, and required extensive assistance from two or more staff members for transfers. Resident #2's weight record included the following weight measurements: 12/6/15 170	F 279	Resident #2 nutrition care plan updated by the Registered Dietitian (RD) or designee on or before 5/24/16 to include current interventions. Resident #12 skin and Activity of Daily Living (ADL) care plan updated by the CNE or designee on or before 5/24/16 to include current interventions. A review of current residents' care plans was completed by the CNE or designee on or before 5/24/16 to ensure current interventions are in place. Corrections made as indicated at the time of the review. Systematic Change: Nutrition care plans will be updated in the weekly Clinically At Risk (CAR) meeting by the RD. Other portions of the care plan will be reviewed during the daily clinical meeting with the interdisciplinary team to validate updates are made as changes occur. Education provided to the RD and licensed staff by the CNE or designee on or before 5/24/16 regarding updating care plans. Beginning the week of 5/30/16 the CNE or designee will review 2 care plans weekly for 4 weeks and monthly for 2		

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F 279	<p>Continued From page 5</p> <p>pounds; 1/3/16 158 pounds; 2/7/16 152 pounds; 3/6/16 145.8 pounds and 4/3/16 145 pounds.</p> <p>Resident #2's Dietary Progress Notes, dated 3/2016, included a recommendation for milk shakes as tolerated to facilitate weight maintenance. The note indicated that although the resident had been routinely refusing most food due to her overall decline in health status, she did seem to enjoy the milk shakes and frequently accepted them.</p> <p>During an interview, conducted with the DM on 4/14/16 at approximately 2:00 PM, the DM stated milk shakes were offered to Resident #2 each day at about 3:00 pm with her afternoon snack. The DM confirmed that Resident #2 seemed to enjoy these shakes and most often accepted them.</p> <p>Resident #2's care plan, dated 4/12/16, failed to include offering the resident a milk shake each afternoon with her afternoon snack.</p> <p>During an interview, on 4/13/16 at approximately 1:30 pm, the Regional Nurse Consultant stated that in March 2016, Resident #2 had an order for a canned health shake. However, this order had been discontinued because Resident #2's refused the drink. A recommendation had been made by the IDT to try milk shakes in March 2016. She acknowledged the milk shakes had not been added to Resident #2's plan of care.</p> <p>Resident #2 was observed being transferred from her wheelchair to her bed on 4/11/16 at approximately 9:00 am. CNA#2 and CNA#4 used a Hoyer lift to transfer Resident #2.</p>	F 279	<p>months. Results will be reviewed by the QAPI committee monthly for 3 months, or until compliance is sustained. The CNE is responsible for compliance.</p>		

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F 279	<p>Continued From page 6</p> <p>During an interview on 4/14/16 at approximately 12:00 pm CNA#2 stated that staff had been using a Hoyer lift to transfer Resident #2 for "quite a while" since she was declining and no longer able to walk or transfer on her own.</p> <p>Resident #2's most recent care plan, dated 4/12/16, indicated she required extensive assistance for all ADLs and that she was at risk for falls. However, Resident #2's care plan did not indicate the use of a Hoyer Lift for transfers.</p> <p>During an interview on 4/13/16 at approximately 4:30 pm, the Regional Nurse Consultant stated a care plan should be in place for staff to use a Hoyer Lift when Resident #2 was transferred.</p> <p>2. Resident #12's Face Sheet indicated she was admitted to the facility on 8/19/2014. Diagnoses included: chronic pain, developmental disability, morbid obesity, arthritis, and muscle wasting and atrophy.</p> <p>Resident #12's most recent MDS, a quarterly assessment dated 1/21/2016, indicated she did not walk, and required extensive assistance from two or more staff members with all transfers. Resident #12's BIMS score was 15, indicating she was able to make daily decisions for herself without assistance.</p> <p>Resident #12 was observed on 4/14/16 at approximately 12:15 pm, while being transferred from her wheelchair to a portable toilet in the shower (CT) room. Two staff members assisted Resident #12 from her wheelchair to the portable toilet chair and back. Resident #12 was able to</p>	F 279			

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F 279	<p>Continued From page 7</p> <p>stand up holding on to the transfer bar to assist with the transfers. Prior to transferring Resident #12 from her wheelchair to the portable toilet chair, CNA #4 asked Resident #12 if a gait belt could be used for the transfer. Resident #12 stated, "No. I don't want the gait belt." The gait belt was not used for the transfer.</p> <p>An interview was conducted with CNA #2 on 4/14/2016 at approximately 12:25 pm. CNA #2 stated staff always asked Resident #12 if they could use a gait belt for transfers, however, Resident #12 almost always refused. CNA #2 stated she would never force Resident #12 to use the gait belt because this would be a violation of her rights.</p> <p>Resident #12's care plan dated 4/17/2016, read, in part, "Focus: Resident requires assistance for ADL care in bathing, grooming, dressing, eating, bed mobility, transfer, locomotion, and toileting due to cognitive loss r/t DD (developmental disability), chronic disease (obesity, arthritis) compromising functional ability; Goal: Resident's care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being x 92 days; Interventions: - Encourage resident's participation while providing ADL care, - Resident is unable to ambulate. She is able to stand in CT room with grab bar. She is able to move herself in wheelchair but often needs assist with mobility in the halls. -Resident requires 2 person extensive dependent assistance with transfers with Hoyer lift.", and "Focus: Resident is at risk for falls: impaired mobility, cognitive loss, lack of safety awareness, morbid obesity; Goal: Resident will have no falls with injury x 92 days; Interventions:</p>	F 279			

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F 279	Continued From page 8 -Place gait belt in room with her name on it. Will educate all taking resident out each time leaving to ensure those taking her are able to use gait belt appropriately." Resident #12's care plan did not include her refusal to wear a gait belt during transfers. During an interview on 4/14/2016 at approximately 12:45 pm, the MCO acknowledged Resident #12's care plan lacked documentation she refused to wear the gait belt during transfers. The MCO stated that many of the residents' care plans had not been updated to reflect the residents' current care interventions.	F 279			
F 309 SS=G	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, record review, and staff interview, it was determined the facility failed to ensure 2 of 12 sampled (#3 and #4) residents were provided the necessary care and services. This failure resulted in harm to Resident #3 when the facility failed to effectively coordinate with hospice and she was placed on a diuretic without potassium added to maintain accepted potassium levels. Resident #3's potassium levels	F 309	Resident #3 discharged from the facility on 4/17/16. Speech Therapy (ST) completed an evaluation for Resident #4 on or before 5/24/16 to validate that current assistance that is being provided was appropriate due to her cognitive status and inability to participate in cueing. The care plan was	6/14/16	

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F 309	<p>Continued From page 9</p> <p>were not monitored and her potassium dropped to a critical level. Resident #4 did not receive appropriate instruction during meals to prevent choking and coughing, which placed her at of aspiration. Additionally the facility failed to ensure Resident #3's swallowing ability was reassessed. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 12/15/15 after a fall at home and placed on hospice care. The resident s admitting diagnoses included: dementia, anxiety, insomnia, and congestive heart failure.</p> <p>On 11/16/15, hospital progress notes and orders documented Resident #3 had chronic diastolic congestive heart failure and had orders for the diuretic furosemide (Lasix), 20 mg tablet once a day. In addition to the diuretic, potassium chloride 20 mEq once a day was ordered.</p> <p>On 12/18/15, the Lasix and potassium chloride were discontinued by hospice.</p> <p>On 1/12/16, hospice ordered the diuretic Bumetanide (Bumex) 2 mg every morning. The order noted hospice was to be contacted if the resident gained more than 3 pounds in one day or more than 5 pounds in a week. The order did not contain a corresponding order for potassium chloride or address potassium.</p> <p>Bumetanide (Bumex) is a Loop diuretic that has contraindications and cautions for elderly patients with decreased renal function. Black Box Warnings: monitor for hypokalemia; intake and output; weight; and electrolyte, BUN , creatine, and carbon dioxide levels frequently. (Nursing</p>	F 309	<p>updated to reflect current status.</p> <p>Current residents with modified diet textures were reviewed by the CNE or designee on or before 5/24/16 to determine if an updated ST evaluation is needed. Corrections made as indicated. A review of current residents receiving a non-potassium sparing diuretic was completed by the CNE or designee on or before 5/24/16 to validate a potassium supplement was in place or potassium levels are being monitored if the physician choses. The physician was notified of any potential needed changes.</p> <p>Systematic Change: Physician orders, including hospice orders, will be reviewed during the daily clinical meeting by members of the interdisciplinary team to validate any noted discrepancies and notify the physician as indicated through review. Changes in resident swallowing will be reviewed in daily morning clinical meeting and the potential need for a speech therapy evaluation.</p> <p>The CNE or designee will re-educate licensed staff on or before 5/24/16 to ensure notifications are made if a change in swallow occurs including, but not limited to, updating the care plan if the resident is no longer able to participate in swallow precautions and filing old information into resident's over flow record, as well as the physician clarification if a non-potassium sparing</p>		

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F 309	<p>Continued From page 10 2016 Drug Handbook (2016). Philadelphia: Wolters Kluwer, 242-243).</p> <p>Nurses' Progress Notes and Nutrition Progress Notes for January, February, and March did not contain documentation regarding Resident #3's use of a loop diuretic or dietary supplements addressing potassium.</p> <p>Review of Resident #3's MAR for January 2016, February 2016 , and March 2016 documented the resident received Bumetanide (Bumex) 2 mg at 6 am for edema. The record did not contain documentation Resident #3 received potassium chloride or was monitored for potassium levels or renal function.</p> <p>On 4/6/16, Physician Progress Notes documented the NP had seen Resident #3 to assess her pressure sore and had ordered labs for baseline studies for the wound clinic.</p> <p>On 4/7/16, Laboratory Reports documented Resident #3's potassium level as "critical" at 2.2 mmol/L with the normal reference range of 3.4-5.0 mmol/L; and BUN 29 mg/dL, high with the normal reference range of 9.0-20.0 mg/dL.</p> <p>On 4/11/16, Laboratory Reports documented Resident #3's potassium level as critical at 1.9 mmol/L with the normal reference range of 3.4-5.0 mmol/L; and BUN 45 mg/dL, high with the normal reference range of 9.0-20.0 mg/dL</p> <p>Hypokalemia (low potassium) can lead to cardiac dysrhythmias and increased Blood Urea Nitrogen (BUN) value are used to evaluate renal function and hydration status (Leeuwen & Bladh (2015),</p>	F 309	<p>diuretic is ordered in the absence of a supplement or routine monitoring.</p> <p>Beginning the week of 5/30/16 a review will be completed by the CNE or designee of 2 residents weekly for 4 weeks and monthly for 2 months receiving diuretics to determine if a potassium supplement is needed. The CNE or designee will also review 2 residents weekly for 4 weeks and monthly for 2 months to determine if any ST evaluations are needed. The results will be reviewed by the QAPI committee monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.</p>		

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F 309	<p>Continued From page 11</p> <p>Comprehensive Handbook of Laboratory & Diagnostic Tests with Nursing Implications, 6th ed. F. A. Davis Company: Philadelphia, 1278).</p> <p>On 4/11/16 at 9:50 am, Nurses' Progress Notes documented the physician was notified of the critical lab values. At 11:54 am, the physician ordered 20 mEq of potassium "now," and suggested Resident #3 be sent to the hospital. Resident #3's family was notified of the critical labs. The family stated they wished to keep the resident at the facility on comfort measures. At 4:03 pm, the resident had refused 3 attempts to give the potassium chloride.</p> <p>On 4/11/16 at 11 am, Resident #3 was observed sitting in her wheelchair in the facility lobby. The resident was extremely thin and non-responsive to verbal stimulus. At 12:10 pm, Resident #3 was in the dining room slowly drinking from a cup. When the lunch tray arrived, Resident #3 moved her utensil through the food, but did not eat. At 12:34 pm, the DON sat with the resident to encourage the resident to eat.</p> <p>On 4/11/16 the Bumex was discontinued.</p> <p>On 4/12/16 at 9:25 am, Resident #3 was observed in bed during a dressing change. The resident did not respond to verbal or tactile stimuli.</p> <p>On 4/13/16 at 4:10 pm, in an interview with the DON and MCO, the MCO stated the labs had been ordered because the NP had seen the resident for her wound and labs had not been done for a long time. They stated the order had come from hospice. They did not know the</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>reason potassium chloride had not been ordered with the Bumex or the reason Resident #3's potassium levels had not been monitored or addressed.</p> <p>2. Resident #4's "Admission Record" stated Resident #4 was admitted to the facility on 9/19/12 with diagnoses including: dementia, dysphagia, long-term use of insulin, and atrophy.</p> <p>Resident #4's most recent MDS, a quarterly assessment dated 3/30/16, included: "mechanically altered/therapeutic diet, extensive assistance from staff was needed for feeding, and the resident had swallowing concerns, including holding food in mouth or residual food in mouth after meals and coughing or choking during meals or when swallowing medication."</p> <p>Resident #4's Speech Therapy Safe Swallow Guidelines, dated 5/29/14 and labeled "Please Leave in Chart" read, in part, "Precautions: 1:1 Supervision; Alternate liquids with solids; cue to clear mouth between bites, upright 90 degrees for meals".</p> <p>Resident #4's recent care plan, dated 4/12/16 included: "Focus: Patient demonstrates difficulty with swallowing secondary to stroke; Goal: Patient will consume meals safely without signs and symptoms of aspiration for 92 days; Interventions: Alternate bites of food with liquids. Use verbal cues to get patient through meal. Ensure patient is upright. Cue patient to chew thoroughly and swallow as indicated."</p> <p>Resident #4 was observed on 4/11/16 between</p>	F 309			

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F 309	Continued From page 13 12:10 p.m. and 12:55 pm during the lunch meal service. Resident #4 was seated in her wheelchair and the back of the wheelchair was reclined back at an approximate 15 to 20 degree angle. Pureed food and three cups of fluid were served. CNA #7 was observed to give Resident #4 several bites of pureed food alternating with one drink of fluid throughout the meal. The resident was not encouraged or assisted to tuck her chin with bites of food or drinks of liquid. Resident #4 was observed to choke and gag eight times throughout the meal. Resident #4 was observed again on 4/12/16 between 12:15 pm and 12:45 pm while eating lunch. The resident was again seated in her wheelchair reclined approximately 15 to 20 degrees. Thickened fluids and pureed food was served. A staff member (CNA #7) was observed to give Resident #4 two to four bites of food alternating with one to two sips of fluid throughout the meal. Resident #4 was not assisted or encouraged to tuck her chin while swallowing food or fluid. The resident was observed to cough or choke six times during the meal. During an interview on 4/12/16 at approximately 4:00 pm, the MCO acknowledged staff should be following the protocols. She stated Speech Therapy would conduct an evaluation of Resident #4's ability to swallow as soon as possible to ensure Resident #4 was being assisted appropriately.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		6/14/16	

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F 314	<p>Continued From page 14</p> <p>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.</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 resident did not develop a pressure sore while at the facility. This was true for 1 of 4 residents reviewed for pressure sores (#3). The facility failed to accurately identify, monitor and timely implement interventions to prevent Resident #3 from developing a pressure sore. As a result, Resident #3 was harmed when she developed a pressure sore which increased in size from 3.2 cm x 1.8 cm on 2/26/16 to 6.5 cm x 5.75 cm on 4/14/16 (49 days), and became infected. Findings included:</p> <p>Resident #3 was admitted to the facility on 12/15/15 after a fall at home and placed on hospice care. The resident's admitting diagnoses included: dementia, anxiety, insomnia, and congestive heart failure.</p> <p>A POST document, dated 12/15/16, documented Resident #3 as do not resuscitate; comfort measures only; "no" feeding tubes or IV fluids; but "yes" to antibiotics and blood products.</p> <p>An Admission Assessment, dated 12/15/15,</p>	F 314	<p>Resident # 3 discharged from the facility on 4/17/16.</p> <p>In house skin sweep completed by CNE and/or designee for other residents residing in the center on or before 5/24/16. Residents identified with skin issues had notifications completed and sent to the MD for new orders, family notifications, and care plan updates by the center licensed nurse. Other residents with wounds were reviewed on or before 5/24/16 by the CNE regarding wound documentation including but not limited to documentation of surrounding skin, wound description, skin integrity report and dressing site. Revisions were made to the orders and care plan updated as indicated through review.</p> <p>Systematic Change: Previous day electronic weekly skin assessments will be reviewed by Interdisciplinary Team (IDT) during morning clinical meeting. Any new wounds will be reviewed for</p>		

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F 314	<p>Continued From page 15</p> <p>documented a skin tear, bruise, calluses on feet/toes, and staples to Resident #3's head. No other skin issues were documented.</p> <p>Resident #3's care plan, dated 12/16/15, identified the resident was at risk for skin breakdown related to limited mobility, dementia, hypertension and low body weight. The care plan initiated the following interventions related to Resident #3's risk for skin breakdown on 12/16/15:</p> <ul style="list-style-type: none"> *Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation. *Evaluate for skin risk factors per protocol. *Float heels while in bed. *Monitor skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decreased sensation, and skin that does not blanch easily. *Observe skin condition with ADL care daily and report abnormalities. *Obtain dietitian consult as needed/ordered. *Offer/encourage fluids of choice. *Pressure redistribution surfaces to bed as per protocol. *Pressure redistribution surfaces to chair as per protocol. *Wound treatment as ordered. *Weekly skin assessments by licensed nurse. *Weekly wound assessment to include measurements and description of wound status. <p>Resident #3's Admission MDS assessment, dated 12/22/15, documented the resident was moderately cognitive impaired; required extensive assistance of 1 to 2 persons for mobility; was wheelchair bound; occasionally incontinent of bladder; always continent of bowel;</p>	F 314	<p>documentation and notifications. Interventions will be added as risk levels rise and/or a Change in Condition occurs that puts residents at risk for skin breakdown</p> <p>Certified Nursing Assistants (CNA) were educated on or before 5/24/16 for implementation of skin sheets to be completed weekly with showers and turned into licensed nurse. Licensed nurse will sign sheet, implement documentation and notifications for any new findings and turn sheet into CNE.</p> <p>Licensed staff were re-educated by CNE on or before 5/24/16 to include documentation of wounds on the skin integrity report at the time of wound identification and weekly until resolved. Education was also completed to licensed staff for notifications to be sent to the MD for wound changes and daily documentation of the wound description including, but not limited to, the surrounding tissue and dressing site.</p> <p>Beginning the week of 5/30/16 CNE or designee will complete a review of 3 residents weekly for 4 weeks and monthly for 2 months to validate documentation and notifications completed as indicated through review. Results of reviews will be presented to the monthly QAPI committee for a minimum of 3 months or until compliance is sustained. CNE is responsible for compliance and follow up.</p>		

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F 314	<p>Continued From page 16</p> <p>weighed 99 pounds; and was at risk for pressure sores.</p> <p>On 12/29/15 and 1/5/16, Nursing Progress Notes documented assessments for predicting pressure sore risk which identified Resident #3 as at mild risk for pressure sores.</p> <p>On 2/26/16, Nursing Progress Notes included, "new onset/change in skin integrity as evidenced by abrasion. Left gluteal measuring 3.2 cm x 1.8 cm ...physician notified." The intervention to trim the resident's nails every week was added to the TAR.</p> <p>On 2/26/16, the TAR stated, "cleanse left gluteal area with NS and cover with non-adherent dressing for protection until healed q day and PRN."</p> <p>On 2/26/16, a Skin Integrity Report documented a 3.2 cm x 1.8 cm x <0.1 cm deep abrasion, intact, inflamed and indurate "scabbed" area. The area for staging the wound was blacked out. Resident #3's care plan identified the resident had an actual skin breakdown, but did not contain documentation of new, revised, or different interventions implemented on admission to prevent skin breakdown.</p> <p>On 3/3/16, a Skin Integrity Report documented a 1.8 cm x 1.0 cm <0.1 cm deep, staging documented as "N/A" [non-applicable], granulated, inflamed, and indurated area with healthy wound edges.</p> <p>The visualization of granulation tissue requires exposure of the wound bed. A stage II pressure</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>ulcer is a partial-thickness loss of dermis presents as a shallow open ulcer with red-pink wound bed exposed without slough. (Treas & Wilkinson (2014), Basic Nursing; Concepts, Skills & Reasoning, Philadelphia: F A Davis Company, 1233-1239).</p> <p>On 3/8/16, a Skin Integrity Report documented a 1.5 cm x 1 cm, 50% granulated, 50% slough area. Staging was documented as "N/A." Surrounding tissue was documented as healthy and pink with odor as "N/A." The box noting care plan updating was left blank.</p> <p>On 3/15/16 and 3/22/16, Skin Integrity Reports documented a 1 cm x 1 cm, 50% granulated, 50% slough area. Staging was documented as "N/A." Surrounding tissue was documented as healthy and pink with odor as "N/A." The box noting care plan updating was left blank.</p> <p>On 3/21/16, Nursing Progress Notes documented an assessment for predicting pressure sore risk which identified Resident #3 as at mild risk for pressure sores.</p> <p>On 3/22/16, the TAR documented, "Left Gluteal Fold: Clean with wound cleanser, apply Hydrogel (moisture regulating dressing) to site, and cover with optifoam (dressing), every three days and PRN."</p> <p>On 3/22/16, Resident #3's Quarterly MDS documented Resident #3 was moderately cognitively impaired; required extensive assistance of 2 persons for mobility; was wheelchair bound; always incontinent of bladder and bowel; weighed 90 pounds; and was at risk</p>	F 314			

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F 314	<p>Continued From page 18 for pressure sores. No pressure sores, staged or un-staged were documented.</p> <p>On 3/22/16 Resident #3's care plan documented the implementation of turning the resident every 2 hours, and then on 3/24/16, the turning schedule was changed to every hour and an air mattress was implemented. The care plan did not contain revisions, new or different interventions for skin at risk from the care plan's implementation on 12/16/15 to 3/22/16.</p> <p>On 3/24/16, Nursing Progress Notes documented, "wound assessed by 2 RN[s]. 25% slough, 50% eschar, peri-wound skin red, inflamed and blanching. No odor observed. Minimal drainage. Area started as abrasion. Resident has weight loss that is addressed by RD. Interventions in place to include high calorie snacks. Air mattress placed in bed with q 1 h [every hour] turning schedule. OT to assess resident for an off loading wheel chair cushion. MD and family made aware." The documentation did not include staging or measurement of the wound area. Resident #3's medical record did not contain documentation that an off-loading wheelchair cushion was implemented.</p> <p>On 3/29/16, a Skin Integrity Report documented a 1.5 cm x 1 cm, 50% eschar, 25% slough, and 25% granulation area. Staging was documented as "N/A." Surrounding tissue was documented as healthy and pink with slight macerated wound edges and odor as "N/A." The box noting care plan updating was left blank.</p> <p>On 3/30/16, the TAR documented, "Santyl Ointment 250 Unit/GM. Apply to left gluteal fold</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>topically every night shift..Clean with wound cleanser; apply Santyl (an enzymatic debriding ointment) to left gluteal fold. Cover with border gauze daily and as needed."</p> <p>On 3/30/16, Nursing Progress Notes documented a wound dressing change due to "saturation of dressing." The notes further stated, "Wound with eschar in the wound base and non-blanching erythema surrounding the wound. Cleansed with wound cleanser. Santyl [medication cream] applied, covered with Borderguaze." Resident #3's medical record did not contain documentation the physician was notified or other measures were implemented.</p> <p>On 4/2/16, Nursing Progress Notes documented a skin check assessment of a "pressure area: Left gluteal fold."</p> <p>On 4/3/16, Nursing Progress Notes documented a dressing change to the left gluteal fold. "LN noted a moderate amount of drainage and odor to area. Turned q hour [every hour] per MD. Denies pain to the left gluteal fold during treatment." Resident #3's medical record did not contain documentation the physician was notified or other measures implemented.</p> <p>On 4/5/16, a Skin Integrity Report documented a 2 cm x 2 cm x <0.1 cm deep, 75% soft eschar, 25% slough area. Staging was documented as "N/A." Surrounding tissue was documented as healthy, pink and blanching with healthy wound edges and odor as "N/A." The box noting care plan updating was left blank.</p> <p>On 4/5/16, IDT Meeting Progress Notes</p>	F 314			

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

PRINTED: 09/26/2016
FORM APPROVED
OMB NO. 0938-0391

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F 314	<p>Continued From page 20</p> <p>documented, "resident has unstageable wound of left hip that is being monitored by the wound care coordinator."</p> <p>On 4/5/16, Resident #3's care plan documented, "position changes for offloading while up in wheelchair and with cares."</p> <p>On 4/6/16, Physician Progress Notes documented an NP assessed Resident #3's wound and ordered labs. The NP documented the "patient is noted to have a very large unstageable decubitus ulcer of the left ischial tuberosity. There is slough and eschar in the center of this wound. Due to this it is unstageable." The plan documented an order to take Resident #3 to the wound clinic for surgical debridement. "I believe it would be in her [Resident #3] best interest that we [the facility] have an expert with wounds evaluate and treat this." The NP also documented Resident #3 was "cachectic" with "very poor intake ...is at extremely high risk for further skin break down ..." "She [Resident #3] occasionally has behavioral issues but spends a majority of her time in her wheelchair. I believe that this is definitely contributing to her skin breakdown."</p> <p>On 4/7/16, Laboratory Reports documented Resident #3 had WBC of 21.1 K/ul with normal reference range of 4.0-10.0 K/ul. On 4/11/16, Laboratory Reports documented Resident #3 had WBC of 27.4 K/ul with the normal reference range of 4.0-10.0 K/ul. An increase in WBC is used as an indicator of infection (Leeuwen & Bladh (2015), Comprehensive Handbook of Laboratory & Diagnostic Tests with Nursing Implications, 6th ed. F. A. Davis Company:</p>	F 314			

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F 314	<p>Continued From page 21 Philadelphia, 523).</p> <p>On 4/8/16, an order was received for an x-ray of Resident #3's left hip to rule out osteomyelitis (bone infection).</p> <p>On 4/11/16 at 11 am, Resident #3 was observed sitting in her wheelchair in the facility lobby. The resident was extremely thin and non-responsive to verbal stimulus. At 12:10 pm, the resident was in the dining room slowly drinking from a cup. When the lunch tray arrived, Resident #3 moved her utensil through the food, but did not eat. At 12:34 pm, the DON sat with Resident #3 to encourage the resident to eat.</p> <p>On 4/12/16 at 9:25 am, an observation of Resident #3's wound assessment with the Skin Integrity Coordinator [wound nurse] and the corporate Manager of Clinical Operations, was completed. Resident #3 was observed awake but non responsive to verbal or tactile stimuli. Resident #3 was observed to have a closed pressure ulcer on her left ischial tuberosity. The pressure area measured "3.8 cm x 3.5 cm", 90% dark eschar, 10% slough with a 1.5 cm of undermining, soft, mushy and rebounding eschar in the center of the pressure sore. In the 8 o'clock position a 1 cm dark purple, non-blanching area extended down from the pressure area into the surrounding area. The surrounding tissue of "9 cm x 8 cm" encompassing the pressure sore had erythema, was red, and inflamed, with slight blanching. The area extended and bulged out approximately 4 cm beyond the surface of the unaffected tissue of Resident #3's left hip. An odor was noted. The wound nurse applied Santyl cream to the</p>	F 314			

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F 314	<p>Continued From page 22 pressure area and covered the area with border gauze dressing.</p> <p>At the time of the wound assessments, the Skin Integrity Coordinator [wound nurse], stated that although she had attended the class for certification, she was not a certified wound nurse. She stated she was from an affiliated facility and came to this facility once a week to do wound care. The wound nurse measured the left gluteal wound and stated the area as "3.8 cm x 3.5 cm, black and yellow slough, necrotic tissue that was red with bleeding edges and no smell." She stated the wound had started as an abrasion and had not been open and therefore unstageable.</p> <p>At this time, the surveyor asked to observe Resident #3's right hip area. Observation revealed the right hip trochanter area to have approximately a 4 cm reddened circular area with slight blanching that remained reddened during cares. Resident #3's medical record was reviewed after the observation and did not include documentation of this.</p> <p>On 4/12/16 at 10:52 am, Nursing Progress Notes by the Skin Integrity Coordinator [wound nurse] documented the observed assessment and dressing change as, "Resident's left gluteal measures 3.8 cm x 3.5 cm with minimum serous drainage, 90% soft eschar and 10% slough, edges are healthy, and surrounding tissues with pink blanching tissues and at about 8 o'clock deep purple non blanching tissue seen. Area is warm without odor. No signs or symptoms of infection locally at site and no signs or symptoms of pain. Continue with treatment as ordered and will continue to follow. "</p>	F 314			

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F 314	Continued From page 23 On 4/13/16 at 4:10 pm, in an interview with the MCO and DON, they stated it was an abrasion and had not been identified as a pressure sore. When the MCO was asked about what she had observed during the dressing change, she had no comments, but did indicate there was an odor present. They stated Resident #3 was admitted on hospice, but were unsure of the diagnosis for hospice. They stated they could not explain the reason the pressure sore had progressed to its current state. The DON stated she had not seen the pressure sore since last week, but had been in contact with the family. The DON and MCO were asked the reason antibiotics were not used, given antibiotic use was consistent with Resident #3's advance directives or POST. The DON stated the family had discontinued hospice care, did not want the resident taken to the wound clinic, and was aware of Resident #3's infection and critical lab values, but wanted only comfort care measures. The MCO stated a new POST should be completed. On 4/13/16 at 4:30 pm, the DON presented an Incident and Accident Report, dated 4/1/16 at 2:40 pm, updating the initial 2/26/16 wound Incident and Accident Report. The report documented the wound now as "unstageable" ..."Resident has self-inflicted abrasion on left gluteal fold. Wound has since worsened." Under the box to "summarize all findings to support 'Unavoidable' determination or provide additional comments as needed:" the box had "See letter from doctor." Attached to the Incident and Accident Report, was an undated, typed letter from the facility's medical director. Within the context of the letter, the 4/7/16 labs with the date	F 314			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2016
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 24 were cited. The inclusion of the labs dated 4/7/16 conflicted with the 4/1/16 date of the Incident and Accident Report. The discrepancy could not be explained. Resident #3's medical records were reviewed. They did not contain documentation the medical director had seen Resident #3 or assessed her pressure sore. On 4/14/16, Nursing Progress Notes documented, "Wound assessed by DON, measurements: 6.5 cm x 5.75 cm. Periwound skin 4 cm x 1 cm. Edges of wound slightly macerated. No odor after cleansing wound. Reddened area bright red, is blanchable. Wound bed covered by thin layer of eschar with center being soft. Continues to be unstageable related to eschar. Although the area is red, no temperature difference between peri-wound skin and surrounding skin. Vital signs remain at baseline. Resident is afebrile. Family does not wish to investigate any further causes of infection such as cultures ...Call to MD to update him on the wound and request MD come out to facility to assess wound." Resident #3 had declined in the last 3 weeks and had stopped eating. Interventions of an air mattress and hourly turning were initiated approximately one month after the pressure sore was identified.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		6/14/16	

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F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to ensure 1 of 12 (Resident #2) sampled residents, remained as free from potential accident hazards. This created the potential for a resident to sustain injury during Hoyer lift transfers. Findings include: 1. According to Resident #2's "Admission Record" Resident #2 was admitted to the facility on 7/20/13 with diagnoses including: dementia with behaviors, dysphagia, depression, and significant weight loss. Resident #2's most recent MDS, a Significant Change of Status assessment dated 1/24/16, indicated Resident #2 required the use of a wheelchair and extensive assistance from two or more staff members for transfers. Resident #2's care plan, dated 4/12/16, indicated Resident #2 required extensive assistance for all ADLs and that she was at risk for falls. Resident #2's care plan did not indicate the use of a Hoyer Lift for transfers. Resident #2 was observed being transferred from her wheelchair to her bed on 4/11/16 at approximately 8:55 am. Two CNAs (CNA #2 and CNA #6) used a Hoyer lift to transfer Resident #2. The locks on Resident #2's wheelchair were not observed to be engaged at any point during the transfer. Staff did not check the locks on	F 323	Resident #2 was evaluated for any injuries related to transfers by the CNE or designee on or before 5/24/16 with no noted change. Resident # 12 was also provided with education by CNE or designee on or before 5/24/16 regarding refusals of gait belt and risk of injury to self and/or staff. The care plan was updated at the time of the assessment. A review was completed by the CNE or designee on or before 5/24/16 of current residents requiring extensive assistance during transfers to ensure wheel chair and shower brakes are locked. Systematic Change: Transfer competencies for nursing staff were completed by the CNE or designee on or before 5/24/16. Nursing staff including CNA # 2 was re-educated by the CNE or designee on or before 5/24/16 regarding safe transfers and locking of wheel and shower chair brakes. Beginning the week of 5/30/16 the CNE or designee will complete a review of 5 transfers per week for 4 weeks and		

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F 323	Continued From page 26 Resident #2's bed to assure they were engaged prior to transferring the resident. Resident #2's wheelchair was observed to move backwards and away from the Hoyer lift approximately one to two feet when the resident was lifted from her chair by the Hoyer lift. During an interview, conducted with CNA #2 on 4/14/16 at approximately 12:00 pm, the CNA stated staff had been using a Hoyer lift to transfer Resident #2 for "quite a while" since she was declining and no longer able to walk or transfer on her own. CNA #2 further stated she never engaged the locks on Resident #2's wheelchair or checked to make sure the wheels were locked on the resident's bed prior to transferring the resident. CNA #2 stated she felt this would be more dangerous for the resident since it might cause equipment (specifically a wheelchair) to get caught in some way during a transfer, potentially causing a staff member to trip and fall. During an interview on 4/14/16 at approximately 11:40 pm, the MCO stated per facility policy, she would expect the breaks of Resident #2's wheelchair and bed to be engaged prior to any transfer. The facility's "Total Lift Protocol," dated 11/30/2015, included, "Ensure wheels of bed or wheelchair are locked before beginning the transfer."	F 323	monthly for 2 months to ensure brakes are being locked on wheelchairs and shower chairs during transfers. The results will be reviewed by the QAPI committee monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.		
F 329 SS=D	483.25(I) 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		6/14/16	

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F 329	<p>Continued From page 27</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, record review, and staff and resident interview, it was determined the facility failed to ensure residents did not receive antipsychotic or antidepressant medications without adequate indications and monitoring for their use. This was true for 3 of 5 (#2, #3, and #8) residents reviewed for antipsychotic and antidepressant use. This resulted in Resident #3 receiving Risperidone and ABHR without adequate indications for their use; and Residents #2 and #8 receiving antidepressants without appropriate behavior monitoring. The deficient</p>	F 329	<p>Resident numbers 2 and 8 received a Gradual Dose Reduction (GDR) ordered by the physician on or before 5/24/16. Behavior flow sheets and psychotropic medication evaluations were modified by the Licensed Social Worker (LSW) on or before 5/24/16 on the aforementioned residents. Resident #3 discharged from the facility on 4/17/16.</p> <p>The CNE or designee completed a review of behavior monitors and medication</p>		

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F 329	<p>Continued From page 28</p> <p>practice had the potential to result in adverse resident outcomes. Findings included:</p> <p>1. Resident #3 was admitted to the facility on 12/15/15 after a fall at home and placed on hospice care. The resident's admitting diagnoses include: dementia, anxiety, insomnia, and congestive heart failure.</p> <p>Resident #3's PASRR, dated 12/15/15, documented the resident did not have a mental illness; no symptoms of mental illness; no history of psychiatric treatment; did have a primary diagnosis of dementia; no psychotropic medications were noted; and no mental retardation or developmental disabilities were documented.</p> <p>On 12/16/15 at 1:23 pm, the Hospice Physician ordered: ABHR cream 1 ml every 4 hours as needed and Risperidone (Risperdal) 1 mg twice a day. No diagnoses for these medications were documented.</p> <p>Resident #3's care plan, dated 12/17/16, identified the resident exhibited behaviors of: physical aggression, wandering and resisting care or treatment. The care plan did not contain documentation Resident #3 was receiving antipsychotic medications.</p> <p>Resident #3's Admission MDS assessment, dated 12/22/15, documented the resident as moderately cognitive impaired and as having periods of inattention and disorganized thinking. Resident #3's Quarterly MDS assessment, dated 3/22/16, did not document inattention and disorganized thinking.</p>	F 329	<p>evaluations for residents receiving psychotropic medications on or before 5/24/16 to validate behaviors are individualized and specific to resident and medication evaluations are complete and accurate.</p> <p>Systematic Change: The IDT will review previous days 24 hour report and progress notes during the daily clinical meeting for documented behaviors. Any noted behaviors will be compared with behavior monitor to validate tracking is completed. Licensed nurses will contact the CNE or designee prior to starting any psychotropic.</p> <p>The LSW and nursing staff were re-educated by the CNE or designee on or before 5/24/16 regarding tracking and documenting resident behaviors. CNE, Center Executive Director, and LSW were re-educated by the regional manager of clinical operations on or before 5/24/16 regarding resident specific behavior tracking, documentation of psychotropic medication evaluations, and completing gradual dose reductions</p> <p>Beginning the week of 5/30/16 the CNE or designee will review 5 behavior monitors and 5 current residents <input type="checkbox"/> psychotropic medications to ensure behaviors that are being tracked are appropriate with the diagnosis and to determine if a GDR is necessary. Results will be reviewed in QAPI meeting monthly for 3 months or until compliance is</p>		

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F 329	Continued From page 29 Behavior Monitoring Records documented the following: December 15-31, 2015 monitored Behaviors: hitting at staff; kicking at staff; and wandering documented the following: *Evening shift: 1 shift with episodes of hitting. *Day shift: 4 shifts with episodes of hitting. January 2016 monitored behaviors: hitting at staff; kicking at staff; wandering; and anxiety documented the following: *Night shift: 5 days with episodes of hitting at staff; 1 shift with episodes of wandering; and 8 shifts with episodes of refusing care; and 11 shifts with episodes of anxiety/agitation. *Day shift: 3 shifts with episodes of refusing care. * Evening shift: No behaviors documented. February 2016 monitored behaviors: hitting at staff; kicking at staff; and wandering documented the following: *Night shift: 2 shifts with episodes of hitting at staff. March 2016 monitored behaviors: hitting at staff; kicking at staff; wandering; and screaming at others documented the following: *Night shift: 2 shifts of hitting at staff; 1 day of refusing cares. *Day shift: 2 shifts of screaming at others; 2 shifts of refusing cares; and 1 shift of hitting at staff. April 1-11, 2015 Behavior Monitoring Records for hitting at staff; refusing cares, and wandering documented the following: *Night shift: 2 shifts with episodes of wandering. *Evening shift: 4 shifts with episodes of	F 329	sustained. The CNE is responsible for compliance.		

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F 329	<p>Continued From page 30</p> <p>wandering.</p> <p>*Day shift: 1 shift with episodes of wandering.</p> <p>Psychotherapeutic Medication Use Evaluations dated 12/18/15, 1/15/16, 2/12/16, and 3/18/16, each listed the targeted behaviors of "wandering, hitting, yelling," as the reason for the use of the antidepressants Lexapro and Trazodone and the use of the antipsychotic medication Risperdal.</p> <p>On 1/12/16, a Psychiatric Note documented Resident #3's family had stated the resident had a history of hallucinations of people breaking into the house and stealing her belongings and had experienced some anxiety and depression off and on for years. Resident #3's medical record did not contain documentation the resident had experience these behaviors while in the facility.</p> <p>On 2/5/16, a Psychiatric Noted documented Resident #3 had improved in terms of anxiety, agitation, depression and even paranoia since the Lexapro (antidepressant) was started. He documented Resident #3 had a diagnosis of major depression, underlying dementia with delusions and insomnia which were doing better on Lexapro and non-drug interventions.</p> <p>On 2/12/16, a Consultation Report from the Pharmacist documented the resident was on Risperdal 0.5 mg twice a day and on 2/2/16 hospice had increased the dose to 0.5 mg in the morning and 1.5 mg in the afternoon for unspecified dementia with behavioral disturbances. The Pharmacist noted it was unclear why the increase in the dose, since the behavior monitoring sheet did not indicate behaviors, agitation or aggression.</p>	F 329			

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F 329	<p>Continued From page 31</p> <p>On 2/18/16, a Consultation Report from the Pharmacist documented Resident #3 was on 1 mg of Risperdal twice a day and ABHR 1 ml every 4 hours and as needed. The Pharmacist documented, "all orders must include an indication of diagnoses for use. Also because the Risperdal is an antipsychotic and the ABHR contains an antipsychotic, I should tell you they cannot be used to treat anxiety, agitation, restlessness, insomnia, or pain." The pharmacist noted Resident #3 did appear to have some psychotic features such as looking for her family in the nursing home. Nursing Progress Notes documented the resident wandering looking for her family on admission. There was no subsequent documentation of wandering looking for her family.</p> <p>On 4/1/16, a Psychiatric Note documented the resident had not been sleeping and was irritable and resistive to cares. Resident #3 had a gradual dose reduction of Risperdal from 2 mg to 1 mg per day. He recommended the resident be kept awake during the daytime as much as possible and non-drug interventions be used.</p> <p>On 4/11/16 at 11:00 am, Resident #3 was observed sitting in her wheelchair in the facility lobby. The resident was extremely thin and non-responsive to verbal stimulus. At 12:10 pm, the resident was in the dining room slowly drinking from a cup. When the lunch tray arrived, Resident #3 moved her utensil through the food, but did not eat. At 12:34 pm, the DON sat with the resident to encourage her to eat. At 1:30 pm, Resident #3 was up sitting in her wheelchair in the hallway leading to dining room. Resident #3</p>	F 329			

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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 329	<p>Continued From page 32</p> <p>was moving the wheelchair back and forth with her right foot about 6 inches. She did not respond to verbal stimulus.</p> <p>On 4/16/16 at 11:00 am, the Social Services Director stated the monthly Psychotherapeutic Medication Use Evaluation Meeting consisted of herself, the DON, and the Pharmacists. She stated the psychiatrist was not part of the meeting, but could be called if necessary. The group reviewed residents on psych medications every month and all residents on antidepressants quarterly. When asked how the group determined what behaviors to monitor for medications, she stated the group list the behaviors related to the diagnoses and also talked to staff. She stated for example, a resident on Lexapro, an antidepressant, would be monitored for sad facial expressions, or a resident on an antipsychotic medication would be monitored for hallucinations. The Social Services Director stated Resident #3 had dementia with the behaviors of hitting, wandering and trying to get out of the facility and was hard to redirect. When asked about whether wandering warranted the use of an antipsychotic medication, she stated the wandering was intrusive, but did acknowledge behavioral documentation did not contain information regarding intrusive wandering. She stated Resident #3 had more behaviors at night, staying up at night and sleeping during the day. When asked about the continued use of the antipsychotic without adequate indicators, implementation of non-drug interventions, or assessment of precipitating factors, she stated the Risperdal had been reduced and non-pharmacological interventions did not always work.</p>	F 329			

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F 329	<p>Continued From page 33</p> <p>On 4/13/16 at 2:30 am, LN #2 stated Resident #3 had been sleeping lately. Resident #3 had not been eating and not trying to get up as much. LN #2 said Resident #3 would usually get up and eat something then go back to sleep. LN #2 stated the resident exhibited "sundowning" symptoms.</p> <p>An interview was conducted with CNA #2 and CNA #3 on 4/13/16 at 2:45 am. CNA #2 and CNA #3 agreed Resident #3 probably was "sundowning." They stated Resident #3 usually has anxiety at night. They stated Resident #3 gets up and sits on the edge of the bed, they take her to the toilet her, give her a snack and she usually lies back down and sleeps. However, once in a while she takes a swing at them. They stated in the last few weeks, Resident #3 has been declining and not eating. When asked why they thought she got agitated or anxious, they stated they thought the resident was, "hurting." The CNAs indicated Resident #3 was only able to answer questions with a "yes or no. " They stated the resident's wandering consisted of moving about the hallway and that Resident #3 was not strong enough to open the door to get out of the facility.</p> <p>On 4/13/16 at 4:10 pm, the DON stated that according to the Resident #3's family, it was normal for her to be up at night wandering around, getting up and eating, then going back to bed. The DON said Resident #3 seemed to have her nights and days mixed up and her agitation and anxiety would increase like "sundowning." The DON stated the facility had issues with the resident's hospice care. Hospice had placed Resident #3 on multiple medications that</p>	F 329			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 34</p> <p>changed her behaviors. The facility would get medications changed and hospice would get the medications reordered. The DON stated the family finally decided to discontinue hospice and place the resident on comfort care.</p> <p>On 4/14/16 at 1:30 pm, during a phone interview with the Psychiatrist, he stated he arrived at a diagnoses based on information from: the resident, the nurses, family and the CNA's. He stated he was not part the psychotropic behavior monitoring evaluation, but was available if needed. He stated the resident was diagnoses with major depression and dementia with psychotic behaviors based on information from the family that she had hallucinations about people entering her home and stealing her belonging. He stated that antipsychotic were FDA approved for off label use in depression if there were a history of hallucinations or delusions. The psychiatrist said these hallucinations or behaviors had not been exhibited while at the facility and these were not the behaviors being monitored or resulting in medication adjustment. He further stated he had not ordered the Risperdal for the resident and had reduced the dosage. He stated he had planned to eventually reduce the Risperdal more and then discontinue its use, but he had not documented his intentions or plan.</p> <p>The medication Risperidone (Risperdal) has a Black Box Warning which states: "Elderly patients with dementia related psychosis treated with antipsychotics are at increased risk for death. Drug isn't approved to treat elderly patients with dementia-related psychosis (Nursing 2016 Drug Handbook (2016), Philadelphia: Wolters Kluwer,</p>	F 329			

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F 329	<p>Continued From page 35 1258-1261).</p> <p>2. Resident #2's clinical record indicated the resident was admitted to the facility on 7/20/13, with diagnoses including dementia with behaviors, dysphagia, and depression.</p> <p>Resident #2's most recent MDS, a Significant Change of Status assessment, dated 1/24/16, indicated the resident received antidepressant medications each of the seven days prior to the Assessment Reference Date (ARD).</p> <p>Resident #2's most recent "Computerized Physician's Orders: (CPOs) dated 4/2016, noted the following medication orders: Sertraline 100 milligrams by mouth one time each day for depression, and Lorazepam 0.25 milliliters by mouth four times daily for anxiety.</p> <p>Resident #2's Behavior Tracking Records for February, March and April 2016 showed the following behaviors were being monitored: Crying and telling untrue or false stories.</p> <p>During an interview, conducted with the Social Services Director (SSD) on 4/14/2016 at approximately 2:25 p.m., she stated Resident #2's often spoke as though she was a younger woman. She further stated Resident #2 told stories that just were not true. When asked if telling these stories might be a normal part of the resident's process of dementia, the SSD stated it very well might be. The SSD indicated that Resident #2 was not distressed or bothered by the perception that she was younger or experiencing things differently than others. The SSD stated that monitoring Resident #2 for false</p>	F 329			

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F 329	<p>Continued From page 36</p> <p>stories was probably not a correct behavior to indicate the presence of depression.</p> <p>3. Resident #8 was admitted to the facility on 7/2/13 with diagnoses including hemiplegia, depression, and history of stroke.</p> <p>Resident #8's most recent MDS, a quarterly assessment dated 1/5/16, indicated the resident received antidepressant medication seven of seven days during the lookback period. The MDS assessment also indicated Resident #8's PHQ9 (Mood Interview) score was 3/27, indicating no depression and that Resident #8 was not exhibiting behaviors to indicate the presence of depression.</p> <p>Resident #8's Physician's Orders" dated 4/2015, included Paxil (an antidepressant) 30 milligrams by mouth each day for depression.</p> <p>Resident #8's Behavior Tracking Logs for March and April of 2016 indicated facility staff were tracking "Making negative statements about staff or others" and "Cursing at others" as the indicators for depression. According to the Behavior Tracking Logs, Resident #8 made negative statements about others one time during the months of March and April. No documentation of cursing at others was present.</p> <p>Resident #8's Physicians' Notes showed the last dosage reduction of the Paxil on 6/18/2014 in response to a Pharmacy Consultation Report dated 6/18/14. The Pharmacy Consultation Report read, in part, "According to staff [the Resident] is experiencing no signs or symptoms of depression." At that time, Resident #8's daily</p>	F 329			

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F 329	<p>Continued From page 37</p> <p>dose was reduced from 40 milligrams to 30 milligrams. The Pharmacist recommended another dose reduction of the Paxil in June of 2015 due to no noted symptoms of depression. The Physician declined to reduce the dose. No reason was noted by the Physician.</p> <p>During an interview on 4/14/16 at approximately 2:30 pm, Resident #8 stated that he did not feel he was depressed. Resident #8 stated he knew what depression was, and he had not felt that way for a "very long time." He further stated he felt that he did not need the antidepressant medication and that he had communicated this to his physician.</p> <p>During an interview on 4/14/16 at approximately 2:25 pm, the SSD stated Resident #8 had told her that he was not depressed. She acknowledged the lack of behaviors to indicate Resident #8 was depressed. She stated a dose reduction had been requested in June of 2015, but Resident #8's physician said, "No." She indicated she did not know the reason.</p> <p>During an interview on 4/14/16 at approximately 4:00 pm, the MCO acknowledged the lack of behaviors exhibited by Resident #8. She stated she would look into the situation.</p>	F 329			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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August 25, 2016

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

Provider #: 135095

Dear Mr. Prescott:

On **April 14, 2016**, an unannounced on-site complaint survey incident was conducted at Cherry Ridge Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007055

The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from April 11 to April 14, 2016.

The following documents were reviewed:

The entire medical record of the identified resident and 11 other residents;
The facility grievance file from January 2016 to April 2016;
Resident Council meeting minutes from January 2016 to April 2016; and
The facility's Admission agreement.

The following interviews were conducted:

Four residents were interviewed at a group interview regarding quality of care issues and resident rights.

Resident family members were interviewed regarding care issues and resident rights;
The facility's Inter-disciplinary team members were interviewed regarding quality of care and resident rights; and
Facility staff were interviewed regarding quality of care issues and resident rights.

Allegation #1: The reporting party alleged an identified resident was due for a follow-up mammogram. The identified resident's guardian had repeatedly requested the test to be scheduled, but the test was never done.

Findings #1: Review of the identified resident's medical record contained documentation the resident had breast cancer. The medical record contained documentation regarding the history related to the breast cancer and related surgeries. The record did not contain documentation the resident or the guardian had requested a follow-up mammogram or that a mammogram had been ordered for the resident. Review of the grievance records did not contain documentation of similar issues. Interviews the facility's inter-disciplinary team did not reveal knowledge of issues with the resident requesting a mammogram. Interviews with Social Services revealed they were unaware of any issue regarding the resident not receiving a mammogram.

Based on record review, interviews and observations, it was determined the facility was in compliance with Federal guidelines.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The reporting party alleged an identified resident's guardian was not notified of care conferences in advance, but instead the facility updated the guardian after the conference had occurred. The reporting party had not been informed how to file a grievance with the facility.

Findings #2: Review of the identified resident's medical record contained documentation the resident had a guardian who was identified. The medical record contained documentation of communication with the guardian. Review of the grievance records did not contain documentation of similar issues. Review of the facility's Admission agreement and policies contained information on resident rights regarding participating in care plan conferences and filing grievances. Interviews with residents, families, resident council, and social services staff did not reveal issues with notification or participation in care planning or filing grievances.

Based on record review, interviews and observations, it was determined the facility was in compliance with Federal guidelines.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Cameron Prescott, Administrator
August 25, 2016
Page 3 of 3

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW". The signature is written in dark ink and is positioned above the typed name.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
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August 17, 2016

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

Provider #: 135095

Dear Mr. Prescott:

On **April 14, 2016**, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007279

The complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted from April 11 to April 14, 2016.

Throughout the survey, observations were made of staffing levels, response to call lights, and facility cleanliness on day, evening, and night shift. Nursing staff schedules for the week of the survey were reviewed, as well as historical "as worked" staffing records. Twelve resident records were reviewed, including the record of the identified resident. The facility's grievance record and Resident Council meeting minutes were reviewed from January through April, 2016. Interviews were conducted with four individual residents, the Resident Group, and family members of non-interviewable residents. The facility's Interdisciplinary Team and direct care staff were interviewed. All interviews conducted included questions about facility cleanliness, staffing, call light response times, and the quality of care and quality of life in the facility.

Allegation #1: The reporting party alleged the facility was understaffed on the night shift and could not assist a resident to bed because of the short staffing.

Cameron Prescott, Administrator
August 17, 2016
Page 2 of 2

Findings #1: The identified resident's medical record did not contain documentation of complaints the facility was understaffed. Review of grievance records from January 2016 to April 2016 did not contain complaints of understaffing. Observation of the facility during the investigation revealed the facility to be adequately staffed on all shifts, including the night shift. Interviews with residents, family members, staff and resident council were conducted regarding staffing, and no issues were found. No problems were discovered when reviewing historical or current staffing and scheduling data.

Based on record review, interviews, and observations, it was determined the facility was in compliance with Federal guidelines.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The reporting party alleged the facility was not always clean.

Findings #2: The identified resident's medical record did not contain documentation of complaints the facility was unclean. Review of grievance records from January 2016 to April 2016 did not contain documentation the facility was unclean. Observation of the facility during the investigation revealed the building to be dated, but not unclean. Housekeeping was observed doing routine cleaning. Interviews with residents, family members, staff and resident council were conducted regarding cleanliness.

Based on record review, interviews, and observations, it was determined the facility was in compliance with Federal guidelines.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt