



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  
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3232 Elder Street  
P.O. Box 83720  
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PHONE: (208) 334-6626  
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May 25, 2016

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

Provider #: 135095

Dear Mr. Prescott:

On **May 18, 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 the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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 **June 4, 2016**. Failure to submit an acceptable PoC by **June 4, 2016**, may result in the imposition of civil monetary penalties by **June 27, 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*.

- As noted in the Bureau of Facility Standards' letter of **May 1, 2016**, following the survey of **April 14, 2016**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a Civil Money Penalty, Denial of Payment for New Admissions effective **July 14, 2016** and termination of the provider agreement on **October 14, 2016**, if substantial compliance is not achieved by that time.

Due to the seriousness of the deficiency(ies) cited, we are recommending that CMS impose the following remedy(ies), in addition, to the remedy(ies) that were previously mentioned to you in the originating survey letter of **May 1, 2016**:

A 'civil money penalty

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.**

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)

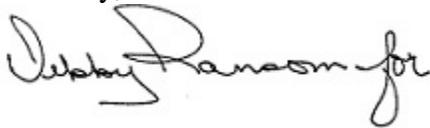
[2001-10 Long Term Care Informal Dispute Resolution Process](#)  
[2001-10 IDR Request Form](#)

Cameron Prescott, Administrator  
May 25, 2016  
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This request must be received by **June 4, 2016**. If your request for informal dispute resolution is received after **June 4, 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,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style.

**Nina Sanderson**, Supervisor  
Long Term Care

ns/pt  
Enclosures

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

PRINTED: 11/01/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135095</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/18/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHERRY RIDGE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 WEST IDAHO BOULEVARD EMMETT, ID 83617</b>
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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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the complaint survey conducted at the facility on May 18, 2016.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN</p> <p>Survey Definitions: ADL = Activity of Daily Living CNA = Certified Nurse Aide CNE = Center Nurse Executive ER = Emergency Room LN = Licensed Nurse MDS = Minimum Data Set assessment</p> <p>F 224 SS=G 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility's policies and procedures, the facility's allegation of neglect findings, and staff interview, it was determined the facility failed to ensure a resident was free from neglect. This affected 1 of 6 (#15) residents reviewed for mechanical lift transfers. Resident #15 was harmed when he sustained several fractures, a facial laceration and skin tears,</p>	F 000		
		F 224	<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</p>	6/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>06/01/2016</b>
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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 224	<p>Continued From page 1</p> <p>during an improper mechanical lift transfer by one staff member. Findings included:</p> <p>The facility's Abuse Prohibition Policy and Procedure, revised on 5/1/16, documented: "Neglect is defined as the failure to provide goods and services necessary to avoid physical harm...Examples include: Staff mistakes that result in the patient's need for hospitalization."</p> <p>The facility's Safe Resident Handling/Transfer Equipment Policy, revised on 11/30/15, documented:</p> <p>"...Staff will be trained in the use of each type of equipment...The Total Lift will be used as the primary intervention to manual lifting, transferring, and repositioning and requires a minimum of two persons to perform the lift...The full body sling is only used when the divided sling is not appropriate..."</p> <p>Resident #15 was admitted to the facility on 9/30/14 with multiple diagnoses, including dementia and a history of falling.</p> <p>Resident #15's 4/5/16 quarterly MDS documented he was totally dependent with two person assistance for transfers.</p> <p>Resident #15's ADL care plan documented a revised intervention on 4/5/16, "Full body sling for all transfers..."</p> <p>Resident #15's Progress Notes on 5/5/16 at 6:15 am, documented he had fallen in his room.</p> <p>The facility's Risk Management System dated</p>	F 224	<p>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 #15 discharged on 5/5/16.</p> <p>A review of residents that require mechanical lift transfer was completed by the Center Nurse Executive (CNE) or designee on or before 6/6/16 to ensure that mechanical lift transfers are being completed with a minimum of two people and that the sling is being properly attached.</p> <p>Systematic Change: The CNE or designee completed mechanical lift competencies with the CNAs on or before 6/6/16. During initial orientation CNAs will complete the mechanical lift competency and a minimum of annually thereafter.</p> <p>The facility staff were re-educated by the Center Executive Director (CED) on or before 6/6/16 on the state reporting guidelines as well as the company abuse prohibition policy. This includes the definition of neglect and examples of providing necessary goods and services.</p> <p>Beginning the week of 5/30/16 the CNE or designee will complete a review of 2 mechanical lift transfers weekly for 4 weeks and monthly for 2 months to ensure that the CNAs are utilizing two</p>		

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F 224	<p>Continued From page 2</p> <p>5/5/16, documented an incident which involved Resident #15 and CNA #1:</p> <p>"CNA [#1] was transferring resident alone with hoyer [mechanical] lift. Resident slipped out of hoyer from a distance of three feet and hit the right side of his head/face on the metal base of the hoyer. CNA [#1] called for help. LN [#1] and another CNA [#2] arrived into room to assist. Resident was bleeding from head. CNA [#2] instructed to hold pressure to stop bleeding and to secure resident's cervical spine. Nurse assessed resident and called 911..."</p> <p>Resident #15's ER record from Hospital #1 documented Resident #15 sustained a stable burst fracture of the first cervical vertebra, a traumatic displacement of the second cervical vertebra, a fracture around the right eye, a facial laceration which required sutures, and skin tears to his left arm and hand. Resident #15 was transferred to Hospital #2 due to a need for a higher level of care.</p> <p>Resident #15's ER record from Hospital #2 documented Resident #15's cervical injuries would require surgical intervention with an external immobilization halo device. Resident #15's family members declined the surgery and he was placed in a cervical neck collar and given pain medications for comfort care.</p> <p>The facility's Allegation of Neglect report, dated 5/11/16, documented Resident #15 fell from a mechanical lift when CNA #1 transferred him from his bed to his wheelchair without one of the four sling straps attached and without a second staff member (The sling rests under the resident</p>	F 224	<p>people for the transfer and that the slings are being properly attached to the mechanical lift. The 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.</p>		

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F 224	<p>Continued From page 3</p> <p>and is gathered by the four corners via the straps which then pull the resident up). A statement written by CNA #1 documented she transferred Resident #15 by herself and one of the straps may not have been attached. A statement written by LN #1 documented CNA #1 called out and LN #1 went to Resident #15's room and found him on the floor and one of the sling straps was not attached to the mechanical lift. LN #1 documented she and CNA #2 were in the facility at the time of the incident and could have helped but CNA #1 did not ask for their help.</p> <p>On 5/18/16 at 1:40 pm, CNA #2 with the Administrator present, said she was in another resident's room at the time of the incident, but could have helped if CNA #1 had asked for help.</p> <p>On 5/18/16 at 2:30 pm, the CNE said the facility policy for all mechanical lift transfers was for two staff members to complete a transfer and CNA #1 did not follow that policy. The CNE asked CNA #1 why she chose to transfer Resident #15 by herself and CNA #1 did not have an answer but said that she knew she 'messed up.' The CNE said there were two other CNAs and a nurse in the facility at the time of the incident and CNA #1 should have asked for assistance.</p> <p>On 5/18/16 at 3:00 pm, the Administrator said the facility determined the allegation of neglect was substantiated.</p>	F 224			



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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 **May 18, 2016**, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. The complaint allegation, findings and conclusions are as follows:

**Complaint #ID00007298**

During the survey, five mechanical lift transfers were observed.

The medical record of the identified resident and five other residents' records were reviewed for mechanical lift transfers. The facility's Grievance file from April 14, 2016 to May 18, 2016 were reviewed. The facility's Allegations of Abuse and Neglect reports from April 14, 2016 to May 18, 2016 were reviewed.

Two CNA staff were interviewed regarding mechanical lift transfers. The Administrator and the Center Nurse Executive were interviewed regarding mechanical lift transfers and abuse and neglect investigations.

**Allegation:** The Reporting Party said an identified resident was improperly transferred by a staff member using a mechanical lift and the resident fell and received multiple fractures and lacerations.

Cameron Prescott, Administrator  
August 25, 2016  
Page 2

**Findings:** The complaint was investigated during an on-site complaint investigation survey on May 18, 2016.

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F224.

**Conclusion:** Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it was addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW".

NINA SANDERSON, LSW, Supervisor  
Long Term Care

NS/pmt