



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 13, 2016

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

Provider #: 135095

Dear Mr. Prescott:

On **June 29, 2016**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **June 14, 2016**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

**0323-Free Of Accident Hazards/supervision/devices-483.25(h)**

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.

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Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 23, 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.
- 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 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.

**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 &**

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**Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **July 23, 2016**. If your request for informal dispute resolution is received after **July 123, 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

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Long Term Care

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>R</b> <b>06/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHERRY RIDGE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 WEST IDAHO BOULEVARD</b> <b>EMMETT, ID 83617</b>		
(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	INITIAL COMMENTS  The following deficiency was cited during the revisit survey conducted June 28, 2016 to June 29, 2016.  The survey team consisted of: Linda Kelly, RN, Team Coordinator Jenny Walker, RN  Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing MDS = Minimum Data Set ROM = Range of motion w/c = Wheelchair	F 000			
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.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of records and policies, it was determined the facility failed to ensure beds and/or wheelchair brakes were locked when staff performed Hoyer lift (mechanical lift) transfers. This was true for 2 of 3 sample residents (#1 and #9). Failure to lock the brakes created the potential for injuries that could lead to death if the equipment moved and the residents fell. Findings	F 323	"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	7/13/16	

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

TITLE

(X6) DATE

Electronically Signed

07/15/2016

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 323	<p>Continued From page 1 included:</p> <p>The facility's Total Lift policy, revised 11/30/15, documented, "...Ensure wheels of bed or wheelchair are locked before beginning the transfer..."</p> <p>1. Resident #1 was admitted to the facility in 2012 with multiple diagnoses, including hemiparesis related to cerebrovascular disease and muscle wasting and atrophy.</p> <p>Resident #1's 4/21/16 annual MDS assessment documented total assistance of 2 people for transfers, limited ROM in 1 upper and 1 lower extremity, and w/c use.</p> <p>Resident #1's ADL care plan, dated 6/10/16, documented, "Resident requires assistance with transfers with 2 person assist hoyer [sic]."</p> <p>On 6/29/16 at 10:30 am, CNA #1 and CNA #2, who said it was her 3rd day of orientation, were observed as they transferred Resident #1 using a Hoyer lift from the bed to the w/c. The brakes on the bed were not locked when Resident #1 was lifted off the bed. The brakes on the w/c, which was positioned in the middle of the room, were not locked and the w/c rolled back 2 to 3 inches. Resident #1 was lowered into the w/c. CNA #1, who was orienting CNA #2, did not mention locking the brakes on the bed and the w/c before, during, or after the transfer.</p> <p>On 6/29/16 at 10:35 am, CNA #1 said the brakes on the bed and on the w/c were not locked during the Hoyer lift transfer for Resident #1.</p>	F 323	<p>legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>The record indicates that for Residents #1 and #9 that there are no adverse effects related to wheelchairs or beds not being locked during a mechanical lift transfer. Certified Nursing Assistant (CNA) #1 was educated by the CNE or designee on or before 6/30/16 on the correct process for mechanical lift transfers.</p> <p>A review of other CNAs completing full mechanical lift transfers was completed, including CNA #2, by the CNE or designee on or before 7/13/16 to ensure that bed and wheelchair brakes are being locked.</p> <p>The CNE or designee will complete an education, as well as competencies, with the center CNAs on or before 7/13/16 on locking bed and wheelchair brakes during mechanical lift transfers.</p> <p>Beginning the week of 7/4/16 the CNE or designee will review 5 mechanical lift transfers, 2 of which will be with CNA #1, weekly for 4 weeks and monthly for 2 months or until compliance is sustained. The results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The CNE is responsible for compliance.</p>		

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F 323	<p>Continued From page 2</p> <p>2. Resident #9 was admitted to the facility in 2010 and readmitted on 2/16/16, with multiple diagnoses, including hereditary and idiopathic neuropathy, osteoarthritis, muscle wasting and atrophy, and chronic pain.</p> <p>Resident #9's 5/25/16 quarterly MDS assessment documented total assistance of 2 people for transfers.</p> <p>Resident #9's ADL care plan, dated 5/30/16, documented, "Resident requires 2 person total assistance with transfers with hoyer [sic] lift."</p> <p>On 6/29/16 at 9:40 am, CNA #1, CNA #2, and CNA #3, positioned Resident #9's w/c between the bed and the wall, then transferred Resident #9 from the bed to the w/c. The w/c brakes were not locked before or during the Hoyer lift transfer.</p> <p>CNA #1 and CNA #3, who were orienting CNA #2, did not mention the need to lock the brakes on the w/c before, during, or after the Hoyer lift transfer.</p> <p>On 6/29/16 at 10:45 am, the DON said staff were expected to lock the brakes on equipment, such as beds and w/c, during transfers with Hoyer lifts.</p>	F 323			