



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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E-mail: fsb@dhw.idaho.gov

March 10, 2017

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

Provider #: 135095

Dear Mr. Prescott:

On **March 2, 2017**, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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) and on or before the "Opportunity to Correct." **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.

Cameron Prescott, Administrator
March 10, 2017
Page 2 of 4

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 **March 20, 2016**. Failure to submit an acceptable PoC by **March 20, 2016**, may result in the imposition of penalties by **April 14, 2017**.

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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 6, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 31, 2017**. A change in the seriousness of the deficiencies on **April 16, 2017**, may result in a change in the remedy.

Cameron Prescott, Administrator
March 10, 2017
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **May 31, 2017** includes the following:

Denial of payment for new admissions effective **May 31, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 29, 2017**, 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 31, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Cameron Prescott, Administrator
March 10, 2017
Page 4 of 4

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 **March 20, 2016**. If your request for informal dispute resolution is received after **March 20, 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 "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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 C 03/02/2017
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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617
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(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	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey conducted at the facility February 28, 2017 to March 2, 2017. The surveyors conducting the survey were: Jenny Walker, RN , Team Coordinator Linda Kelly, RN Marci Clare, RN Edith Cecil, RN Abbreviations: CED = Center Executive Director HIV = Human Immunodeficiency Virus LSW = Licensed Social Worker	F 000		
F 153 SS=D	483.10(g)(2)(3) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS (g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof	F 153		3/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/17/2017
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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 153	<p>Continued From page 1</p> <p>(including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:</p> <p>(A) Labor for copying the records requested by the individual, whether in paper or electronic form;</p> <p>(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and</p> <p>(C) Postage, when the individual has requested the copy be mailed.</p> <p>(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form This REQUIREMENT is not met as evidenced by: Based on staff interview and review of medical records and facility policy, it was determined the facility failed to provide a resident's legal guardian with the medical records they were seeking. This was true for 1 of 1 sample resident (#7) reviewed for medical records request. The failure created the potential for poor coordination of care and psychological harm when residents did not receive copies of their own medical records as requested. Findings include: The facility's Authorization for Release of Information policy, revised 11/28/16, documented</p>	F 153	<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>		

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F 153	<p>Continued From page 2</p> <p>the facility would, "Provide copies of records to patient/resident/legal representative in the form or format requested, if they are readily producible in such form or format, within two (2) working days of a request."</p> <p>Resident #7 was admitted to the facility on 4/15/13 and readmitted on 12/5/13 with multiple diagnoses, including alcohol related dementia. The resident transferred to another facility on 1/9/17.</p> <p>Resident #7's legal guardian requested copies of the resident's "Entire Medical Record" on 1/22/17 on the facility's Request And Authorization For Release of Health Information form. The release form included options for release of HIV information, tests and results; alcohol and drug treatment; and mental health information, all of which the guardian authorized with her/his initials.</p> <p>On 3/2/17 at 10:10 am, the LSW said the facility's previous medical records employee did not provide Resident #7's medical records to the guardian as requested. The LSW said that on "about" 2/1/17 she sent some of the medical records to the guardian, but not the entire medical record.</p> <p>On 3/2/17 at 10:40 am, the CED said he would have provided Resident #7's entire medical record to the guardian at no cost but he thought the guardian had received the records s/he wanted.</p>	F 153	<p>Resident #7's complete medical record was copied and sent to his guardian by the Center Nurse Executive (CNE) or designee on 3/16/17.</p> <p>The Center Executive Director (CED) or designee will complete a review on 3/16/17 of record requests made in the last 30 days to ensure records were sent to authorized persons as requested.</p> <p>A new Medical Records designee was hired and started work on 3/7/17. An education was completed with the Medical Records designee by the CED or designee on 3/16/17 to ensure that medical records are sent to authorized persons as requested.</p> <p>Beginning the week of 3/20/17 the CED or designee will complete a review of medical record requests weekly for 4 weeks and monthly for 2 months to ensure that Medical Records are sent to authorized persons as requested. Results will be reviewed in Quality Assurance and Performance Improvement meetings monthly for 3 months or until compliance is sustained. The CED is responsible for compliance.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001270	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/02/2017
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NAME OF PROVIDER OR SUPPLIER CHERRY RIDGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST IDAHO BOULEVARD EMMETT, ID 83617
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint investigation survey conducted at the facility February 28, 2017 to March 2, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN , Team Coordinator Linda Kelly, RN Marci Clare, RN Edith Cecil, RN</p> <p>Abbreviations: CED = Center Executive Director TV = Television</p>	C 000		
C 159	<p>02.100.09 Record of Ptnt/Rsdnt Personal Valuables</p> <p>09. Record of Patient's/Resident's Personal Valuables. An inventory and proper accounting shall be kept for all valuables entrusted to the facility for safekeeping. The status of the inventory shall be available to the patient/resident, his conservator, guardian, or representative for review upon request.</p> <p>This Rule is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to maintain a complete and accurate inventory of residents' belongings. This was true for 1 of 9 sample residents (#7). This failed practice created disagreement between the facility and the resident's guardian when the discharge Inventory List form was blank and did not include items that were brought to or left the facility for Resident #7.</p>	C 159	<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</p>	3/17/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/17/17
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C 159	<p>Continued From page 1</p> <p>Findings include:</p> <p>Resident #7 was admitted to the facility on 4/15/13 and readmitted on 12/5/13 with multiple diagnoses, including alcohol related dementia. The resident transferred to another facility on 1/9/17.</p> <p>Resident #7's Inventory List contained 2 sections. The top section, labeled "On Admission" and dated 12/5/13, documented 5 hats, 1 pair of socks/hose, 1 pair of shoes, 3 sweaters, 3 undershirts, 1 watch, 1 fanny pack, 1 cell phone and 1 brace. The bottom section, labeled "On Discharge" was blank except for the resident's guardian's undated signature. Both sections included areas to document items "acquired after admission." No items were listed in either area for "acquired after admission.</p> <p>On 3/1/17 at 5:00 pm, the CED said that in late January 2014, Resident #7 bought a "big" TV and had it delivered to the facility. The CED said the TV was too large for the table in the resident's room however, and the resident would not agree to have it mounted on the wall and the resident called a friend to come and get the TV. The CED said the resident was able to make those types of decisions at that time. The CED said the resident's "On Discharge" Inventory List was signed by the resident's new guardian, but not signed by facility staff.</p> <p>On 3/2/17 at 10:20 am, the CED said the "On Discharge" section of Resident #7's Inventory List was blank and that it would have been better to have a "paper trail" of items that were brought to Resident #7 and signed off when they were removed from the facility.</p>	C 159	<p>legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident #7 discharged on 1/9/17.</p> <p>A review of current residents' inventory sheets was completed by the Center Nurse Executive (CNE) on or before 3/16/17 of current residents to ensure the inventory sheet is completed and signed by the resident/resident representative and a facility representative.</p> <p>Systematic Change CNE will include the inventory sheet in a chart review to ensure that the sheet has been filled out and signed by the resident/resident representative and a facility representative.</p> <p>The CNE or designee completed an education with nursing staff on or before 3/16/17 to ensure they are filling out the inventory sheet upon admission.</p> <p>Beginning the week of 3/20/17 the CNE or designee will review 3 charts weekly for 4 weeks and monthly for 2 months to ensure that the inventory sheet is filled out and signed by the resident/resident representative and a facility representative. Results will be reviewed in Quality Assurance and Performance Improvement meeting monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.</p>	
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May 19, 2017

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

Provider #: 135095

Dear Mr. Prescott:

On **March 2, 2017**, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. This complaint was investigated February 28, 2017 through March 2, 2017. During the complaint survey, nine residents were reviewed, including the identified resident. Observations were made of the evening meal service and staff interactions with residents. The identified resident's clinical record was reviewed, which included physician orders, medications, and treatments. The Care Plan, Social Service and Physician Progress notes, and Nursing Notes were reviewed. Nutritional assessment and Dietary Notes were reviewed. Radiology/Ultrasound report was reviewed. Therapy notes were reviewed for this identified resident. Abuse investigations were reviewed and resident interviews were completed during this complaint survey.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007378

ALLEGATION #1:

The identified resident is a "big man" who is not being fed at the facility.

FINDINGS:

The identified resident was no longer in the facility at the time of the survey.

The identified resident's record contained documentation that he/she had a legal guardian in place who was not the Reporting Party.

Cameron Prescott, Administrator
May 19, 2017
Page 2 of 2

The identified resident had a number of endstage disease processes which impacted his nutritional intake and weight. The facility recognized the disease processes and developed a plan of care consistent with current standards of practice. No deficiencies were cited for this allegation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident did not receive therapy or exercise in the facility.

FINDINGS:

The physician ordered physical therapy for the identified resident, however the resident declined these services because his illness prevented him from participating.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident was mistreated by staff.

FINDINGS:

Multiple resident interviews were completed during the survey. The residents had no concerns with the treatment or care the staff provided. Observations made of staff interacting with residents were noted to be kind and attentive. No deficiencies were cited for this allegation.

CONCLUSIONS:

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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

Cameron Prescott, Administrator
May 19, 2017
Page 3 of 2

DS/lj



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May 19, 2017

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

Provider #: 135095

Dear Mr. Prescott:

On **March 2, 2017**, an unannounced on-site investigation of an entity-reported incident was conducted at Cherry Ridge Center. The complaint was investigated from February 28, 2017 through March 2, 2017.

Call light response times were observed throughout the survey. Nursing staff were observed throughout the survey. The Administration staff members were observed throughout the survey. Residents were observed for needs being met throughout the survey.

Eight resident records were reviewed for Quality of Care concerns, Resident Rights, and Quality of Life. The facility's Grievance file, Resident Council minutes, and Incident and Accident reports from April 2016 through March 2017 were reviewed. In addition, the facility's staffing records from December 2016 through March 2, 2017 were reviewed.

Several residents, nurses and Certified Nursing Aides (CNAs), the Administrator, and the Director of Nurses were interviewed regarding Quality of Care, Resident Rights, and Quality of Life concerns. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007455

ALLEGATION #1:

The Reporting Party said there was not sufficient staff during the nightshift, making it necessary for residents to wait more than an hour for assistance; the Administrator and the DNS were aware of the problem and failed to resolve the facility's staffing shortage and its adverse effect on residents.

Cameron Prescott, Administrator
May 19, 2017
Page 2 of 2

FINDINGS:

Call lights were observed throughout the survey and no concerns were identified.

All nursing shifts were observed throughout the survey and no concerns were identified.

The schedule for Nurses and CNAs were reviewed throughout the survey and no concerns were identified.

The Resident Council minutes were reviewed and no concerns were identified.

Several residents were interviewed and no concerns were identified regarding staffing. Several CNA's and nurses were interviewed and said the facility had hired more staff and the management assists with residents' needs. The Administrator and the Director of Nursing said they ensured the facility was staffed sufficiently even if they had to provide direct assistance to residents.

Based on observation, record review, and staff interview, it was determined the allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

David Scott, R.N., Supervisor
Long Term Care

DS/lj



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May 19, 2017

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

Provider #: 135095

Dear Mr. Prescott:

On **March 2, 2017**, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. The complaint was investigated from February 28, 2017 through March 2, 2017. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007465

ALLEGATION #1:

The Reporting Party stated that on several occasions there was not sufficient staff to meet residents' needs, including at meal times, evening shift, and during times residents required assistance with activities of daily living.

FINDINGS:

Call light response times were observed throughout the survey and on multiple shifts. Residents were observed for needs being met during multiple shifts, meal times, and during the provision of services and cares related to activities of daily living.

Cameron Prescott, Administrator
May 19, 2017
Page 2 of 2

The clinical record of the identified resident and seven other residents were reviewed for quality of care concerns. Documents reviewed included the facility's Grievance File from April 2016 through March 2017; Resident Council minutes from April 2016 through March 2017; Incident and Accident Reports from April 2016 through March 2017; and facility staffing records from December 2016 through March 2017.

Several residents, CNAs, nurses, the Director of Nursing, and the Administrator were interviewed regarding quality of care concerns.

Based on observation, record review, and staff interview, it was determined the allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Allegation did not occur.

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 black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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Boise, Idaho 83720-0009
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May 31, 2017

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

Provider #: 135095

Dear Mr. Prescott:

On **March 2, 2017**, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. The complaint was investigated during a complaint investigation survey conducted at the facility from February 28, 2017 to March 2, 2017.

During all days of the survey, five individual residents, and all residents in general, were observed for grooming, cleanliness, and appropriate attire. Licensed Nurses and Certified Nursing Assistants were observed interacting with and assisting residents during two meal services in the main dining room, the low-stimulation dining room, and in resident rooms. The nurses and nursing assistants were also observed during the provision of direct care, including toileting assistance and mechanical lift transfers.

The clinical records for nine residents, five current residents and four closed records of residents who had been discharged, were reviewed. The facility's grievance files, investigations of allegations of abuse, Resident Council meeting minutes, admission/discharge/transfer logs, posted staffing information, and staffing schedules and actual hours worked, were also reviewed.

Interviews were conducted with three individual residents, a resident's previous guardian, several nurses and nursing assistants, the Director of Nursing, Administrator, and Social Worker.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007466

ALLEGATION #1:

The identified resident's television is missing and the Administrator gave conflicting stories about the disposition of the television. Also, the resident's electric wheelchair was thrown away by the facility. A facility employee and the Administrator said the facility tried to fix the wheelchair, but it could not be fixed. The facility did not provide evidence the wheelchair was broken or what efforts were made to repair it.

FINDINGS #1:

Based on interview with the facility's Administrator, the identified resident had a "large" television three years prior. The administrator provided a February 4, 2014 merchant receipt in the resident's name for a television with a "Ship-to" address different from the facility's address. The Administrator said the television was placed in the facility's storage because it was too big for the table it was on, which made it unsafe, and the resident did not want it mounted on the wall. The Administrator said the resident had a friend pick up the television when s/he discharged and moved to a rental house. The Administrator said the television did not come back to the facility when the resident was readmitted to the facility a day later. Regarding the resident's electric wheelchair, the Administrator said it was old and in disrepair. The Administrator said the wheelchair's seat and arms were broken and torn, the foot rest was broken, and the battery would not hold a charge. The Administrator said the facility "patched" the wheelchair several times because that was what the resident wanted and it was finally discarded with the resident's approval.

The resident's previous guardian said the resident "has a mind of (###) own" and was capable of making some decisions and frequently "arranged things" with friends.

The allegation was substantiated, however deficient practice was not identified or cited.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident had a decline in activities of daily living after the facility took away his/her electric wheelchair and shoes, discontinued Physical Therapy, and left the resident in bed. Bi-polar disorder and shingles was documented in the resident's medical record one time but not referenced again.

FINDINGS #2:

The identified resident's clinical record documented the use of Prevalon boots related to a chronic

pressure ulcer on the heel and high risk for the development of pressure ulcers. The record also documented no change in the level of assistance s/he needed for bed mobility, transferring, dressing, eating, personal hygiene or bathing prior to the resident's most recent discharge from the facility. Also, the resident received physical therapy services for nearly four months with minimal improvement.

The resident's clinical record documented bi-polar disorder was addressed by psychiatric services and that shingles was treated with an antiviral medication for five days.

Several individual residents no voiced complaints or concerns that the facility took away belongings, such as shoes or assistive devices. In addition, the facility's grievance file did not contain any resident concerns concerning their personal belongings being removed by the facility. The Administrator said the facility did not take away residents' personal belongings.

Due to a lack of evidence, the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident's inventory sheet at discharge was blank, there was no documentation for an electric wheelchair or any other item the resident stated s/he brought to the facility.

FINDINGS #3:

The clinical record contained documentation that the identified resident's inventory list was blank. The deficient practice was substantiated and cited a C159.

CONCLUSIONS:

Substantiated. State deficiencies related to the allegation are cited.

ALLEGATION #4:

An identified resident's medications, specifically Flomax and Seroquel, were inconsistently given and there was no diagnosis for the Seroquel. The facility failed to treat and diagnosis the resident for Parkinson's Disease.

FINDINGS #4:

The identified resident's clinical record contained documentation that Flomax and Seroquel were administered as ordered by a physician and a diagnosis for Seroquel was provided. The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

When an identified resident was transferred to a new facility, the transferring facility did not send a complete medication list or history and baselines had to be re-established.

FINDINGS:#5

Based on interview with the facility's Licensed Social Worker and review of the identified resident's clinical record, the facility provided current physician's orders and Medication Administration Records, a history and physical, physician progress notes and "a couple months worth" of nursing notes to the new facility on the same day the resident was transferred. The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

An identified resident's interested party received only part of the clinical records requested.

FINDINGS #6:

Based on review of the identified resident's clinical record and interviews with the Administrator and Licensed Social Worker, it was determined the request for clinical records was not honored. The allegation was substantiated and the failed practice cited at F153.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

The social service notes for an identified resident are demeaning and condescending, and there were no other social service notes to document social services was involved with the resident's care.

FINDINGS #7:

The clinical record documented social service progress notes monthly, except for one month., and frequently there were two or three progress notes per month. There was evidence of on-going social

Cameron Prescott, Administrator
May 31, 2017
Page 5 of 5

services involvement in the identified resident's care during the last two years s/he lived in the facility. The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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 will be 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 black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

DS/lj