



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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June 8, 2017

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

Provider #: 135095

Dear Mr. Prescott:

On **June 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
June 8, 2017
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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 19, 2017**. Failure to submit an acceptable PoC by **June 19, 2017**, may result in the imposition of penalties by **July 13, 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 **July 7, 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 **August 31, 2017**. A change in the seriousness of the deficiencies on **July 17, 2017**, may result in a change in the remedy.

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

Denial of payment for new admissions effective **August 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 **November 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 **August 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>

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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 **June 19, 2017**. If your request for informal dispute resolution is received after **June 19, 2017**, 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 cursive script that reads "Nina Sanderson (L.S.W.)".

Nina Sanderson, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 06/26/2017
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 06/02/2017
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	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility on May 30, 2017 through June 2, 2017. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Beverly Briggs, RN Eunice Taylor, RN Abbreviations: ACNE = Acting Chief Nursing Executive CNA = Certified Nursing Assistant IP = Infection Preventionist LPN = Licensed Practical Nurse MDS = Minimum Data Set NA = Nursing Assistant PROM = Passive Range of Motion RN = Registered Nurse ROM = Range of Motion UTI = Urinary tract infection	F 000			
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in	F 318		6/21/17	

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

TITLE

(X6) DATE

Electronically Signed

06/14/2017

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 318	<p>Continued From page 1</p> <p>mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 1 of 5 residents (#7) reviewed for treatment and services related to ROM. The failed practice created the potential for more than minimal harm when Resident #7 did not receive passive ROM (PROM) as care planned to prevent deterioration of existing ROM limitations. Findings include:</p> <p>Resident #7 was admitted to the facility in 2014, with multiple diagnoses including traumatic brain injury, muscle spasm, and muscle wasting and atrophy.</p> <p>Resident #7's most recent quarterly Minimum Data Set (MDS), dated 3/14/17, documented he had severely impaired cognition, required total assistance for bed mobility, transfers, dressing, toileting, personal hygiene and bathing; had functional limitations in ROM in both upper and both lower extremities [arms and legs]; had not received physical therapy since 5/1/15; and did not receive ROM.</p> <p>Resident #7's annual MDS, dated 12/19/16, documented PROM was performed 7 days in the look back period.</p> <p>The care plan documented Resident #7 "exhibits or is at risk for alterations in functional mobility" as a focus area in 2014. Interventions included PROM 2 times daily, initiated in 2014.</p>	F 318	<p>Resident affected: Resident #7 referred to therapy for an evaluation of a new restorative nursing program on 6/14/17.</p> <p>Potential Residents: A review of residents care planned for restorative nursing was completed by the CNE or designee on or before 6/16/17 to ensure that the restorative plan is being followed and documented. Follow up was completed by the CNE or designee, including the re-implementation of restorative programming or a referral to therapy, as indicated, on or before 6/16/17.</p> <p>Systematic Change: The CNE will be responsible for the implementation of restorative nursing when it is deemed necessary for a resident to receive restorative nursing services.</p> <p>Nursing staff was educated by the CNE or designee on or before 6/16/17 to ensure that restorative nursing is being provided and documented for residents with a restorative nursing care plan.</p> <p>Review: Beginning the week of 6/19/17 the CNE or designee will review 2 residents with restorative nursing care plans weekly for 4 weeks and monthly for 2 months to</p>		

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F 318	<p>Continued From page 2</p> <p>On 5/31/17 at 5:30 pm, 6/1/17 at 10:30 am, 11:30 am, 2:15 pm, and 3:25 pm; and 6/2/17 at 11:50 am, Resident #7's left fingers were observed closed into a fist.</p> <p>On 5/31/17 at 5:30 pm, 6/1/17 at 2:15 pm and 3:25 pm, and 6/2/16 at 11:50 am, Resident #7's right second, third, and fourth fingers were observed to be straight with each of the medial interphalangeal joints [second finger joint] hyperextended [extended too far] and his thumb and little finger touching.</p> <p>On 6/1/17 at 3:25 pm, Certified Nursing Assistant (CNA) #1 said she "sometimes" placed a rolled cloth in Resident #7's hands to "open them." CNA #1 said she did not perform PROM and that she was not sure how to do PROM on the resident's right fingers. Resident #7 was able to open his left and right hands and extend his fingers when the CNA asked his to do so.</p> <p>On 6/2/17 at 11:50 am, Nursing Assistant (NA) #1 said she did not perform PROM for Resident #7. The NA said she did not know PROM was included on Resident #7's care plan.</p> <p>On 6/2/17 at 12:00 pm, Licensed Practical Nurse (LPN) #1 said she was working as a CNA that day. The LPN said she occasionally worked as a CNA when CNAs did not come to work. She said she provided PROM "sometimes" for Resident #7 when she worked as a CNA. The LPN said she did not know where PROM would be documented.</p> <p>Resident #7's electronic and paper clinical</p>	F 318	<p>ensure that the restorative nursing is being completed and documented. The results will be reviewed in Quality Assurance and Performance Improvement (QAPI) meeting monthly for 3 months or until compliance is sustained.</p>		

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F 318	Continued From page 3 records did not contain documentation of PROM.	F 318			
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed	F 514		6/21/17	

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F 514	<p>Continued From page 4 professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's Infection Control Program, and staff interview, it was determined the facility failed to ensure clinical records included the results of laboratory test. This was true for 1 of 10 sample residents (#2) and a random resident (#11). The failure to have Resident #2's Dilantin level results, and Resident #11's urine culture sensitivity results, in their respective clinical records, created the potential for medical decisions to be based on incomplete information. Findings include:</p> <p>1. Resident #2 was admitted to the facility in 2013, with multiple diagnoses including epilepsy.</p> <p>Resident #2's Order Summary Report documented a 2/21/17 physician order for Dilantin (anticonvulsant medication) twice a day and a 2/9/17 order for a Dilantin level blood test every 90 days.</p> <p>Resident #2's May 2017 Medication Administration Record documented the Dilantin was administered twice daily in May and a Dilantin level blood test was done on 5/5/17.</p> <p>Resident #2's clinical record contained a laboratory report which documented a Dilantin level was done on 5/5/17, but it did not include the test results.</p> <p>On 6/2/17 at 10:00 am, the Acting Chief Nursing</p>	F 514	<p>Residents Effected: Resident #2 and #11 <input type="checkbox"/>s missing labs were put into their charts by the CNE on or before 6/5/17.</p> <p>Potential Residents: A review of the last 30 days of labs was completed by the CNE or designee on or before 6/16/17 with no other lab reports missing from resident charts.</p> <p>Systematic Change: Beginning 6/5/17 the Interdisciplinary Team (IDT) will review labs in morning clinical meeting and ensure that new labs were received and filed in the resident <input type="checkbox"/>s medical record.</p> <p>Licensed nurses were educated by the CNE or designee on or before 6/16/17 to ensure that when labs are received from the lab they are reviewed with the residents <input type="checkbox"/> attending physician and immediately filed in the resident <input type="checkbox"/>s medical record.</p> <p>Review: Beginning the week of 6/19/17 the CNE or designee will review 2 charts weekly for 4 weeks and monthly for 2 months to ensure that labs are correctly filed. The results will be reviewed in QAPI meeting</p>		

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F 514	<p>Continued From page 5</p> <p>Executive (ACNE) said the Dilantin level was done on 5/5/17 and she would look for the results.</p> <p>On 6/2/17 at 11:00 am, the ACNE provided Resident #2's Dilantin level results, which were within the accepted reference range. The ACNE said the laboratory sends test results to the physician but the facility has to request of them and the Dilantin level test results were faxed to the facility that day.</p> <p>2. Resident #11 was admitted to the facility in 2007, with multiple diagnoses including dementia and macular degeneration.</p> <p>On 6/2/17 at 9:50 am, the facility's Infection Control Program was reviewed with the Infection Preventionist (IP) and Registered Nurse (RN) #1. They said Resident #11 experienced signs and symptoms of a urinary tract infection (UTI) and that a urine analysis with culture and sensitivity, if indicated, was ordered the evening of 5/9/17. A urine sample was obtained early on 5/10/17 and a culture report that evening showed an alpha streptococcus infection and Cipro (antibiotic) was ordered.</p> <p>On 6/2/17 at 9:55 am, the IP said Resident #11's clinical record did not contain the culture sensitivity report with which to determine if the bacteria was sensitive to Cipro. The IP said that floor nurses were responsible for reviewing laboratory reports and reporting the results to the physician. The IP said, and Resident #11's clinical record documented, the UTI did resolve with the use of the antibiotic.</p>	F 514	monthly for 3 months or until compliance is sustained. The CNE is responsible for compliance.		



IDAHO DEPARTMENT OF
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RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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DEBBY RANSOM, R.N., R.H.I.T – Chief
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July 19, 2017

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

Provider #: 135095

Dear Mr. Prescott:

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

Complaint #ID00007517

The complaint was investigated during a federal recertification and State licensure survey conducted at the facility from May 30, 2017 to June 2, 2017.

Throughout the survey, observations were made of staff interactions with residents during the provision of care and services by Licensed Nurses and Certified Nursing Assistants. Staff responses to call lights, the administration of medications, including pain medications, and the whereabouts of the keys for two medication carts were also observed.

The clinical records of the identified resident and nine other residents were reviewed. Resident Council meeting minutes, grievance files, investigations of allegations of abuse, and staffing schedules and actual hours worked were also reviewed.

Interviews were conducted with three individual residents, two residents in a Resident Group Interview, three Registered Nurses, two Licensed Practical Nurses, two Certified Nursing Assistants, the interim Director of Nursing, Social Worker, one Activities Staff, the Dietary Manager, and the Administrator.

Allegation #1: An identified resident was not treated with dignity as evidenced by a note from one nurse to another that documented, "Read for a good laugh."

Findings #1: Per the facility's investigation, a staff member opened a sealed envelope labeled "Read for a good laugh" on the exterior of the envelope and addressed to a different staff member. The staff member who opened the envelope shared its contents with the identified resident and the resident was upset by the enclosed note and exterior comment. The identified resident confirmed that s/he was upset about the event.

The facility investigated the situation and counseled the staff member who addressed and sealed the envelope to another staff member. The staff member who shared the information with the identified resident was suspended and eventually terminated by the facility.

Although the allegation was substantiated, the facility acted appropriately and deficient practice was not identified.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: Two nurses accused an identified, bedbound, resident of seeking medication. The Reporting Party stated the identified resident's pain was not controlled while these two nurses were on duty.

Findings #2: Per interview with the identified resident, his/her pain was adequately controlled. In addition, per interviews with other residents, Licensed Nurses, and Certified Nursing Assistants, and review of clinical records, including that of the identified resident, as well as staffing schedules, there was little-to-no difference in residents' concerns regarding unaddressed pain or the administration of pain relief medications.

The allegation was not substantiated for lack of sufficient evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The facility is short-staffed and nurses are not available to residents or to answer call lights.

Findings #3: Based on review of staffing schedules and actual hours worked, as well as interviews with residents and staff members, the facility was adequately staffed and Licensed Nurses answered call lights. In addition, Licensed Nurses were observed answering call lights in a timely fashion during the complaint investigation survey.

The allegations was not substantiated for lack of sufficient evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Only one Certified Nursing Assistant worked the night shift on occasion.

Findings #4: Based on review of staffing schedules, actual hours worked, the facility's resident census, and interviews with residents, Licensed Nurses and Certified Nursing Assistants, the facility was adequately staffed with one Certified Nursing Assistant at night. In addition, a second Certified Nursing Assistant worked the night shift when the census was twenty-three or more.

The allegation was substantiated, but deficient practice was not identified.

Conclusion #4: Substantiated. No deficiencies related to the allegation are cited.

Allegation #5: A nurse's friend who was not employed by the facility was observed removing labels from used medication cards for shredding, giving him/her access to residents' private information.

Findings #5: Based on interviews with Licensed Nurses, Certified Nursing Assistants and the Administrator, only staff members employed by the facility handled residents' used medication cards.

The allegation was not substantiated for lack of sufficient evidence.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The medication cart keys were found inside a tissue box in an identified resident's room.

Findings #6: The medication cart keys were observed in the possession of the Licensed Nurses when they were administering medications from the medication carts. Per interviews with the Licensed Nurses, they kept the keys in their pockets when they were not using them to open the medication carts. Per interview with the identified resident, medication cart keys were never left in his/her room.

The allegation was not substantiated for lack of sufficient evidence.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Cameron Prescott, Administrator
July 19, 2017
Page 4 of 4

Two of the allegations were substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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 "D" is stylized with a vertical line through it, and "Scott" is written in a cursive-like font.

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt