



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RUSSELL S. BARRON -- Director

TAMARA PRISOCK -- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 8, 2018

Todd Russell, Administrator
Cherry Ridge Center
501 West Idaho Boulevard
Emmett, ID 83617-9694

Provider #: 135095

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Russell:

On **April 24, 2018**, a Facility Fire Safety and Construction survey was conducted at **Cherry Ridge Center** by the Department of Health & Welfare, 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 Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 21, 2018**. Failure to submit an acceptable PoC by **May 21, 2018**, may result in the imposition of civil monetary penalties by **June 10, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 29, 2018**, (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 29, 2018**. A change in the seriousness of the deficiencies on **May 29, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **May 29, 2018**, includes the following:

Denial of payment for new admissions effective **July 24, 2018**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **October 24, 2018**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 **April 24, 2018**, 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:

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

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **May 21, 2018**. If your request for informal dispute resolution is received after **May 21, 2018**, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

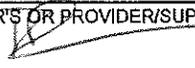
PRINTED: 05/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2018
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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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K 000	INITIAL COMMENTS The facility is a single story, Type V (000) building, originally constructed in 1959, with subsequent addition/remodeling in 1971. The structure has a private well and above ground storage tank that supplies the automatic fire extinguishment system, which is equipped with quick response sprinklers in habitable spaces. Currently the facility is licensed for 40 SNF/NF beds with a census of 24 on the date of the survey. The following deficiencies were cited during the annual life safety survey conducted on April 24, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	 <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth or the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal or state law."</p>	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Todd Russell 	TITLE CED	(X6) DATE 5/18/18
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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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K 353	<p>Continued From page 1</p> <p>b) Who provided system test</p> <hr/> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components has the potential to hinder system performance during a fire event and/or render the facility not fully sprinklered after an activation or repair. This deficient practice affected 24 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided facility inspection and testing records conducted on 4/24/18 from 8:30 - 10:30 AM, no records were available indicating an internal tank inspection had been conducted on the fire suppression system holding tank.</p> <p>Interview of the Administrator and the Maintenance Director revealed neither was aware of the last time the tank had an internal inspection.</p> <p>Actual NFPA standard:</p> <p>NFPA 25</p> <p>9.2.6 Interior Inspection. 9.2.6.1 Frequency.</p>	K 353	<p>Facility will have internal tank inspection done in correlation with the required 5 year fire system inspection which is due this year. This will facilitate less down time of the fire suppression system and have the least amount of impact on the facility. Facility to follow policy related to loss of fire protection system during this process. This exercise is scheduled to be done by the end of June 2018.</p> <p>All residents have the potential to be affected by the overdue tank internal inspection.</p> <p>CED/designee has had the Tels system updated to include an automatic prompt/documentation for the required internal inspection of the fire holding tank. Our fire system contractor has also been asked to include this testing in there inspection routine of this facility. In addition, Maintenance Director has been educated on this requirement. These changes/education have been implemented/completed as of 5/25/18.</p>		

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K 353	Continued From page 2 9.2.6.1.1* The interior of steel tanks without corrosion protection shall be inspected every 3 years. 9.2.6.1.2 The interior of all other types of tanks shall be inspected every 5 years.	K 353	Initial requirements/results will be reported at the next QAPI meeting, and then, requirements for the next inspection cycle to be reported based on the inspections due and results of completed testing.	5/25/18

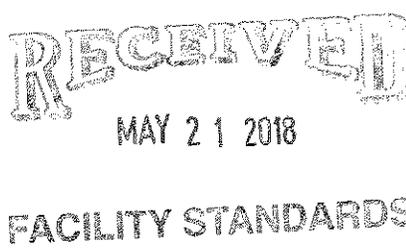
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E 000	Initial Comments The facility is a single story, Type V (000) building, originally constructed in 1959, with subsequent addition/remodeling in 1971. The structure has a private well and above ground storage tank that supplies the automatic fire extinguishing system, that is equipped with quick response sprinklers in habitable spaces. There is a natural gas, emergency EPSS generator and the facility is supported by a municipal fire authority, including county emergency response services. Currently the facility is licensed for 40 SNF/NF beds with a census of 24 on the date of the survey. The following deficiencies were cited during the emergency preparedness survey conducted on April 24, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal or state law"	
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Todd Russell	TITLE CED	(X6) DATE 5/18/18
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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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E 004	<p>Continued From page 1</p> <p>with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>The emergency preparedness program must include, but not be limited to, the following elements:]</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program in accordance with 42 CFR 483.73 that includes geographically relevant risks. Provisions of non-geographically relevant risks in the Hazard Vulnerability Analysis (HVA), creates unnecessary information and training platforms. This deficient practice affected 24 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/24/18 from 8:30 - 10:30 AM, review of the provided emergency plan, policies and procedures revealed the provided emergency plan HVA, included information of the probability</p>	E 004	<p>The emergency plan HVA was reviewed and changed to reflect the geographical relevant risks to this facility. "Hurricane" was found to not be apart of the risk to this facility and was removed from the risk assessment. New copies of the updated HVA were made and placed in each of the facilities EPP manuals. Inservices were conducted with staff to update on the new policy change. These changes/education were completed by 5/25/18</p> <p>All residents, staff and visitors have the potential to be affected by the incorrect HVA assessment.</p> <p>CED/designee to review the HVA at least annually or on an as needed basis to re-assess potential hazards to the facility. This will be done with an all hazards approach to the assessment process. All changes found on the assessment will be implemented on the facility policy reflected within our EPP.</p>	

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E 004	Continued From page 2 and impact of Hurricanes, which are not geographically relevant to the facility location. When asked, about the inclusion of the risk in the plan, the Administrator stated he had not been aware the HVA in the facility plan included this risk. Reference: 42 CFR 483.73 (a)	E 004	CED/Designee to continue ongoing assessment of potential hazards to the facility. Findings to be reported at facility QAPI meeting.	5/25/18	
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the	E 018	Facility has developed and implemented a "Shelter in Place" policy. This policy addresses the process to track residents, staff/caregivers and any volunteers during an emergency. This policy was implemented by 5/25/18 All residents, staff/caregivers, and volunteers have the potential to be affected by the deficient practice. CED/ designee to review EPP policies and procedures quarterly for 6 months and then annually to insure policies meet requirements. This will include review of the Shelter in Place policy. Reviews/changes/education of the EPP will be reported to the QAPI committee monthly.	5/25/18	

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E 018	<p>Continued From page 3 emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</p> <p>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.</p> <p>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and</p>	E 018		

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E 018	Continued From page 4 procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and residents has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the 24 residents, staff and visitors in the facility on the date of the survey. Findings include: On 4/24/18 from 8:30 - 10:30 AM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency. Reference: 42 CFR 483.73 (b) (2)	E 018			
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including	E 039			

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E 039	<p>Continued From page 5</p> <p>unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set</p>	E 039	<p>Facility had a Tabletop exercise on 4/11/2018. The facility is in process of completing the "Hotwash" of this tabletop exercise. Based on the findings of this process, this facility will review-change the EPP policies to reflect identified areas of improvement.</p> <p>In June 2018, this facility will be conducting a full scale exercise that is individual based. This exercise will test the facilities ability to successfully navigate a partial loss of the facility fire suppression system. This exercise will be done as a joint effort with the county/city fire department.</p> <p>Based on the facility "Hot Wash" or review of our exercises, Inservices will be provided to staff.</p>		

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

PRINTED: 05/11/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2018
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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E 039	<p>Continued From page 6 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to complete the required full-scale exercises which tested the emergency preparedness readiness of the facility. Failure to participate in a full-scale or tabletop exercise events has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 24 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 4/24/18 from 8:30 - 10:30 AM, review of provided emergency plan documents, documentation revealed the facility failed to document completion of two (2) full-scale exercises, testing the effectiveness of the emergency preparedness plan, policies and procedures.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (1)</p>	E 039	<p>In addition, this facility will continue to seek out opportunities to practice and improve our readiness for potential hazards or threats to this center.</p> <p>CED/designee will continue efforts to improve the facilities readiness for potential hazards. This will be accomplished through seeking out additional education opportunities, continuation of participation in community committees and exercises and then applying what we learn to make our facility better prepared.</p> <p>Maintenance Director/Designee educated on the requirements of the EPP. Review to include the requirements related to Tabletop and community or individual exercises. Review of the EPP to be completed quarterly for 6 months and then annually thereafter.</p> <p>All reviews/changes and education of the EPP will be reported to the QAPI committee.</p>	5/25/18	