



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

June 3, 2019

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

Provider #: 135095

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Russell:

On **May 20, 2019**, an Emergency Preparedness 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 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. 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 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.

Todd Russell, Administrator

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 17, 2019**. Failure to submit an acceptable PoC by **June 17, 2019**, may result in the imposition of civil monetary penalties by **July 8, 2019**.

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 **June 24, 2019**, (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 . A change in the seriousness of the deficiencies on **July 18, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 24, 2019**, includes the following:

Denial of payment for new admissions effective **August 20, 2019**.  
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.

Todd Russell, Administrator

June 3, 2019

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 20, 2019**, 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 **May 20, 2019**, 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>

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

Todd Russell, Administrator

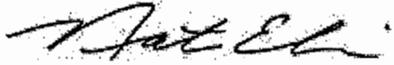
June 3, 2019

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This request must be received by **June 17, 2019**. If your request for informal dispute resolution is received after **June 17, 2019**, 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,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135095</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>CHERRY RIDGE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 WEST IDAHO BOULEVARD EMMETT, ID 83617</b>		
(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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V (000) building, originally constructed in 1959, with subsequent addition/remodeling in 1971. Facility potable water is provided from a private well, which includes an above ground storage tank supplying the fire suppression system.</p> <p>There is an interconnected fire alarm/smoke detection system with coverage in common areas and corridors. Emergency power is supplied through an on-site, spark ignited natural gas, Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 40 SNF/NF beds with a census of 18 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life safety survey conducted on May 20, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Health Care Occupancy, in accordance with 42 CFR 483.70</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed because it required by the provision of federal or state law.</p>	
K 511 SS=D	<p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p>	K 511		

**RECEIVED**  
**JUN 12 2019**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *LED* (X6) DATE: *6/13/19*

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 511	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure the use of approved, safe electrical installations in accordance with NFPA 70 and listed assemblies. Use of extension cords as a substitution of the fixed wiring and relocatable power taps (RPTs) outside of approved listing and design, has been historically linked to facility fires. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 5/20/19 from 1:00 - 1:45 PM, observation of the Laundry room revealed the use of an extension cord to supply power to a coffee maker.</p> <p>2) During the facility tour conducted on 5/20/19 from 2:15 - 2:30 PM, observation of the Director of Nursing (DON) office revealed the use of a RPT to supply power to a coffee maker.</p> <p>Actual NFPA standard:  NFPA 70  110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed. 110.3 Examination, Identification, Installation, and</p>	K 511	<p><b>K511</b></p> <p><u>Residents affected:</u></p> <p>No residents were affected by the deficient practice. However, coffee maker and extension cord was removed from the Laundry. The coffee maker was removed from the RPT in the DON office. Plant Director completed rounds in the facility to insure that no more extension cords or RPT's were connected with Coffee pots or that extension cords were in use. None were found.</p> <p><u>Potential residents:</u></p> <p>All residents have the potential to be affected by this deficient practice.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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K 511	<p>Continued From page 2 Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p>	K 511	<p><u>Systemic:</u></p> <p>CED/Designee to perform rounds in the facility to look for extension cords or items plugged into RPT's that are unauthorized. Rounds to continue 2 x monthly For 3 months. Additionally, inservice given to staff to educate on proper use of extension cords and RPT's within the facility.</p> <p><u>Monitoring:</u></p> <p>Results of facility rounds to be reported at facility QAPI meeting monthly for 3 months or until compliance is met.</p> <p><b>Completion date 6/17/19</b></p>	

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K 511	Continued From page 3  400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage  Additional reference: UL 1363 Standard for Relocatable Power Taps	K 511		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101  Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		

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K 914	<p>Continued From page 4</p> <p>manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident room electrical receptacles were maintained in accordance with NFPA 99. Failure to test resident room electrical receptacles annually has the potential to hinder system response during an emergency that encompasses a loss of power. This deficient practice affected 18 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance documents conducted on 5/20/19 from 8:30 - 10:30 AM, no documentation was available demonstrating an annual test conducted on resident room outlets.</p> <p>Interview of the Maintenance Director on 5/20/19 at approximately 2:30 PM established he had not yet completed an annual test on resident room outlets.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 Chapter 6 Electrical Systems</p> <p>6.3.3.2 Receptacle Testing in Patient Care</p>	K 914	<p><b>K914</b></p> <p><u>Residents Affected:</u></p> <p>No residents were affected by this deficient practice. However, the annual receptacle inspection was completed with minimal issues noted and repaired.</p> <p><u>Potential residents:</u></p> <p>All residents have the potential to be affected by the deficient practice.</p>	

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K 914	<p>Continued From page 5 Rooms.</p> <p>6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.</p> <p>6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.</p> <p>6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.</p> <p>6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz).</p> <p>6.3.4.1 Maintenance and Testing of Electrical System.</p> <p>6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device.</p> <p>6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data.</p> <p>6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.</p>	K 914	<p><u>Systemic:</u></p> <p>Maintenance Director inserviced on importance and compliance with required Annual Receptacle testing.</p> <p>CED/Designee to insure completion of required testing during Life Safety and EPP annual preparation.</p> <p><u>Monitoring:</u></p> <p>Maintenance Director to report to QAPI for Life Safety/EPP annual review and preparation.</p>	
K 918 SS=F	<p>Electrical Systems - Essential Electric Syste CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this</p>	K 918	<p><b>Completion date 6/17/19</b></p>	

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K 918	<p>Continued From page 6</p> <p>capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the Essential Electrical System (EES) generator was maintained in accordance with NFPA 110. Failure to inspect the system weekly and test for load monthly, has the potential of hindering system performance during a power loss or other emergency. This deficient practice affected 18 residents and staff on the date of the survey.</p> <p>Findings include:</p>	K 918	<p><b>K918</b></p> <p><u>Residents Affected:</u></p> <p>No residents affected by this deficient practice.</p> <p><u>Potential residents:</u></p> <p>All residents have the potential to be affected by the deficient practice.</p> <p><u>Systemic:</u></p> <p>Maintenance Director inserviced on the required Generator weekly and monthly tests/inspections.</p> <p>CED/Designee to audit inspections weekly X 3 months to insure compliance.</p> <p><u>Monitoring:</u></p> <p>Results of generator audits to be reported at Facility QAPI meetings.</p> <p><b>Completion date 6/17/19</b></p>	

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K 918	<p>Continued From page 7</p> <p>1) During review of annual inspection and maintenance records conducted on 5/20/19 from 1:15 - 1:30 PM, records revealed four missing monthly tests of the twelve months documented for the prior year (2018).</p> <p>2) During review of annual inspection and maintenance records conducted on 5/20/19 from 1:15 - 1:30 PM, records revealed the following weekly inspections were missing:</p> <ul style="list-style-type: none"> <li>- Week of May 27 to June 2</li> <li>- Week of June 17 to June 23</li> <li>- Week of July 15 to July 21</li> <li>- Week of August 26 to Sept. 1</li> <li>- Week of Sept. 16 to Sept. 22</li> <li>- Week of Sept. 23 to Sept. 29</li> <li>- Week of Oct. 1 to Oct. 6</li> <li>- Week of Nov. 11 to Nov. 17</li> <li>- Week of Nov. 18 to Nov. 24</li> </ul> <p>On 5/20/19 at approximately 1:45 PM, interview of the Maintenance Director revealed he was not aware of the missing documentation for weekly inspections and monthly load testing.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.</p>	K 918		



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PHONE 208-334-6626  
FAX 208-364-1888

June 3, 2019

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 **May 20, 2019**, 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 **June 17, 2019**. Failure to submit an acceptable PoC by **June 17, 2019**, may result in the imposition of civil monetary penalties by **July 8, 2019**.

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 **June 24, 2019**, (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 18, 2019**. A change in the seriousness of the deficiencies on **July 4, 2019**, 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 **June 24, 2019**, includes the following:

Denial of payment for new admissions effective **August 20, 2019**.  
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 **November 20, 2019**, 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 **May 20, 2019**, 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:

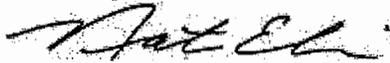
BFS Letters (06/30/11)

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

This request must be received by **June 17, 2019**. If your request for informal dispute resolution is received after **June 17, 2019**, 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: 05/30/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135095</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>CHERRY RIDGE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 WEST IDAHO BOULEVARD EMMETT, ID 83617</b>		
(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
E 000	Initial Comments  The facility is a single story, Type V (000) building, originally constructed in 1959, with subsequent addition/remodeling in 1971. It is situated within a municipal fire district with both county and state EMS support services available. Facility potable water is provided from a private well, which includes an above ground storage tank supplying the fire suppression system.  There is an interconnected fire alarm/smoke detection system with coverage in common areas and corridors. Emergency power is supplied through an on-site, spark ignited natural gas, Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 40 SNF/NF beds with a census of 18 on the date of the survey.  The following deficiency was cited during the emergency preparedness survey conducted on May 20, 2019. 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	<b>RECEIVED</b>  <b>JUN 12 2019</b>  <b>FACILITY STANDARDS</b>  <u>E041</u>  <u>Residents Affected:</u>  No residents affected by this deficient practice.  <u>Potential residents:</u>  All residents have the potential to be affected by the deficient practice.  <u>Systemic:</u>  Maintenance Director inserviced on the required Generator weekly and monthly tests/inspections  CED/Designee to audit inspections weekly X 3 months to insure compliance.  <u>Monitoring:</u>  Results of generator audits to be reported at Facility QAPI meetings.  Completion date 6/17/19	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)  (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.	E 041		

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

*Sam Burbank*

TITLE

*CED*

(X6) DATE

*6/13/19*

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 041	<p>Continued From page 1</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the</p>	E 041		

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E 041	Continued From page 2 Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a> . If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.	E 041		

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E 041	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the EPSS generator was maintained in accordance with NFPA 110. Failure to conducted required mothly load testing for the backup Emergency Electrical System (EES), has the potential to render the facility without necessary electrical support during a power loss or other disaster. This deficient practice affected 18 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided EPSS generator records conducted on 5/20/19 from 8:30 - 10:30 AM, no load tests were documented for four of the previous twelve months. Interview of the Maintenance Director on 5/20/19 at approximately 1:00 PM, established he was not aware of the missing documentation for load tests.</p> <p>Actual NFPA standard:</p> <p>8.3 Maintenance and Operational Testing. 8.3.1* The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.</p> <p>Reference: 42 CFR 483.73 (e) (1)</p>	E 041		

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E 041	Continued From page 4  Additional reference CMS 2567 K-tag 918	E 041		