



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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December 18, 2019

Nathan Chinchurreta, Administrator  
Cherry Ridge Center  
501 West Idaho Boulevard  
Emmett, ID 83617-9694

Provider #: 135095

Dear Mr. Chinchurreta:

On **December 4, 2019**, 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 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.

**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.

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 **December 30, 2019**. Failure to submit an acceptable PoC by **December 30, 2019**, may result in the imposition of penalties by **January 20, 2020**.

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 **January 8, 2020 (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 **March 3, 2020**. A change in the seriousness of the deficiencies on **January 18, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 4, 2020** includes the following:

Denial of payment for new admissions effective **March 4, 2020**. [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 **June 4, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, 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 **March 4, 2020** 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:

Nathan Chinchurreta, Administrator  
December 18, 2019  
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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 **December 30, 2019**. If your request for informal dispute resolution is received after **December 30, 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, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, , Supervisor  
Long Term Care Program

bd/lj

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

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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>C</b> <b>12/04/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHERRY RIDGE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 WEST IDAHO BOULEVARD</b> <b>EMMETT, ID 83617</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint survey conducted from December 2, 2019 through December 4, 2019.  The surveyors conducting the survey were:  Cecilia Stockdill, RN, team coordinator Sallie Schwartzkopf, LCSW  Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing E.D. = Executive Director I&A = Incident and Accident MDS = Minimum Data Set NA = Nursing Assistant LPN = Licensed Practical Nurse RN = Registered Nurse	F 000			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		1/5/20	

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

TITLE

(X6) DATE

Electronically Signed

12/26/2019

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 600	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, I&amp;A review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents were free from abuse, this was true for 1 of 8 residents (#300) reviewed for allegations of abuse. The deficient practice placed residents at risk of undetected psychosocial and/or verbal abuse. Findings include:</p> <p>The facility's policy for Abuse Prohibition, revised 8/1/16, documented staff shall identify events, occurrences, patterns, and trends which may constitute abuse, including resident-to-resident abuse. The policy also stated the E.D. or designee will conduct an immediate and thorough investigation, and the investigation will be documented on the Incident/Accident Investigation form. This policy was not followed.</p> <p>The facility's Incident/Accident Investigation form, copyright 2003, documented the form was to be completed for injuries of known or unknown origin, allegations of abuse, resident-to-resident incidents, and any incident which was determined an investigation was needed.</p> <p>Resident #300 was admitted to the facility on 10/17/18, and readmitted on 11/22/19, with multiple diagnoses including generalized muscle weakness, mild intellectual disabilities, and morbid (severe) obesity.</p> <p>A quarterly MDS assessment, dated 9/24/19, documented Resident #300 was cognitively intact, had delusions, required extensive</p>	F 600	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cherry Ridge Center does not admit that the deficiencies listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for these deficiencies.</p> <p>F600 Resident #300 incident was been investigated and findings reported to resident. The weeks after the incident, Resident #300 was monitored by Social Services Director, for psychosocial well-being.</p> <p>All facility residents, who are interview capable, will be interviewed regarding abuse. Any new allegations will be reported and investigated.</p> <p>Facility staff will be re-educated regarding abuse reporting process, forms and policies by the Nurse Practice Educator.</p> <p>Facility Center Executive Director, or designee, will conduct a staff member Interview regarding the abuse reporting process. Audit frequency will be: 2 staff members interviewed/audited weekly x 4</p>		

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F 600	<p>Continued From page 2</p> <p>assistance by one person with hygiene, and had total dependence on one person for bathing, and was not steady when moving from seated to standing position and turning and facing the opposite direction while walking. Resident #300 walked with a walker.</p> <p>Resident #300's Care Plan documented she required assistance for ADL care with bathing due to diagnosis of disorders of psychological development (developmental disorders that can involve impairment in areas such as language, learning, and motor) and morbid obesity. It documented Resident #300 may require one person assist to dress and undress, and she had been dressing herself independently.</p> <p>An LSW progress note, dated 10/11/19, documented Resident #300 had an encounter with a staff member the morning of 10/11/19 that upset Resident #300, and the LSW would monitor her for psychosocial side effects.</p> <p>An LSW progress note, dated 10/21/19, documented Resident #300 did not seem psychosocially affected by the staff interaction 2 weeks ago, and her behaviors remained the same. No additional documentation was found.</p> <p>On 12/2/19 at 3:00 PM, the LSW said two months ago a CNA talked to Resident #300 in a way considered verbally abusive. She said the incident was investigated. The LSW said the CNA was sent home and later decided to quit. The LSW said there were two versions of what happened, and it was hard to know what was true. The LSW said when she received a report [of potential abuse] she informed the DON and</p>	F 600	<p>weeks and then 1 staff member audited monthly x 2 months. The results of the audit will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement as necessary.</p> <p>Center Executive Director is responsible for compliance.</p>		

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F 600	<p>Continued From page 3 the E.D., and they would speak to the CNA.</p> <p>On 12/3/19 at 9:00 AM, the DON said Resident #300 had a developmental delay and she was screaming while being showered. The DON said the CNA said "stop screaming," and the Activities Director overheard them. The DON said the CNA was pulled into the E.D.'s office and the CNA was told not to talk that way to residents and she needed to write a statement of what happened, and then go home. The DON said the CNA called later that evening and quit. The DON said the staff had dementia training but not training for developmentally delayed residents.</p> <p>On 12/3/19 at 9:27 AM, the E.D. said staff were challenged by Resident #300's behavior. He said he confronted the CNA about the lack of customer service provided to Resident #300. The E.D. said the CNA was pushy and rushing Resident #300. He said he told the CNA he would monitor Resident #300 and the CNA. The E.D. said the LSW followed up with Resident #300. He said he sent the CNA home 2 hours early that day and later she called and said she quit. The E.D. said the incident was not reported "because it was not deemed abuse," it was deemed "customer service" reporting. The E.D. said he had the Business Office Manager witness his conversation with the CNA and would provide a copy of the investigation by staff.</p> <p>The E.D. provided the following:</p> <p>An e-mail message, dated 10/11/19, from the E.D. to the LSW read: "Please check-in with Resident #300 every day next week to monitor for any psychosocial ill-effects from today's lack</p>	F 600			

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F 600	<p>Continued From page 4</p> <p>of quality customer service from our staff member. This might be going a bit extreme, but I want to be cautious. Let us please discuss at subsequent morning clinical meetings."</p> <p>An e-mail message, dated 10/11/19, from the Business Office Manager read: "On Friday 10/11/19 at approximately 11:50 AM, the Business Office Manager was asked to sit in as a witness as the E.D. counseled a CNA. The E.D. read a statement out loud to the CNA from a witness who overheard the CNA in the shower room speaking to the resident in a gruff, borderline manor [sic] to the resident. The E.D. questioned the CNA to get her side of the story. She did not deny the allegations and stated she had a difficult time dealing with [Resident #300] because of her mental capabilities and acting like a child. The CNA stated she did not deal well with children and regardless of [Resident #300's] developmental disability, she still looked at her as a full-grown adult who should not act out and cry the way she did. The CNA said she felt like [Resident #300] was acting out more in an attention seeking way than a developmental way. The E.D. explained to the CNA regardless of her personal feelings toward any of the residents, they were treated with respect. He explained her behavior was borderline and would not be tolerated. He told the CNA to leave for the rest of the day. He asked if she was scheduled the next day and she said yes. The E.D. told the CNA she could return the following day, but she needed to write a statement [regarding the incident] in her own words and make sure he had it in his possession when he returned Monday morning. The E.D. also told the CNA he would speak to her direct supervisor on Monday about the</p>	F 600			

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F 600	<p>Continued From page 5 incident. The E.D. asked the CNA if she had any questions and she said no and left the building for the day."</p> <p>On 12/3/19 at 1:12 PM, the Activities Director said she overheard the CNA and Resident #300 on 10/11/19 while she was walking down the hall, and they were "very loud." She said she heard Resident #300 "crying differently" than she usually did, and Resident #300 said, "stop it." The CNA said "you are getting a shower whether you like it or not" in a forceful tone. The Activities Director said Resident #300 sounded fearful. The Activities Director said she quietly entered the shower room and watched the CNA who said [Resident #300] was "getting a shower whether she liked it or not." The Activities Director said she heard the CNA say, "Okay I will leave you here if not." The Activities Director said the CNA then turned toward the door and saw the Activities Director standing there. Resident #300 was sitting on the shower chair undressed and the CNA was standing in proximity of Resident #300. The Activities Director said she went straight to the E.D. and reported it.</p> <p>The Activities Director provided a copy of her written statement, dated 10/11/19 which read: "On Friday, 10/11/19 at approximately 11:10 [AM] I could hear someone crying as I was walking down the hall. I checked all rooms and found that it was coming from the shower room. From outside the door, I could hear [Resident #300] crying loudly that she didn't like the CNA, and that she didn't want to be showered by her. I heard the CNA say 'I don't care' several times to muffled requests from [Resident #300]. I stepped into the shower and heard [Resident #300] say</p>	F 600			

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F 600	Continued From page 6 she wanted the CNA to stop and she was going to tell the LSW. The CNA replied, 'I don't care, I have to get this shower done because I have other work to do.' [Resident #300] cried again that she wanted her to stop and the CNA stated 'fine, I am leaving' as if she was leaving her alone. As the CNA turned, she saw me and just shook her head and started talking nice to [Resident #300], stating 'we'll be done in just a minute' in a caring voice."	F 600			
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4)  §483.12(a) The facility must-  §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.  §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it	F 606		1/5/20	

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F 606	<p>Continued From page 7</p> <p>has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by:</p> <p>Based on employee record review, employee time audit review, policy review, and staff interview, it was determined the facility failed to ensure employee reference checks were completed prior to employment. This was true for 1 of 6 employees (Employee A) reviewed for pre-employment background checks. This failure created the potential for harm if residents received care from staff who had a history of adverse actions. Findings include:</p> <p>The facility's policy for Reference Checks, dated 3/15/16, documented references were checked for individuals applying for certain clinical and professional positions. The policy also stated reference checks were conducted prior to the employment offer. This policy was not followed.</p> <p>The background and reference check documentation for Employee A included an undated Candidate Reference Check Form which documented the contact information of two individual references from previous employment. There was no documentation the references were contacted to verify employment and obtain reference information. The facility did not provide documentation of completed reference checks for Employee A.</p> <p>Employee time audits for November 2019, documented Employee A worked on 11/6/19, 11/9/19, and 11/10/19. It was also documented Employee A's start date was 2/10/17 and her</p>	F 606	<p>F606 Employee A reference checks have been completed.</p> <p>All employees <input type="checkbox"/> reference checks will be audited. Any incomplete reference checks will be completed.</p> <p>Facility Management staff, responsible for the hiring process, will be re-educated regarding required reference check policies. All new hire personnel files and reference checks will be reviewed by the Center Executive Director, or designee, prior to working as a direct care worker in the facility. This review will happen at weekly morning management meeting.</p> <p>Facility Center Executive Director, or designee, will conduct a personnel file audit to review completed employee reference checks. Audit frequency will be: 3 employee files audited weekly x 4 weeks and then 1 employee file audited monthly x 2 months. The results of the audit will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement as necessary.</p> <p>Center Executive Director is responsible for compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>CHERRY RIDGE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 WEST IDAHO BOULEVARD</b> <b>EMMETT, ID 83617</b>		
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F 606	Continued From page 8 termination date was 11/10/19.  On 12/2/19 at 1:30 PM, the DON said Employee A previously worked at the facility, and she resigned her position about a month ago.  On 12/4/19 at 2:00 PM, the DON said she was aware reference checks were to be completed for new hire candidates, and there was an attempt to reach Employee A's references but there was no follow through.	F 606			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, I&A review, policy review, and resident and staff interview, it was determined the facility failed to appropriately investigate injuries of unknown	F 610	F610 Resident <input type="checkbox"/> s #300 and #301 incidents have been investigated and findings reported to the resident.	1/5/20	

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F 610	<p>Continued From page 9</p> <p>origin and resident to resident interactions. This was true for 2 of 8 residents (#300 and #301) reviewed for potential abuse. The deficient practice placed residents at risk of undetected physical, psychosocial, and/or verbal abuse. Findings include:</p> <p>The facility's policy for Abuse Prohibition, revised 8/1/16, documented staff shall identify events, occurrences, patterns, and trends which may constitute abuse, including resident-to-resident abuse. The policy also stated the E.D. or designee will conduct an immediate and thorough investigation, and the investigation will be documented on the Incident/Accident Investigation form. This policy was not followed.</p> <p>The facility's Incident/Accident Investigation form, copyright 2003, documented the form was to be completed for injuries of known or unknown origin, allegations of abuse, resident-to-resident incidents, and any incident which was determined an investigation was needed.</p> <p>1. Resident #300 was admitted to the facility on 10/17/18, and readmitted on 11/22/19, with multiple diagnoses including generalized muscle weakness, mild intellectual disabilities, and morbid (severe) obesity.</p> <p>A quarterly MDS assessment, dated 9/24/19, documented Resident #300 was cognitively intact, had delusions, required extensive assistance by one person with hygiene, and had total dependence on one person for bathing, and was not steady when moving from seated to standing position and turning and facing the opposite direction while walking. Resident #300</p>	F 610	<p>All facility residents, who are interview capable, will be interviewed regarding abuse and the follow-up investigation. Any new information or adverse effects will be reported and investigated.</p> <p>Facility Management staff, responsible for the investigation process, will be re-educated regarding required investigation process policies and procedures by the Nurse Practice Educator.</p> <p>Facility Center Executive Director, or designee, will conduct investigation audits, of allegations or incidents and accidents. Audit frequency will be: 1 investigation file audited weekly x 4 weeks and then 1 investigation file audited monthly x 2 months. The results of the audit will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement as necessary.</p> <p>Center Executive Director is responsible for compliance.</p>		

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F 610	<p>Continued From page 10 walked with a walker.</p> <p>Resident #300's Care Plan documented she required assistance for ADL care with bathing due to diagnosis of disorders of psychological development (developmental disorders that can involve impairment in areas such as language, learning, and motor) and morbid obesity. It documented Resident #300 may require one person assist to dress and undress, and she had been dressing herself independently.</p> <p>An LSW progress note, dated 10/11/19, documented Resident #300 had an encounter with a staff member the morning of 10/11/19 that upset Resident #300, and the LSW would monitor her for psychosocial side effects.</p> <p>An LSW progress note, dated 10/21/19, documented Resident #300 did not seem psychosocially affected by the staff interaction 2 weeks ago, and her behaviors remained the same. No additional documentation was found.</p> <p>On 12/2/19 at 3:00 PM, the LSW said two months ago a CNA talked to Resident #300 in a way considered verbally abusive. She said the incident was investigated. The LSW said the CNA was sent home and later decided to quit. The LSW said there were two versions of what happened, and it was hard to know what was true. The LSW said when she received a report [of potential abuse] she informed the DON and the E.D., and they would speak to the CNA.</p> <p>On 12/3/19 at 9:00 AM, the DON said Resident #300 had a developmental delay and she was screaming while being showered. The DON said</p>	F 610			

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F 610	<p>Continued From page 11</p> <p>the CNA said "stop screaming," and the Activities Director overheard them. The DON said the CNA was pulled into the E.D.'s office and the CNA was told not to talk that way to residents and she needed to write a statement of what happened, and then go home. The DON said the CNA called later that evening and quit. The DON said the staff had dementia training but not training for developmentally delayed residents.</p> <p>On 12/3/19 at 9:27 AM, the E.D. said staff were challenged by Resident #300's behavior. He said he confronted the CNA about the lack of customer service provided to Resident #300. The E.D. said the CNA was pushy and rushing Resident #300. He said he told the CNA he would monitor Resident #300 and the CNA. The E.D. said the LSW followed up with Resident #300. He said he sent the CNA home 2 hours early that day and later she called and said she quit. The E.D. said the incident was not reported "because it was not deemed abuse," it was deemed "customer service" reporting. The E.D. said he had the Business Office Manager witness his conversation with the CNA and would provide a copy of the investigation by staff.</p> <p>The E.D. provided the following:</p> <p>An e-mail message, dated 10/11/19, from the E.D. to the LSW read: "Please check-in with Resident #300 every day next week to monitor for any psychosocial ill-effects from today's lack of quality customer service from our staff member. This might be going a bit extreme, but I want to be cautious. Let us please discuss at subsequent morning clinical meetings."</p>	F 610			

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F 610	<p>Continued From page 12</p> <p>An e-mail message, dated 10/11/19, from the Business Office Manager read: "On Friday 10/11/19 at approximately 11:50 AM, the Business Office Manager was asked to sit in as a witness as the E.D. counseled a CNA. The E.D. read a statement out loud to the CNA from a witness who overheard the CNA in the shower room speaking to the resident in a gruff, borderline manor [sic] to the resident. The E.D. questioned the CNA to get her side of the story. She did not deny the allegations and stated she had a difficult time dealing with [Resident #300] because of her mental capabilities and acting like a child. The CNA stated she did not deal well with children and regardless of [Resident #300's] developmental disability, she still looked at her as a full-grown adult who should not act out and cry the way she did. The CNA said she felt like [Resident #300] was acting out more in an attention seeking way than a developmental way. The E.D. explained to the CNA regardless of her personal feelings toward any of the residents, they were treated with respect. He explained her behavior was borderline and would not be tolerated. He told the CNA to leave for the rest of the day. He asked if she was scheduled the next day and she said yes. The E.D. told the CNA she could return the following day, but she needed to write a statement [regarding the incident] in her own words and make sure he had it in his possession when he returned Monday morning. The E.D. also told the CNA he would speak to her direct supervisor on Monday about the incident. The E.D. asked the CNA if she had any questions and she said no and left the building for the day."</p> <p>On 12/3/19 at 1:12 PM, the Activities Director</p>	F 610			

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F 610	<p>Continued From page 13</p> <p>said she overheard the CNA and Resident #300 on 10/11/19 while she was walking down the hall, and they were "very loud." She said she heard Resident #300 "crying differently" than she usually did, and Resident #300 said, "stop it." The CNA said "you are getting a shower whether you like it or not" in a forceful tone. The Activities Director said Resident #300 sounded fearful. The Activities Director said she quietly entered the shower room and watched the CNA who said [Resident #300] was "getting a shower whether she liked it or not." The Activities Director said she heard the CNA say, "Okay I will leave you here if not." The Activities Director said the CNA then turned toward the door and saw the Activities Director standing there. Resident #300 was sitting on the shower chair undressed and the CNA was standing in proximity of Resident #300. The Activities Director said she went straight to the E.D. and reported it.</p> <p>The Activities Director provided a copy of her written statement, dated 10/11/19 which read: "On Friday, 10/11/19 at approximately 11:10 [AM] I could hear someone crying as I was walking down the hall. I checked all rooms and found that it was coming from the shower room. From outside the door, I could hear [Resident #300] crying loudly that she didn't like the CNA, and that she didn't want to be showered by her. I heard the CNA say 'I don't care' several times to muffled requests from [Resident #300]. I stepped into the shower and heard [Resident #300] say she wanted the CNA to stop and she was going to tell the LSW. The CNA replied, 'I don't care, I have to get this shower done because I have other work to do.' [Resident #300] cried again that she wanted her to stop and the CNA stated</p>	F 610			

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F 610	<p>Continued From page 14</p> <p>'fine, I am leaving' as if she was leaving her alone. As the CNA turned, she saw me and just shook her head and started talking nice to [Resident #300], stating 'we'll be done in just a minute' in a caring voice."</p> <p>On 12/3/19 at 2:31 PM, the E.D. said the incident was not deemed abuse at the time. He said the CNA left, and he could not follow up with her. He said the LSW followed up with Resident #300 but was not certain if it was documented.</p> <p>The facility failed to complete a thorough investigation into alleged abuse for Resident #300.</p> <p>2. Resident #301 was admitted to the facility on 4/2/19, with multiple diagnoses including palliative care (specialized medical care for people living with a serious illness focused on providing relief from the symptoms and stress of the illness), heart failure (heart cannot pump enough blood to meet the body's needs), muscle weakness, anxiety disorder, bipolar disorder, and PTSD (Post Traumatic Stress Disorder - difficulty recovering from a terrifying event).</p> <p>A quarterly MDS assessment, dated 10/10/19, documented Resident #301 had moderate cognitive impairment and delusions (beliefs contrary to reality).</p> <p>Resident #301's Smoking Evaluation, dated 9/23/19, documented Resident #301 was able to safely hold a cigarette, and had the ability to light a cigarette.</p> <p>On 12/2/19 at 2:00 PM, Resident #301 said he</p>	F 610			

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F 610	<p>Continued From page 15</p> <p>had an incident with the NA who "manipulated, pushed buttons, and got another resident to swing at him." He said he reported it to management and they said they would take care of it.</p> <p>Review of the facility's I&amp;A reports did not include an incident submitted by Resident #301.</p> <p>Resident #301's Progress Notes, dated 11/25/19 to 12/4/19, did not include documentation about an incident with the NA or another resident.</p> <p>The NA was interviewed on 12/4/19 at 3:50 PM, regarding the incident Resident #301 had mentioned. The NA said Resident #301 wanted to go out and smoke and she said he could go out and smoke only at designated times, but "not yet." When they did go out for the smoking break, the NA said Resident #301 "closed the door on her" when he went out [in front of her], and at one time it hit Resident #304. The NA said while she was lighting Resident #301's cigarette, she asked him not to swing the door shut, and he cussed her out. She said Resident #304 then stood up and swung and hit her, and she asked him to sit down, which he did. Resident #301 and #304 continued to argue, and she told the RN on night duty inside, who said "if they don't stop, bring them both inside." The NA said when they finished their first cigarette, she brought them inside, and she "messed the DON about it." The NA said she kept her distance until she and Resident #301 were talking and joking around as they had before.</p> <p>On 12/2/19 at 3:00 PM, the LSW said a complaint was placed on Wednesday 11/27/19, by Resident</p>	F 610			

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F 610	<p>Continued From page 16</p> <p>#301. At the time of the interview, the LSW said they were going to investigate the complaint. She said "one could not believe everything [Resident #301] said," and they discovered what Resident #301 told them in the past "had been lies." The LSW said she returned [after Thanksgiving] on Friday, 11/29/19, and Resident #301 said he since smoked "okay" in the NA's presence and everything was fine. The LSW said when she received a report [complaint] regarding a CNA from a resident, she informed the DON and the E.D., and they discussed it with the NA or CNA. She said the NA and Resident #301 had different accounts of the reported conversation, so it was hard to know what happened. The LSW said she was conservative and took resident complaints seriously, but she said what she observed [regarding Resident #301] she called "rude or being short."</p> <p>On 12/3/19 at 8:51 AM, the DON said Resident #301's complaint incident occurred on Tuesday, 11/26/19, and she investigated it. She said Resident #301 "did not like the NA for some reason" and "he lied a lot." The DON said the NA supervised an outdoor smoking break, and she was going to light Resident #301's cigarette and he objected. She said the NA stepped back, and Resident #304 stood and created a fist as if to protect the NA, "but he was far back." She said, "No one felt threatened at any time." The DON said Resident #301 claimed his cigarette pack was opened which led to anger and the incident. The DON said the NA was off work Wednesday, 11/27/19, and did not supervise smoking on Thursday 11/28/19. She said Resident #301 wrote the complaint [on 11/27/19] and came to her on Friday 11/29/19, and said the incident was</p>	F 610			

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F 610	Continued From page 17 resolved; he had a great day Thursday and was not concerned. The DON said when the LSW received a complaint the LSW informed herself and the E.D. and they investigated it. The DON said they "did not write this incident up because it was resolved."  On 12/3/19 at 9:20 AM, the E.D. said there was a conflict between the statements he received from Resident #301 and the NA. He said the report was being worked on, but he had not received it. The E.D. said he understood no reportable resident-to-resident abuse happened, and if it had "they would have called me." The E.D. said he spoke to Resident #301 who said he was "all cool" but then changed his mind. The E.D. said a lie does not matter, they talk to all parties to investigate.	F 610			
F 684 SS=D	The facility failed to complete a thorough investigation regarding the incident.  Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents received care and treatment which met	F 684	F684 Resident□s #7 and #11 wounds have been examined by the Medical Director,	1/5/20	

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F 684	<p>Continued From page 18</p> <p>professional standards of practice for wounds. This was true for 2 of 2 residents (#7 and #11) who were reviewed for wounds. This failed practice had the potential for wounds to become infected or worsen if care and services were not provided to treat and prevent further deterioration. Findings include:</p> <p>The National Alliance of Wound Care and Ostomy's website, accessed 12/13/19, stated the RN plays a key role in oversight of the patient-at-risk of or with wound care needs.</p> <p>The website documented the RN's role included:</p> <ul style="list-style-type: none"> <li>* Develop and implement wound prevention, skin management, and wound treatment programs</li> <li>* Delegate appropriate wound prevention and wound care actions to LPN/LVNs and unlicensed assistive personnel (e.g. nursing assistants)</li> <li>* As an interdisciplinary wound care team member, collaborate to establish individualized, comprehensive care plans that promote wound prevention and healing</li> </ul> <p>The website also stated the LPN's role included:</p> <ul style="list-style-type: none"> <li>* As an interdisciplinary wound care team member, provide input for care plan consideration</li> <li>* Implement preventative care, monitors skin status, and perform wound treatments per orders</li> <li>* Observe patient response and wound status, and report changes to the registered nurse or supervising clinician</li> </ul> <p>1. Resident #7 was admitted to the facility on 7/20/13, with multiple diagnoses including</p>	F 684	<p>or designee, and recommendations/plans of care have been implemented and documented.</p> <p>Facility licensed nursing staff will be re-educated regarding wound care documentation completeness. All current facility residents will have skin audits performed. Wound care documentation will be audited for specific descriptions and plans of care.</p> <p>Resident wound care documentation will be reviewed during morning clinical meeting with the management team.</p> <p>Facility Center Nurse Executive, or designee, will conduct resident wound care documentation audits. Audit frequency will be: 3 resident audits weekly x 4 weeks and then 1 resident audit monthly x 2 months. The results of the audits will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement as necessary.</p> <p>Center Nurse Executive is responsible for compliance.</p>		

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F 684	<p>Continued From page 19 Alzheimer's disease and dementia.</p> <p>Resident #7's physician orders, dated 3/27/19, documented to perform skin checks weekly on Mondays.</p> <p>Resident #7's care plan directed staff to observe her skin condition with Activities of Daily Living (ADL) care daily and to report abnormalities. A licensed nurse was to perform skin assessments. The interventions were initiated on 6/19/16.</p> <p>A Progress Note, dated 7/1/19 at 9:45 AM, documented Resident #7 had a change in condition relating to a skin wound or pressure ulcer. A second progress note on 7/1/19 at 11:54 PM, documented round, reddened areas were present on top of the second and fourth toes on Resident #7's foot. There was no further documentation describing the wounds.</p> <p>A Progress Note, dated 7/2/19 at 7:54 AM, documented Resident #7 had abrasions/sores present on her left foot. There was no further documentation or description of the abrasions/sores.</p> <p>A Progress Note, dated 7/3/19 at 7:54 AM, documented the wound assessment and recommendations were reviewed with the DON. There was no documentation of who did the assessment and what the recommendations were.</p> <p>Progress Notes on 7/7/19 at 9:22 AM, 7/14/19 at 7:49 AM, and 7/28/19 at 7:45 AM, documented Resident #7's wounds were evaluated on the second and fourth toes of her left foot. The</p>	F 684			

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F 684	<p>Continued From page 20</p> <p>documentation did not include who evaluated the wounds or further description of the wounds.</p> <p>A Progress Note on 9/5/19 at 11:57 AM, documented the scabs on Resident #7's toes were healed.</p> <p>There were no skin injuries or wounds documented on subsequent Progress Notes through 12/1/19.</p> <p>Resident #7's Skin Check assessments, dated 7/7/19 at 9:22 AM, 7/14/19 at 7:49 AM, and 7/28/19 at 7:49 AM, documented she had abrasions or other wounds to her left second and fourth toes. There was no further documentation regarding the wounds.</p> <p>An I&amp;A Report, dated 7/1/19 at 7:00 AM, documented Resident #7 experienced an event of "Abuse-alleged-injury of unknown origin." The report documented it was noticed when a staff member assisted Resident #7 with dressing that she had two small circular areas on the second and fourth toes on her left foot. The I&amp;A stated, "Will have M.D. [Medical Doctor] assess for possibility of wounds being vascular." The corrective action included awaiting the physician's determination of the wound.</p> <p>An untitled, unsigned, handwritten document was provided by the DON, which stated the following:</p> <p>* 7/1/19: A nurse and the DON noticed 2 small circular areas on Resident #7's second and fourth toes on her left foot. "Suspect vascular [relating to the blood vessels] d/t [due to] declining health."</p>	F 684			

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F 684	<p>Continued From page 21</p> <p>* 7/3/19: The Nurse Practitioner from a wound clinic was to look at the wound to rule out pressure wounds. "She agrees it is vascular in nature..[Resident #7] was on hospice previous, will recommend a new referral"</p> <p>* 7/18/19: "[Nurse Practitioner] confirmed vascular."</p> <p>There was no documentation in Resident #7's record the wounds on her toes were examined or evaluated by a provider. Resident #7's record did not include orders for treatment of the identified wounds.</p> <p>On 12/2/19 at 3:00 PM, the DON said Resident #7 had a skin issue on her toes related to vasculitis (inflammation of the blood vessels), and another skin issue resulted when staff forgot to apply her boots prior to transferring her with the Hoyer (a mechanical lift) and she was bumped during the transfer.</p> <p>On 12/3/19 at 11:10 AM, the DON said the wound nurse and the Nurse Practitioner gave their opinion the red areas on Resident #7's toes were vascular wounds, and neither the wound nurse or Nurse Practitioner documented this in Resident #7's record. The DON said she asked the wound care nurse and Nurse Practitioner in passing about Resident #7's wounds, and they looked at the wounds but did not document it.</p> <p>On 12/4/19 at 3:35 PM, LPN #1 said Resident #7 had red areas on her toes and she did not think it was from pressure. LPN #1 said she notified the DON of the wounds, and she did not think the wounds were from pressure. LPN #1 said she talked to CNAs regarding the wounds on</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>Resident #7's toes, and she did not have a definite answer for the cause of the wounds.</p> <p>The facility failed to provide treatment of the wounds identified on Resident #7's toes.</p> <p>2. Resident #11 was readmitted to the facility on 9/27/16, with multiple diagnoses including dementia, Alzheimer's disease, and stroke.</p> <p>Resident #11's care plan documented the following:</p> <ul style="list-style-type: none"> <li>* A licensed nurse was to perform weekly skin assessments, initiated on 10/13/16.</li> <li>* Staff were directed to assess factors that contribute to skin injury and revise the plan of care to prevent additional incidents, initiated on 11/14/16.</li> <li>* Staff were directed to observe his skin condition with ADL care daily and to report abnormalities, initiated on 11/14/16.</li> </ul> <p>Resident #11's Skin Check assessment, dated 9/1/19 at 7:05 AM, documented a new skin injury/wound was identified on his right great toe. Resident #11's subsequent Skin Check assessments, dated 9/8/19 to 12/1/19, did not include documentation of the wound to his right great toe.</p> <p>There was no documentation in Resident #11's record the skin injury on his right great toe, identified on 9/1/19, was investigated to determine the cause of the wound.</p> <p>On 12/3/19 at 2:45 PM, the DON said she did not know about the wound on Resident #11's toe, or</p>	F 684			

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F 684	Continued From page 23 why it was documented on 9/1/19 and it was not documented anywhere else in his record. The DON said if a new wound was found on Resident #11's skin, a change of condition and an I&A form should have been completed.  On 12/3/19 at 3:25 PM, Resident #11 had a round, red/brown abrasion to his left knee and 2 linear (thin and in a line) abrasions to his left lower leg. LPN #1 said it looked like scratches on Resident #11's leg, and perhaps it happened when he was propelling himself in his wheelchair. LPN #1 said she was not previously aware of the abrasions on Resident #11's left lower leg. There was no documentation in Resident #11's record regarding the abrasions on his left lower leg.  On 12/4/19 at 3:35 PM, LPN #1 said she talked to the CNAs about the abrasions on Resident #11's left lower leg, and it happened on 12/1/19. LPN #1 said Resident #11 would "fight" when staff provided care to him, and he bumped his leg on the wall. LPN #1 said it happened often due to Resident #11's behavior during cares, and the DON was going to update his care plan to put something on his wall to protect his skin when he bumped his leg.  The facility failed to provide treatment of the wound identified on Resident #11's toe and document and provide treatment for the wounds identified on his lower leg.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689			1/5/20

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F 689	<p>Continued From page 24 as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, I&amp;A review, and staff interview, it was determined the facility failed to provide adequate supervision to prevent elopement. This was true for 2 of 4 residents (#302 and #303) reviewed for supervision. This failure created the potential for harm if residents sustained an injury or an adverse event during the elopement. Findings include:</p> <p>The facility's policy for Elopement of Patient, revised 5/15/14, documented the following:</p> <p>* "Patients will be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury."</p> <p>* Staff were directed to review the nursing assessment and elopement evaluation upon admission, re-admission, quarterly, or with a significant change in condition.</p> <p>This policy was not followed.</p> <p>1. Resident #302 was admitted to the facility on 10/7/19, with multiple diagnoses including dementia, heart failure, atrial fibrillation (irregular heart rhythm), and chronic kidney disease.</p>	F 689	<p>F689 Residents #302 and #303 have been evaluated for elopement risk and care plans updated to reflect the change.</p> <p>All facility residents will be audited to ensure their elopement risk evaluations are completed. Any changes will be reflected in the resident care plan.</p> <p>Facility licensed nurse personnel will be re-educated regarding elopement risk evaluations documentation upon admission. All new facility resident admissions elopement risk evaluations will be reviewed during morning clinical review meeting.</p> <p>Facility Center Nurse Executive, or designee, will conduct resident elopement risk evaluation audits. Audit frequency will be: 3 resident audits weekly x 4 weeks and then 1 resident audit monthly x 2 months. The results of the audit will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement is necessary.</p> <p>Center Nurse Executive is responsible for compliance.</p>		

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F 689	Continued From page 25  Resident #302's care plan documented he required assistance for mobility, initiated on 10/7/19, and he had an impairment/decline in cognitive function or impairment in thought processes related to dementia, initiated on 10/14/19.  Resident #302's admission MDS assessment, dated 10/14/19, documented he was moderately cognitively impaired, he required extensive assistance of 2 individuals for bed mobility and transfers, and he required a wheelchair.  A Nursing Assessment, dated 10/22/19, documented the following:  * Resident #302 was admitted to the facility after a fall. * He received multiple medications. * He required oxygen. * He had a pacemaker. * He had difficulty with decision making for new tasks or situations. * His balance was not steady, but he was able to stabilize with staff assistance. * He did not wander in the last 30 days or since admission. * He had weakness in both legs. * He required a wheelchair or walker for mobility.  An elopement evaluation, dated 10/22/19 at 2:46 PM, documented Resident #302 had dementia, he exhibited multiple behaviors indicating a risk for elopement, and he had a history of actual elopement or attempted elopement.  A Progress Note, dated 10/22/19 at 2:58 PM,	F 689			

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F 689	<p>Continued From page 26</p> <p>documented Resident #302 was found outside the facility in the middle of the road. The note documented he was returned to the facility, an elopement assessment was completed, and a Wanderguard (device that alerts staff if he exited through the door) was placed on his wheelchair.</p> <p>Resident #302's care plan was revised on 10/24/19, two days after he eloped, and documented that he was at risk for elopement. The care plan stated staff were to monitor his location by visual checks every 2 hours, as needed, and a security bracelet was utilized.</p> <p>There was no I&amp;A or investigation in Resident #302's record regarding his elopement on 10/22/19.</p> <p>On 12/4/19 at 11:25 AM, the DON said Resident #302 had an elopement, and "he was just sitting outside... residents have the right to sit outside." The DON said there was no I&amp;A report for the elopement on 10/22/19.</p> <p>On 12/4/19 at 4:25 PM, the DON said Resident #302 did not demonstrate elopement behavior prior to 10/22/19, and he had not demonstrated further elopement attempts since then. The DON said the elopement on 10/22/19 occurred when Resident #302 was looking for his truck or his daughter, and a Wanderguard was placed on his wheelchair after the elopement. The DON said an Elopement Assessment would be triggered on the admission Nursing Assessment if there were behaviors that indicated a risk for elopement. The DON said if there were no behaviors on the Nursing Assessment, then an Elopement Assessment would not be triggered until there</p>	F 689			

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F 689	<p>Continued From page 27 was an actual elopement.</p> <p>The facility did not assess Resident #302 for elopement risk upon admission, as directed by facility policy. Resident #302 subsequently eloped from the facility.</p> <p>2. Resident #303 was admitted to the facility on 10/10/19, with multiple diagnoses including kidney failure, major depressive disorder, atrial fibrillation (irregular heart rhythm), muscle weakness, and unsteadiness on his feet.</p> <p>Resident #303's admission MDS assessment, dated 10/17/19, documented he was severely cognitively impaired and he required a mobility device (walker or wheelchair).</p> <p>Resident #303's care plan documented he had impaired/declined cognitive function related to short term memory loss and impaired decision making, initiated on 10/14/19, and he was at risk for falls related to muscle weakness, unstable gait, and low back pain, initiated on 10/23/19. The care plan did not document Resident #303's elopement behavior or the use of a Wanderguard.</p> <p>An I&amp;A report, dated 10/30/19 at 5:00 PM, documented Resident #303 eloped from the facility. The report documented a church across the street from the facility called to alert the facility that Resident #303 wandered over to their location. Resident #303's daughter was notified by phone call and consent was obtained for placement of a Wanderguard. The report documented an elopement evaluation was completed when Resident #303 returned to the</p>	F 689			

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F 689	Continued From page 28 facility, and the care plan was updated as needed. The root cause/conclusion of the incident was Resident #303 was confused and he went across the street to find a barber. The corrective actions were: Wanderguard placed, the elopement binder was updated, and a hair cut was scheduled.  There was no documentation of an elopement assessment in Resident #303's record. There was no documentation of changes to his plan of care regarding his elopement behavior following his elopement.  On 12/4/19 at 4:30 PM, the DON said Resident #303 eloped from the facility when he was looking for a barber. The DON said an Elopement Assessment was not completed for Resident #303. She assumed the reason was because he was "looking for a barber."  The facility did not assess Resident #303 for his elopement risk upon admission, as directed by facility policy. Resident #303 subsequently eloped from the facility.	F 689			
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)  §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		1/5/20	

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F 727	<p>Continued From page 29</p> <p>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on employee time audit review, policy review, nursing schedule review, and staff interview, it was determined the facility failed to ensure an RN was on duty at least 8 hours a day, 7 days a week. This was true for 3 of 21 days reviewed. The failure created the potential for harm if routine and/or emergency nursing needs went unmet. Findings include:</p> <p>The facility's policy Staffing/Center Plan, revised 9/1/13 and reviewed 6/1/19, documented the facility would provide qualified and appropriate staffing levels to meet the needs of the patient population. The staffing plan would include all shifts, seven days per week. The process included the facility maintained appropriate staffing levels, with qualified personnel, 24 hours/day, seven days/week on each shift to assure that patients were safe, and their needs were met. This policy was not followed.</p> <p>The facility provided the nursing schedule for 11/10/19 to 11/30/19. The nursing schedule documented there was not 8 hours of RN coverage on 11/23/19, and no RN coverage on 11/24/19 and 11/30/19. The employee time audits for 11/23/19, documented 2 hours of RN coverage. The audits for 11/24/19 and 11/30/19, did not include an RN was on duty.</p> <p>On 12/3/19 at 9:10 AM, the DON said that RN</p>	F 727	<p><b>F727</b> No residents were harmed or adversely affected. A Registered Nurse has been on duty for 8 hours every day in December.</p> <p>January Staff schedule will be audited for 8 hour Registered Nurse coverage</p> <p>Facility personnel responsible for nursing staff scheduling will be re-educated regarding the 8 hour Registered Nurse scheduling requirement. The Center Nurse Executive, or designee, will review weekly and monthly schedules for appropriate 8 hour Registered Nurse coverage. This review will happen at weekly morning management meeting.</p> <p>Facility Center Nurse Executive, or designee, will conduct Registered Nurse coverage audits of the employee schedule. Audit frequency will be: 1 audit weekly x 4 weeks and then 1 audit monthly x 2 months. The results of the audit will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement as necessary.</p> <p>Center Nurse Executive is responsible for compliance.</p>		

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

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F 727	Continued From page 30 hours were to be 8 hours each day, and there was no documentation of an RN on duty for 8 hours on 11/23/19, 11/24/19 and 11/30/19.	F 727			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		1/5/20	

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F 880	<p>Continued From page 31</p> <p>communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on personnel record review, policy review, and staff interview, it was determined the facility failed to ensure there was documented</p>	F 880	<p>F880 No residents have been adversely impacted. The E.D and Employee B TB</p>		

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F 880	<p>Continued From page 32</p> <p>evidence of employees being free from tuberculosis (TB). This was true for 2 of 27 employees (Employee B and the E.D.) whose TB test results were reviewed, and had the potential to affect all residents, visitors, and other employees in the facility. This failure created the potential for harm if an employee had undetected TB and exposed residents, visitors, and other employees. Findings include:</p> <p>The Centers for Disease Control and Prevention website, accessed 12/11/19, stated "All U.S. health care personnel should be screened for TB upon hire."</p> <p>The facility's policy for Tuberculosis Screening, revised 10/15/19, documented the following:</p> <ul style="list-style-type: none"> <li>* The facility provided TB screening and diagnostic measures as needed for all existing and potential employees.</li> <li>* TB screening was performed for new employees including evaluation of symptoms, individual TB risk assessment, and a screening test for those without documentation of prior TB infection.</li> <li>* Following an offer for employment, the two-step TST (tuberculin skin test) was initiated, with the exception of those employees who had documentation of a negative TST within the past year.</li> </ul> <p>This policy was not followed.</p> <p>A New Hire File Check document, dated 12/4/19, included documentation of TB test results for 27 employees. The results of the Step 1 and Step 2 TB test were blank for Employee B, who was</p>	F 880	<p>testing was completed and documented.</p> <p>All personnel files have been audited to ensure all employees have appropriate TB test screening completed and documented.</p> <p>Facility hiring personnel have been re-educated regarding employee TB testing requirements and documentation. All new hire personnel files will be reviewed by the Center Executive Director, or designee, prior to working as a direct care worker in the facility. This review will happen at weekly morning management meeting.</p> <p>Facility Center Executive Director, or designee, will conduct a personnel file audit to review completed employee TB test screening. Audit frequency will be: 1 audit weekly x 4 weeks and then 1 audit monthly x 2 months. The results of the audit will be forwarded to the Quality Assurance committee, monthly for 3 months, for review and Performance Improvement as necessary.</p> <p>Center Executive Director is responsible for compliance.</p>		

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F 880	<p>Continued From page 33</p> <p>hired on 9/17/18. The results of the Step 1 TB test documented "Records requested," and the results of the Step 2 TB test were blank for the E.D., who was hired on 9/23/19. The facility did not provide documentation the 2 employees received the required TB testing.</p> <p>On 12/3/19 at 2:50 PM, the DON said the E.D. had a TB test done at another facility and did not provide documentation of the test or results. The DON said the E.D. did not have another TB test at the facility. The DON said she did not know what happened to the step 2 TB test for Employee B.</p> <p>On 12/4/19 at 9:35 AM, the Infection Preventionist (IP) said she administered TB tests to new employees if she was in the facility, otherwise any nurse could administer it. The IP said new employees were supposed to be provided with a health history and TB screening packet, and she made sure the employee received the first TB test. The IP said the facility should be tracking employee TB tests to make sure it was done, and they were trying to improve the process. The IP said employees should not work on the floor before the results of the TB test were read. The IP said it was possible staff worked on the floor without having a TB test, and she occasionally encountered new staff she did not recognize as previously having a TB test. The IP said the E.D. worked at another facility and did not bring in the results of his TB test. The IP said she did not know why the E.D. was allowed to work in the facility without documentation of the TB test, and she asked him to have the test done at the facility and he declined. The IP said all employees should be tested for TB.</p>	F 880			

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F 880	Continued From page 34  The facility failed to ensure all employees had screening and/or documentation of a negative TB test prior to working in the facility.	F 880			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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February 14, 2020

Nathan Chinchurreta, Administrator  
Cherry Ridge Center  
501 West Idaho Boulevard  
Emmett, ID 83617-9694

Provider #: 135095

Dear Mr. Chinchurreta:

On **December 2, 2019** through **December 4, 2019**, an unannounced on-site complaint survey was conducted at Cherry Ridge Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008208**

**ALLEGATION #1:**

The facility failed to ensure residents were free from abuse.

**FINDINGS #1:**

The records of 10 residents were reviewed. Grievances and Incident and Accident reports were reviewed for the prior 6 months. Resident Council Notes were reviewed for the previous 2 meetings, and a Resident Council meeting was observed with 4 residents in attendance. Four staff members were interviewed. Three residents and 2 resident representatives were interviewed. Observations were conducted of staff interactions with residents, and residents were observed for signs of abuse throughout the survey.

One resident's record documented an incident where a staff member overheard another staff member speaking to the resident in a verbally abusive manner. During interviews with the Licensed Social Worker on 12/2/19 at 3:00 PM, the Director of Nursing on 12/3/19 at 9:00 AM, the Executive Director on 12/3/19 at 9:27 AM, and the Activities Director on 12/3/19 at 1:12 PM, it was confirmed the incident occurred; however, the Executive Director said the incident was not considered abuse at that time.

One resident's record documented there were round, reddened areas on the top of her left foot. An Incident and Accident report documented the wounds were noticed on the resident's foot on 7/1/19, and the physician or medical provider would evaluate the wounds. There was no documentation treatment was provided to the wounds, and there was no documentation by a medical provider the wounds were assessed by the medical provider.

On 12/2/19 at 3:00 PM, the Director of Nursing said the resident had a skin issue on her toes related to vasculitis (inflammation of the blood vessels), and she experienced another skin issue when staff forgot to apply her boots prior to transferring her with a Hoyer lift (a mechanical lift) and she was bumped during the transfer.

On 12/3/19 at 11:10 AM, the Director of Nursing said the Wound Nurse and the Nurse Practitioner said the resident had vascular wounds, but they did not document it in her record.

Another resident's record documented he had a skin injury/wound on his right great toe. There was no documentation the skin injury was investigated to determine the cause of the wound. On 12/3/19 at 2:45 PM, the Director of Nursing said she was unaware of the wound on the resident's toe, and there was no further documentation regarding the wound.

On 12/2/19 at 3:00 PM, the Director of Nursing said the resident had a skin issue on her toes related to vasculitis (inflammation of the blood vessels), and she experienced another skin issue when staff forgot to apply her boots prior to transferring her with a Hoyer lift (a mechanical lift) and she was bumped during the transfer.

On 12/3/19 at 11:10 AM, the Director of Nursing said the Wound Nurse and the Nurse Practitioner said the resident had vascular wounds, but they did not document it in her record.

Another resident's record documented he had a skin injury/wound on his right great toe. There was no documentation the skin injury was investigated to determine the cause of the wound. On 12/3/19 at 2:45 PM, the Director of Nursing said she was unaware of the wound on the resident's toe, and there was no further documentation regarding the wound.

During an observation on 12/3/19 at 3:25 PM, the resident had multiple abrasions on his left lower leg. A nurse said she was not previously aware of the abrasions, and she was unsure of the cause. There was no documentation in the resident's record regarding the abrasions on his leg. On 12/4/19 at 3:35 PM, the previously mentioned nurse said she talked to the Certified Nursing Assistants, and the resident sustained the abrasions to his left lower leg on 12/1/19 when he bumped his leg on the wall during cares.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F600 as it related to the facility's failure to ensure residents were free from abuse and F610 as it related to the facility's failure to ensure they appropriately investigate injuries of unknown origin and resident to resident interactions.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The facility failed to ensure residents received incontinence care in a timely manner.

**FINDINGS #2:**

The records of 10 residents were reviewed. Grievances were reviewed for the prior 6 months. Resident Council Notes were reviewed for the previous 2 meetings, and a Resident Council meeting was observed with 4 residents in attendance. Four residents and 2 resident representatives were interviewed. Residents were observed for signs of lack of incontinence care throughout the survey.

There were no concerns expressed regarding lack of incontinence care during the Resident Council meeting or during resident/resident representative interviews. Staff were observed performing incontinence care within an acceptable time frame for residents who experienced incontinence episodes. There were no observed signs of residents being soiled for a lengthy time during the survey.

Based on the investigative findings, the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The facility failed to ensure staff appropriately supervised residents, and used gait belts appropriately during transfers.

**FINDINGS #3:**

The records of 10 residents were reviewed, residents were observed, and staff were interviewed.

Review of one resident's record documented he eloped from the facility and was found in the middle of the road. Review of the resident's record found the facility did not assess the resident for elopement risk until after he eloped from the facility, when the facility's policy for Elopement directed staff to perform an elopement assessment upon admission, re-admission, or with a significant change in condition. There was no documented Incident and Accident report regarding the resident's elopement.

During an interview with the Director of Nursing on 12/4/19 at 11:25 AM, she confirmed the resident eloped from the facility, there was no Incident and Accident Report regarding the resident's elopement, and the facility did not perform an elopement assessment until after the resident eloped.

Review of another resident's record and Incident and Accident report documented he eloped from the facility, and he was found at a church across the street from the facility.

During an interview with the Director of Nursing on 12/4/19 at 4:30 PM, she confirmed the resident eloped from the facility and was found at a church across the street. The Director of Nursing confirmed the facility did not perform an elopement assessment until after the resident eloped.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F689 as it related to the facility's failure to ensure appropriate supervision of residents to prevent elopement.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #4:**

The facility failed to ensure appropriate infection control measures were implemented.

**FINDINGS #4:**

The records of 10 residents were reviewed. Grievances and reports of Incidents and Accidents were reviewed for the prior 6 months. Resident Council Notes were reviewed for the previous 2 meetings, and a Resident Council meeting was observed with 4 residents in attendance. Four residents and 2 resident representatives were interviewed. Staff were observed providing care to residents, and residents were observed for signs and symptoms of infection throughout the survey. The records of tuberculosis testing were reviewed for all current employees. Two staff members were interviewed. During observation of staff providing personal cares, 1 nurse and 4 CNAs wore gloves when indicated, and they performed hand hygiene appropriately.

One resident's record documented she was admitted to the facility with an infected wound on her leg, and she was being treated appropriately for the infection. During observation of a dressing change to the wound, the nurse implemented appropriate infection control measures and appropriate hand hygiene.

Upon review of the records of employee tuberculosis testing, it was found 2 employees did not have documented evidence of negative tuberculosis status or receiving tuberculosis testing per the facility's policy.

During an interview on on 12/3/19 at 2:50 PM, the Director of Nursing said one employee had tuberculosis testing done at another facility, he did not provide documentation of the test or the results, and he did not have another tuberculosis test at the facility. The Director of Nursing said she did not know what happened to the step 2 tuberculosis test for another employee.

During an interview on 12/4/19 at 9:35 AM, the Infection Preventionist said new employees were supposed to be provided with a health history and tuberculosis screening packet, and she made sure the employees received the first tuberculosis test. The Infection Preventionist said the facility should be tracking employee tuberculosis tests to make sure it was done, and they were trying to improve the process. The Infection Preventionist said employees should not work on the floor before the results of the tuberculosis test were read, and it was possible staff had worked on the floor without having a TB test. The Infection Preventionist said one employee worked at another facility and did not bring in the results of his tuberculosis test, and she did not know why he was allowed to work in the facility without documentation of the tuberculosis test. The Infection Preventionist said she asked the employee to have the tuberculosis test done at the facility and he declined.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F880 as it related to the facility's failure to ensure tuberculosis surveillance was implemented for staff.

Nathan Chinchurreta, Administrator  
February 14, 2020  
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**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson", is written over a faint, circular watermark or stamp.

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj