STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135095	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Ridge of Cascadia	501 West Idaho Boulevard Emmett, ID 83617

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and interviews it was determined the facility failed to consider caregiver/support person availability, capacity, and capability to perform required care as part of the identification of discharge needs. This was true for 1 of 3 residents (Resident #1) reviewed for the facility's transfer and discharge process. This deficient practice created the potential for harm when Resident #1 was transported to a homeless shelter that was unable to provide the required level of care. Findings include: The facility's Discharge or Transfer policy revised 8/30/25, documented upon transfer of a resident, information necessary to meet the resident's needs should be provided.Resident #1 was readmitted to the facility on [DATE] with chronic kidney disease, morbid obesity (BMI ?70), muscle weakness, difficulty walking, and anxiety/adjustment disorders.A Discharge MDS assessment dated [DATE], documented Resident #1 was cognitively intact and required supervision/touching assistance for eating, hygiene, dressing, toileting, and footwear, and substantial/maximal assistance for bathing.Resident #1's TAR dated January 2026 through February 2026 documented the following active wound care orders:Left second toe wound care twice weeklyCalmoseptine to bilateral buttocks twice daily for MASDRight lower extremity wound dressing changes every shiftA wound care progress note dated 1/26/26, documented Resident #1 had a chronic ulcer on her left lower leg with exposed subcutaneous tissue. The assessment documented the patient was refusing cares and garments which led to unhealable wounds and could cause sepsis and death.Resident #1's Discharge - Anticipated/Planned evaluation dated 2/2/26, documented Resident #1 had a follow-up medical appointment scheduled for 2/10/26 with her [patient preferred clinic].Resident #1's record did not include a referral to a wound care clinic, documentation of the receiving setting's ability to meet ADL or wound?care needs, and a signed discharge plan.On 2/3/26 at 2:18 PM, the [Homeless Shelter] Case Manager #1 stated their bed cots cannot support individuals over 400 lbs and they cannot provide wound care or mobility assistance. She also stated the facility did not contact them prior to dropping off Resident #1 and confirmed they could not meet her care needs. On 2/4/26 at 11:16 AM, the [Homeless Shelter] provided documentation of their medically fragile program documenting the following requirements:Individuals must be independent with ADLsThey require advance notification from LTC facilities to verify bed availability and care capability.An in?person assessment prior to acceptance is required.On 2/3/26 at 12:53 PM, and on 2/4/26 at 11:47 AM, the [Transportation Company] stated on 2/2/26 at 1:20 PM the [Transport Company] departed the facility with Resident #1. They arrived at [Homeless Shelter] at 2:10 PM. Resident #1 was offloaded at the homeless shelter when the shelter staff informed the driver, they could not accept the resident. The [Transportation Company] attempted to call the facility at 2:34 PM but had to leave a message. At 2:59 PM, the facility returned the call and was informed the shelter could not accept the resident. However, the facility did not request the resident be returned. Resident #1 remained outside the shelter until she was transported to the ER at 3:10 PM.On (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/3/26 at 2:50 PM, the Social Services Director stated the facility did not notify the shelter because it is a homeless shelter and stated she did not refer Resident #1 to a wound clinic because she felt Resident #1 could perform her own care.On 2/4/26 at 1:21 PM, the DON stated Resident #1 could not apply cream to bilateral buttocks without assistance.On 2/4/26 at 11:31 AM, Administrator #2 stated [LTC Facility] was notified by [Transport Company] between 2:00 - 2:30 PM that Resident #1 had not been accepted into [Homeless Shelter]. Administrator #2 stated [Transport Company] informed him Resident #1 had already been taken to the ER.Cross-reference F656 and F657

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, CMS SOM Appendix PP, policy review, and staff interview, it was determined the facility failed to ensure resident centered care plans were comprehensively written. This was true for 1 of 3 residents (Resident #1) whose care plans were reviewed in the sample. This deficient practice created the risk of adverse outcomes if residents comprehensive care plans did not reflect the care necessary for each resident. Findings include:The CMS SOM, Appendix PP dated 7/23/25, documented each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences, goals, and address the resident's medical, physical, mental and psychosocial needs.A Resident Assessment (RAI) & Comprehensive Care Plans Policy and Procedure, revised 9/3/25, documented under section 4a: The Interdisciplinary team (IDT) will develop a comprehensive, person-centered care plan within 7 days of the completion of the comprehensive assessment.Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease, venous insufficiency peripheral (poor blood flow to the extremities), and morbid severe obesity.Resident #1's Quarterly MDS assessment dated [DATE], documented under M1040 in Section A, Yes for the question, Infection of the foot and under Section C, Yes for the question Other open lesion foot. However, there was documentation in Resident #1's electronic medical record to indicate she was being treated for wounds.Resident #1's care plan initiated on 3/1/24, revised on 9/29/25, did not include directions to care for the wound on her foot.On 2/4/25 at 12:37 PM, the MDS Nurse reviewed Resident #1's MDS record and care plan, and stated, Resident #1 did not have a care plan for the foot infection and there should have been one.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, CMS SOM Appendix PP, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 1 of 3 residents (Resident #1) whose care plans were reviewed in the sample. This deficient practice created the risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include:The CMS SOM, Appendix PP, dated 7/23/25, documented a resident's care plan must be reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.A Resident Assessment (RAI) & Comprehensive Care Plans Policy and Procedure, revised on 9/3/25, documented under section 4b: The Care Plan will reflect: Discharge Planning Goals. Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic kidney disease, venous insufficiency peripheral, and morbid severe obesity.Resident #1's care plan initiated on 3/1/24, revised on 9/29/25, documented Resident #1 wanted to stay at the facility long term. Resident #1's care plan was not updated to include current discharge planning which reflected the resident's goals, preferences, and care needs. On 2/3/25 at 2:00 PM, the MDS Nurse reviewed Resident #1's care plan and stated, she did not have an updated care plan which reflected discharge planning from the facility. When asked why Resident #1's discharge care plan was not updated, the MDS Nurse stated, Resident #1s discharge plan kept changing so she chose not to update the care plan.