| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135095 | A. Building<br>B. Wing | 08/22/2024 |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>50603<br><br>Based on observations and interviews, it was determined that the facility failed to treat each resident with respect and dignity. This was true for 3 of 7 residents (Resident's #24, #26, and #29) observed during dining in the facility. This deficient practice had the potential for residents to experience embarrassment, and low feelings of self-worth. Findings include:<br><br>The facility's Dining Policy, revised 9/10/20, states the dining environment should enhance the quality of life of their residents by providing a pleasant atmosphere, including when the resident would like to eat, and having enough staff to serve the residents during mealtime.<br><br>On 8/19/24 the following was observed:<br><br>- At 12:10 PM, Resident #24 was sitting at a table by himself in the back corner. Resident #26 and Resident #29 were sitting at the end of the main table with two additional residents seated at the table with them.<br><br>- At 12:25 PM, the facility staff began serving residents their meals.<br><br>- At 12:31 PM, the tray cart was removed from the dining room. Resident #24, #26, and #29 had not been served their meal or beverages.<br><br>- Between 12:35 PM and 12:41 PM, Resident #26, requested a cold Pepsi three times. CNA #3, who was helping Resident #10 with her meal, told Resident #26 each time that someone would get it to her when they could.<br><br>- At 12:41 PM, the Staffing Coordinator brought a warm can of Pepsi to Resident #26's table, and left without opening the can of Pepsi. Resident #29, who was sitting next to Resident #26, opened the Pepsi, and asked the Staffing Coordinator to bring a cup of ice for Resident #26.<br><br>- At 12:46 PM, the Staffing Coordinator brought in a cup of ice, and poured Resident #26's Pepsi into the cup.<br><br>- At 12:48 PM, Resident #24, #26, #29 were served their meal trays.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/22/24 at 2:18 PM, the DON stated the facility will send available staff to assist with meals in the dining room, unless they are redirected to pass out [hall] trays. The DON stated, sometimes, there is not enough staff. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>50981<br><br>Based on policy review and staff interview, it was determined the facility failed to ensure residents were provided with clean equipment to obtain vital signs and perform transfers. This deficient practice created the potential for residents to experience psychosocial harm if unclean equipment was used for their care. Findings include:<br><br>The facility's Resident's Environment policy and procedure, revised 11/28/19, documented the residents are to have a safe, clean, comfortable, and homelike environments provided that allows the resident to receive treatment and supports daily living safely.<br><br>1. On 8/19/24 at 12:40 PM and on 08/20/24 at 10:24 AM the following equipment was observed:<br><br>- Two Hoyer lifts were visibly dusty. Their bases were observed to have clear dried brown substance on them. Thick white or gray type of material was observed wrapped around the wheels. One of the Hoyer lift control wands for electric lifting was smeared with a light brown substance.<br><br>- Three mobile blood pressure machines were noticeably dusty on reading screen, top, legs, and bases. One of the BP cuff was smeared with light brown substance on it.<br><br>On 8/21/24 at 4:14 PM, CNA #4 stated he cleans the mobile blood pressure machines after each resident, and he cleans any part that touches the resident such as the blood pressure cuff. When CNA #4 was asked what the substance was on the top and bottom of the mobile blood pressure machines was, he stated it looked like dust on the top and dirt on the bottom. CNA #4 then used a disinfectant wipe to remove the substances from both areas. When asked about the thick white or gray material wrapped around the wheels of the 2 Hoyer lifts, he stated it looked like hairs. He then pulled the hairs out of the wheels.<br><br>On 8/22/24 at 3:00 PM, the DON stated nursing staff are responsible to clean the mobile blood pressure machines and Hoyer lifts after each resident use.<br><br>50603 |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981<br><br>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure resident records were provided to the hospital upon transfer. This was true for 1 of 2 residents (Resident #16) reviewed for hospital transfers. This deficient practice created the potential for harm if Resident #16 was not treated in a timely manner due to lack of information provided upon transfer. Findings include:<br><br>The facility's Transfer and Discharge policy and procedure, revised 10/15/22, documented upon transfer of a resident the following information should be provided to the receiving provider:<br><br>a. Contact information of the practitioner who was responsible for the care of the resident;<br><br>b. Resident representative information, including contact information;<br><br>c. Advanced directive information;<br><br>d. Special instructions and /or precautions for ongoing care, as appropriate;<br><br>e. The resident's comprehensive care plan goals; and<br><br>f. All information necessary to meet the resident's needs.<br><br>Resident #16 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including diabetes, legal blindness, congestive heart failure (when the heart does not pump blood as effectively as it should), and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues).<br><br>A nursing progress note, dated 4/18/24, at 12:58 PM, documented Resident #16 was hard to arouse, sternal rub ineffective. Notified MD, one dose of narcan and stat transfer to ER. Report given to EMT (Emergency Medical Technician) and a report was made to the nurse of the receiving facility. Resident #16's record did not include documentation of what records were sent to the hospital.<br><br>On 8/22/24 at 4:00 PM, the Clinical Resource Nurse #1 stated she was not able to find any documentation of what information was sent to the hospital with the Resident #16 on 4/18/24. She said there should have been a checklist of what was sent to hospital, and it should have been documented, but was unable to locate the documentation. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193<br><br>Based on observation, record review, and staff interview, it was determined the facility failed to ensure medication was administered according to professional standards of practice. This was true for 1 of 5 residents (Resident #31) observed during medication administration. This created the potential for Resident #31 to develop a yeast infection when she did not rinse her mouth with water after taking her medication. Findings include:<br><br>The Drugs website accessed on 8/27/24 stated to rinse your mouth well with water after taking fluticasone propionate (corticosteroid) to decrease the risk of a mouth infection. Spit out the water you rinsed with (do not swallow).<br><br>Resident #31 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (low levels of oxygen in the body tissue).<br><br>Resident #31 physician's order included fluticasone propionate inhalation 2 puffs inhale orally two times a day related to moderate persistent asthma.<br><br>On 8/21/24 at 8:09 AM LPN #1 handed the fluticasone propionate inhaler to Resident #31. Resident #31 shook the medication and took two puffs orally and gave back the inhaler to LPN #1. Resident #31 did not rinse her mouth after taking two puffs of the inhaler orally.<br><br>On 8/21/24 at 10:00 AM, the Clinical Resource Nurse #1 reviewed Resident #31's physician's order and stated the order did not include to rinse and spit after taking the inhaler. When asked if it should be in the order to instruct the resident to rinse her mouth and spit the water out after taking the fluticasone propionate orally, the Clinical Resource Nurse stated, Yes it should be in the order.<br><br>On 8/21/24 at 10:22 AM, during telephone interview, the Pharmacist stated fluticasone propionate was a corticosteroid and residents should be instructed to rinse their mouth after taking the medication orally and spit the water out. The Pharmacist stated going forward it would be good to add the instructions in the physician's order. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603<br><br>Based on observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of practice was followed for 1 of 13 residents (Resident #32) reviewed for standards of practice. Resident #32's care plan was not followed as directed. This deficient practice created a potential for harm to Resident #32 if care and services were not delivered according to her care plan. Findings include:<br><br>The facility's Care Plan policy, revised 10/15/22, states that care plans are developed for a resident's specific condition, to include specific, measureable objectives, to meet the resident's needs as identified by their assessment, and response to the interventions or change in the resident's condition.<br><br>Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including chronic kidney disease and morbid obesity.<br><br>Resident #32's care plan, dated 3/11/24, directed staff to monitor/document/report to the physician as needed the following signs/symptoms: Edema, weight gain of over 2 pounds (lbs.) a day, neck vein distension, difficulty breathing, increased heart rate, elevated blood pressure, skin temperature, peripheral pulses, level of consciousness, and monitor breath sounds for crackles.<br><br>A review of records showed that Resident #32 had the following recorded weights:<br><br>- June 2024: 409.6 lbs.<br><br>- July 2024: 422.6 lbs. (13.2 lb. increase)<br><br>- August 2024: 433.2 lbs. (10.4 lb. increase)<br><br>Resident #32's record documented she was weighed one time per month. There was no documentation in Resident's #32's record the physician was notified of her 13.2 lb. weight gain between June 2024 and July 2024, and 10.4 lb. weight gain between July 2024 and August 2024. There was no documentation her weight was checked to determine if she had a daily weight gain of 2 lbs.<br><br>On 8/22/24 at 2:30 PM, when asked how would they determine if Resident #32 had a weight gain of 2 lbs. per day as directed by the care plan, the DON stated the care plan is a PRN order to be activated only if there was a problem and they did not weigh Resident #32 daily.<br><br>On 8/26/24, an email was received from the Administrator regarding Resident #32, which documented, The phrase 'PRN' indicates that these checks should be performed when the patient shows general signs of illness or other clinical changes, which then trigger further assessment. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401<br><br>Based on record review, review of the State Survey Agency's Long-Term Care Reporting Portal, hospital record review, and staff interview, it was determined the facility failed to ensure a resident's care plan was followed to prevent falls. This was true for 1 of 4 residents (Resident #10) whose records were reviewed for falls. This failure harmed Resident #10 when she suffered fractures to her right lower leg after a fall from her bed. Findings include:<br><br>Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including multiple sclerosis (an irreversible condition in which the body's immune system attacks the central nervous system), and Alzheimer's disease.<br><br>On 8/8/22, Resident #10's care plan documented she required total assistance for transfers with two staff and a mechanical lift.<br><br>On 8/14/22, Resident #10's care plan documented an intervention was initiated to use fall mats on the right side of the bed and to have her bed in the lowest position.<br><br>On 10/1/22, Resident #10's care plan documented she used bolsters to the sides of her mattress to help her define the edges of the bed.<br><br>On 11/1/23 at 11:20 AM, a fall report documented CNA #1 and #2 witnessed Resident #10 have ground level fall. The report documented after CNA #1 put a sling under Resident #10, they lowered the bed to the lowest position, and left the room to retrieve the mechanical lift and CNA #2 to assist with transferring her. Upon reentering the room, CNA #1 and #2 observed Resident #10 rolling over the bolster on right side of her bed onto the floor, landing on her right hip and, at that time, she was assessed and was not showing symptoms of injury.<br><br>On 11/1/23 at 8:00 PM, Resident #10 was observed to have swelling and bruising of her right lower leg and the physician directed staff to transport her to the ED for an x-ray.<br><br>On 11/1/23 at 8:47 PM, an x-ray report documented tibial and fibular fractures on her right lower leg.<br><br>On 11/8/23, the facility submitted their investigation report for the fall to the State Survey Agency Long-Term Care Reporting Portal. The report documented the facility investigation found the bed was not at the lowest position and the fall mat was not in place when Resident #10 fell out of bed.<br><br>On 8/22/24 at 3:30 PM, the DON stated during their investigation they recognized inconsistencies in the reports from CNA #1 and #2 and determined the reports provided by the CNA's involved were not honest or accurate. The DON stated CNA #1 and #2 did not follow Resident #10's care plan and were terminated on 11/3/23 due to their dishonesty related to Resident #10's fall.<br><br>The facility took the following actions:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -A licensed nurse assessed Resident #10 immediately after the fall for signs on injury.<br><br>-Resident #10's family representative was informed of the incident.<br><br>-Alert charting was initiated to monitor for signs of injury.<br><br>-The facility's Medical Director, Administrator, and Director of Nursing were notified.<br><br>-When symptoms of injury became apparent, the facility notified the physician.<br><br>-The physician sent her to be assessed and the injury was treated appropriately.<br><br>-The Bureau of Facility Standards was notified through the reporting portal.<br><br>-On 11/2/23, all nursing staff were reeducated and assessed to be knowledgeable about following care plans and appropriately handling falls with injury.<br><br>-On 11/3/23, all CNA's were assessed to be proficient in following care plans and safely transferring residents with mechanical lifts.<br><br>-The incident and Resident #10's care plan were reviewed with the IDT and identified the two CNA's involved had been dishonest and her care plan remained appropriate, but the failure to follow the care plan was what made the injury occur.<br><br>-CNA #1 and #2 were terminated.<br><br>-The facility followed up with specialists to care for the fractures.<br><br>These investigative findings represent past noncompliance with this regulatory requirement. There was sufficient evidence the facility investigated and corrected the noncompliance as of 11/3/23. At the time of this survey the facility was in substantial compliance for this regulatory requirement and therefore does not require a plan of correction for this citation. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>50981<br><br>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a RN was on-site 8 consecutive hours a day, 7 days a week to provide care and treatment to the residents. This is true for 5 of 21 days reviewed for sufficient staffing. This failure created the potential for harm if routine and /or emergency nursing needs were unmet and had the potential to affect all 33 residents in the facility. Findings include:<br><br>The facility's Sufficient Qualified Nurse Staffing policy and procedure, released 11/28/17, documented the facility use the service of an RN for at least eight consecutive hours a day, 7 days a week.<br><br>A Three-Week Nursing Schedule dated 7/28/24 - 8/17/24 documented there was no RN on-site for 8 consecutive hours on the following dates: 7/28/24, 8/2/24, 8/4/24, 8/9/24, and 8/11/24.<br><br>On 8/22/24 at 3:00 PM, the DON stated she and another RN take turns being on-call and come in as needed when an RN is not available for a shift in a 24-hour day. The DON stated she was not aware a RN was required to be on-site 8 consecutive hours, 7 days a week, and thought being nearby and on-call was sufficient. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981<br><br>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents taking antipsychotic medications received an abnormal involuntary movement scale (AIMS) evaluation. This is true for 2 of 5 residents (Resident's #5 and #16) reviewed for unnecessary medications. This deficient practice created the potential for harm if residents receiving antipsychotic medications were not monitored for adverse side effects. Findings include:<br><br>The American Psychiatric Association (APA) website, accessed on 8/28/24, recommended that all patients taking an antipsychotic medication should be screened for tardive dyskinesia (a movement disorder that causes sudden, uncontrollable movements in the face and body) every six months.<br><br>1. Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including traumatic subdural hemorrhage (a serious medical condition that occurs when blood collects between the skull and the surface of the brain), diabetes, and schizoaffective disorder (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior).<br><br>A physician's order documented Resident #5 was to receive the following:<br><br>-Depakote (anticonvulsant) oral tablet delayed release 500 mg, give 3 tablets by mouth every morning and at bedtime for schizoaffective disorder: start date 11/27/23.<br><br>-Zyprexa (antipsychotic) oral tablet 15 mg, give one tablet by mouth one time a day related to schizoaffective disorder: start date 3/22/24.<br><br>-Zyprexa oral tablet 20 mg, give one tablet by mouth at bedtime related to schizoaffective disorder: start date 3/22/24.<br><br>Resident #5's care plan, dated 9/23/23 documented he uses antipsychotic medications related to schizophrenia and staff were directed to evaluate him for AIMS at least every 6 months and as needed.<br><br>Resident #5 records documented he was evaluated for AIMS on 9/15/23 and 9/20/23. There were no AIMS completed in March 2024.<br><br>On 8/22/24 at 4:00 PM, Clinical Resource Nurse #1 stated she was unable to locate any AIMS assessments for Resident #5 after the 9/20/23 assessment. She stated the AIMS assessment should have been performed and documented for Resident #5 every 6 months and it was not.<br><br>2. Resident #16 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including diabetes, legal blindness, and schizoaffective disorder (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior).<br><br>A physician's order documented Resident #16 was to receive the following:<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Zyprexa oral tablet 15 mg, give one tablet by mouth one time a day related to schizoaffective disorder: start date 4/30/24.<br><br>Resident #16's care plan dated 4/27/21, documented he used antipsychotic medications related to schizophrenia and staff were directed to evaluate him for AIMS at least every 6 months and as needed.<br><br>Resident #16 records documented he was evaluated for AIMS on 3/14/23 and 7/29/23. There were no AIMS completed in January 2024 and July 2024.<br><br>On 8/22/24 at 4:00 PM, Clinical Resource Nurse #1 stated she was not able to locate any AIMS for Resident #16 after the 7/29/23 assessment. She stated the AIMS assessment should have been performed and documented for Resident #16 every 6 months and it was not. |