



IDAHO DEPARTMENT OF
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March 5, 2015

G. David Chinchurreta, Administrator
Sunny Ridge
2609 Sunnybrook Drive
Nampa, ID 83686-6332

Provider #: 135102

Dear Mr. Chinchurreta:

On **February 19, 2015**, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint allegations, findings and conclusions are as follows:

Complaint #6871

ALLEGATION #1:

Residents are verbally abused by staff and no action is taken on incidents that are reported.

FINDINGS #1:

During the complaint investigation; observations, review of abuse investigations, grievances, accident and injury reports and resident council meeting minutes; as well as resident and staff interviews were completed with the following results:

The facility's abuse investigations for the previous six months were requested. One investigation had been completed for an allegation of potential physical abuse. The documentation showed a thorough investigation had been completed and the allegation was unsubstantiated. No grievances had been filed during the requested review period.

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The facility's accident and injury reports from September 1, 2014 through February 17, 2015, were reviewed. None of the accident injury reports documented concerns regarding potential abuse of residents by staff.

The facility's Resident Council Meeting minutes from September 2014 through February 2015 were reviewed. All of the meeting's minutes documented concerns reported by residents had been addressed. For example, the meeting's minutes dated November 13, 2014, documented residents expressed concerns about Certified Nurse Aides (CNAs) speaking loudly amongst themselves about events in their lives rather than to the residents. The meeting's minutes documented training was provided to the CNAs. Subsequent meeting's minutes dated December 11, 2014, documented the issue had been resolved.

Additionally, the November 13, 2014, meeting's minutes documented concerns about food temperature and food being served at a timely inanner. The meeting's minutes documented a steam table had been replaced and dietary staff had received additional training to correct the issue.

Observations were conducted throughout the complaint investigation, including during the afternoon meal on February 17, 2015. During those times, all staff were observed providing appropriate verbal interactions with residents at the facility.

Eight current residents and one former resident were interviewed during the course of the complaint investigation. All nine residents denied they had ever experienced any form of abuse at the facility. The nine residents stated they were not aware of anyone residing at the facility being physical, verbally or emotionally abused. They all stated they knew who to speak to and would be comfortable reporting any concerns they might have of potential abuse.

Additionally, all nine residents stated any issues brought to the attention of the facility had been addressed. For example, two residents stated the dining room had been cold at one point but stated the concern was reported and the situation had improved. One resident stated the CNAs were speaking loudly and around residents to each other, but the concern was reported and the issue was resolved. The resident stated one particular CNA who was very loud and abrupt no longer worked at the facility.

Seven CNAs and three Dietary Aides were interviewed during the course of the complaint investigation. They all stated they had never witnessed anyone being abusive towards residents in anyway. They said they would report any potential abuse they witnessed.

One CNA reported she and a former staff had filed a written statement about a third staff member making an inappropriate comment about a resident. The CNA reported she did not think the

issue had been addressed.

However, when asked about the written statement during an interview on February 19, 2015, at 11:23 a.m. the Nurse Practice Educator and Director of Nursing Services both stated the concern had been addressed as a personnel issue rather than an allegation of abuse since the statement was made about a resident to another staff member and not directly to the resident.

The supervisor of the accused staff was interviewed on February 19, 2015, at 11:40 a.m. In addition to the written statement provided by the two staff, the supervisor stated she had received a verbal report at the time of the incident by another staff member. The supervisor provided written documentation regarding the incident, documentation of counseling that took place with the accused staff, a monitoring plan that was implemented following the counseling and documentation of the monitoring that occurred. The documentation was signed by both the supervisor and the accused staff.

There was no evidence that residents were being subjected to abuse or that allegations of abuse were not being addressed. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Staff are not sufficiently trained to know who to report allegations of abuse, neglect and mistreatment to.

FINDINGS #2:

During the complaint investigation, review of staff training programs and staff training records, as well as staff interviews were completed with the following results:

Seven Certified Nurse Aides (CNAs) and three Dietary Aides were interviewed during the course of the complaint investigation. All of the CNAs and Dietary Aides stated they had been trained on the facility's abuse identification and reporting policies when they were initially hired and that training continued on a regular basis throughout the year. All CNAs and Dietary Aides stated training included the use of video classes, classroom training with written information and written tests being completed. They were all able to identify examples of different forms of abuse (i.e., verbal, physical, psychological, sexual abuse) and who to report concerns to, including following a chain of command if they did not feel allegations were appropriately

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addressed.

The facility's training program was reviewed and information regarding forms of potential abuse and reporting processes were included.

Four personnel files, including training records, were randomly selected for review. All files documented initial and continuing training in relation to abuse detection and reporting.

Additionally, professional staff including the Nurse Practice Educator, Director of Nursing Services, Dietary Supervisor, Clinical Care Coordinator, Resident Care Manager and Social Service Specialist were interviewed during the course of the complaint investigation. All professional staff interviewed confirmed the facility's abuse identification and reporting training process.

The facility staff demonstrated knowledge of when, how and to whom to report incidents of potential abuse. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj