December 31, 2015

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

Provider #: 135102

Dear Mr. Chinchuneta:

On September 17, 2015, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007113

Allegation #1: The complainant reported the facility did not answer an identified resident's call light for an hour and the resident experienced an episode of incontinence.

Findings #1: Accommodation of needs were investigated as part of a Recertification Follow-Up survey. Based on interview with residents about call light wait times; observations of call lights; observations of toileting; and review of grievances, this concern was unsubstantiated based on lack of evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported only one Certified Nursing Assistant was working the floor and there was a delay getting residents to bed. It was also reported the residents express concern not having enough staff and are fearful their needs will not be met.
Findings #2: Staffing and accommodation of needs were investigated as part of a Follow-Up survey September 15, 2015 to September 17, 2015. Staffing schedules and hours were adequate and congruent with the regulatory standard. There were no observations of residents not being accommodated with needs on the evening shift, and across shifts. Resident interviews and interview with social services did not reveal any concerns with accommodation of needs due to staffing needs. Review of grievances and neglect investigations by the facility did not document concerns related to low staffing. The allegation was unsubstantiated based on lack of evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The complainant reported residents and staff are fearful of retaliation if they talk to the administration about their concerns.

Findings #3: Fear of retaliation was investigated as part of the Follow-Up survey September 15, 2015 to September 17, 2015. Based on interviews with staff and residents about their ability to bring up concerns to the facility administration without fear of retaliation, this concern was unsubstantiated based on lack of evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

[Signature]

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt
Dear Mr. Chinchurreta:

On September 17, 2015, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007133**

The complaint was investigated in conjunction with the facility's Follow-Up Recertification survey conducted from September 15 to September 17, 2015.

The following observations were completed:
- Call lights;
- Resident and staff interactions; and,
- Residents' cares.

The following documents were reviewed:
- The medical records of six other residents were reviewed for Quality of Care concerns;
- Nursing staff records were reviewed for August 23 to September 12, 2015; and
- The facility's Incident and Accident reports from July to September 2015.

The following interviews were completed:
- 14 residents and two family members;
- Three nurses and five CNAs; and,
- The Director of Nursing Services and the Administrator were interviewed regarding various Quality of Care concerns.
Allegation #1: The complainant reported a correlation between low staffing and resident falls for July 23, 2015 to July 30, 2015.

Findings #1: Call lights and response times were observed to be appropriate; Staffing levels and hours for August 23 to September 12, 2015 were within acceptable standards; Residents, family members, and staff interviews did not reveal a consistent day or time for any delay in call light response times or connection to increased falls; Review of residents' medical records did not reveal any adverse resident outcomes related to deficient care (such as any pressure ulcers, lack of hygiene, increase in falls, etc.); Review of Incident and Accident reports revealed no correlation of lower-staffed shifts to falls; Resident Council meeting minutes did not document concerns with understaffing; and, Grievances did not document concerns regarding staffing issues.

This allegation was not substantiated based on lack of evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported seven residents did not have a bowel movement for four days, residents' nails were not cut, and residents were not being showered.

Findings #2: Residents' bowel movement flow sheets documented residents went less than four days without a bowel movement and appropriate interventions were implemented; Resident interview did not reveal concerns with quality of care; Residents' nails were observed to be cut and clean; Residents' shower schedules aligned with showers documented on ADL flow sheets.

This allegation was not substantiated based on lack of evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/pmt
December 8, 2015

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

Provider #: 135102

Dear Mr. Chinchurreta:

On September 17, 2015, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007134

The complaint was investigated in conjunction with the facility's Follow-Up Recertification survey conducted from September 15 to September 17, 2015.

The following observations were completed:
Daily Medication Passes were observed;
Call lights were observed; and,
Resident and Licensed Nurses interactions were observed.

The following documents were reviewed:
The medical records of seven residents were reviewed for Quality of Care concerns, which included the review of medication administration for September 1 to September 16, 2015;
The Medication Administration records for 14 residents were reviewed for July 31, 2015;
Nursing staff records were reviewed for August 23 to September 12, 2015;
Nursing staff schedule, clocked, and paid hours for July 31, 2015 were reviewed;
The facility's Grievance reports from July to September 2015 were reviewed;
The facility's Allegation of Abuse reports from July to September 2015 were reviewed; and,
The facility's Incident and Accident reports from July to September 2015 were reviewed.
The following interviews were completed:
14 residents and two family members were interviewed;
Three nurses and five CNAs were interviewed;
The Director of Nursing Services and the Administrator were interviewed regarding various
Quality of Care concerns.

Allegation: The complainant alleged a licensed nurse had left the facility early on July 31, 2015
during their assigned shift and did not return to work. The other licensed nurse still working was
then responsible for 38-40 residents and thus many of the residents had not received their
evening medications.

Findings: Call lights and response times were observed to be appropriate. Staffing numbers for
July 31, 2015 and August 23 to September 12, 2015 were reviewed and within the acceptable
regulatory requirements. Two Licensed nurses were verified with worked hours for their entire
shifts on July 31, 2015. Medication Pass observations were completed without any concerns.
All 14 residents' medications reviewed had been administered correctly on July 31, 2015.
Residents and family members did not voice any concerns with medication administrations or
licensed nursing staff. Resident Council meeting minutes did not document any issues with
medication administration or the licensed nursing staff. Grievances did not document concerns
regarding medication pass or the licensed nursing staff. The facility's Incident and Accident
reports did not reflect any concerns with medication administration. The facility's reports on
Allegations of Abuse and Neglect did not reflect any concerns with medication administration or
the licensed nursing staff.

Based on observations, medical record review, and resident, family, and staff interviews, this
allegation was unsubstantiated based on lack of supporting evidence.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, no response is necessary. If you have questions,
comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina
Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for
the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt
December 8, 2015

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

Provider #: 135102

Dear Mr. Chinchurreta:

On September 17, 2015, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007155

The complaint was investigated in conjunction with the facility's Follow-Up Recertification survey conducted from September 15 to September 17, 2015.

The following observations were completed:
Daily Medication Passes were observed;
Call lights were observed;
Staff hand hygiene was observed;
Contaminated waste disposal was observed;
Resident and staff interactions were observed; and,
Residents' cares were observed.

The following documents were reviewed:
The medical record of the identified resident was reviewed for Quality of Care concerns;
The medical records of six other residents were reviewed for Quality of Care concerns;
Nursing staff records were reviewed for August 23 to September 12, 2015;
Infection Control Policy and Procedures were reviewed;
Abuse Policy and Procedures were reviewed;
The facility's Grievance reports from July to September 2015 were reviewed;
The facility's Allegation of Abuse reports from July to September 2015 were reviewed; and,
The facility's Incident and Accident reports from July to September 2015 were reviewed.
The following interviews were completed:
14 residents and two family members were interviewed;
Three nurses and five CNAs were interviewed; and,
The Director of Nursing Services and the Administrator were interviewed regarding various
Quality of Care concerns.

Allegation #1: The complainant reported a resident had experienced a fall in July 2015, when the resident had been left unattended on the toilet with the bathroom door open. The resident had tried to close the door for privacy and had fallen. The resident's fall had resulted in a major injury.

Findings #1: The identified resident had fallen, when the bathroom door had swung back open and the resident attempted to close the door for privacy, without calling for assistance. The identified resident was interviewed about his/her ability to use the call light and if the call light had ever been unavailable, in which the resident stated he/she could use the call light and the call light was available at all times. The facility's Incident and Accident reports, along with the investigations were reviewed, and found to be complete and interventions appropriately placed as needed. The identified resident and six other residents' medical record were reviewed and revealed appropriate care was received and documented. Residents, family members, and staff were interviewed about the Quality of Care concerns and there were no deficient practices identified. Call lights and response times were observed to be appropriate.

This complaint was unable to be substantiated because of the lack of sufficient evidence to support the facility had a deficient practice as it related to the resident's fall.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant reported a resident was left unattended in his/her bathroom and was not positioned correctly on the toilet. The resident had tried to reposition by themselves and this had resulted in a fall with injury.

Findings #2: The identified resident had fallen when he/she tried to reposition themselves briefly after being left by staff for privacy, without calling for assistance. The identified resident was able to use his/her call light and there was a call light available in the bathroom. The identified resident and six other residents' medical record were reviewed and revealed appropriate care was received and documented. Residents, family members, and staff were interviewed about the Quality of Care concerns and there were no deficient practices identified. The facility's Incident and Accident reports, along with the investigations were reviewed, and found to be complete and interventions appropriately placed as needed. Call lights and response times were observed to be appropriate.
This complaint was unable to be substantiated, because of the lack of sufficient evidence to support the facility had a deficient practice as it related to the resident's fall with injury.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The complainant stated after a resident had fallen in his/her bathroom the staff lifted the resident inappropriately.

**Findings #3:** The resident had fallen in his/her bathroom and staff had utilized a recognized clinically appropriate technique to remove the resident from a small space, after the resident was evaluated. Review of the identified resident's medical record did not reveal any inappropriate care was received. Residents, family members, and staff were interviewed about the Quality of Care concerns and there were no deficient practices identified. The facility's Incident and Accident reports, along with the investigations were reviewed and found to be complete and interventions appropriately placed as needed.

The complaint was unsubstantiated because of the lack of sufficient evidence to support an inappropriate transfer had been performed.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The complainant alleged the facility had not notified the physician or had a resident been assessed for injuries after a fall.

**Findings #4:** This complaint was investigated by the review of the identified resident's medical record, the resident, family and staff were interviewed, and the facility's Incident and Accident reports were reviewed. The identified resident's physician had been notified at the time of the fall, the resident was assessed for 72 hours, the nursing staff had followed the physician's orders, and the resident's care plan had interventions implemented appropriately.

The complaint was unsubstantiated because of lack of sufficient evidence.

**Conclusion #4:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #5:** The complainant reported the facility was not aware of the resident's diseases and their progression. The resident was diagnosed by the facility, without the resident's Physician being in agreement of these diagnoses.

**Findings #5:** The complaint was investigated by review of residents' medical records which included the identified resident's record. Care Plans and interventions were reviewed for individualized directives of care related to known diagnoses and revealed there were no areas of concern.
Residents' medications administration records and behavior monitors were reviewed and found to have appropriate interventions and actions taken. Families, residents, and staff were interviewed regarding facility care plan conferences and there were no unaddressed issues.

This complaint was unsubstantiated because of the lack of evidence to support the facility had any deficient practices.

**Conclusion #5:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #6:** The complainant stated a report of neglect had not been taken serious when there were related staff personnel involvement including a supervisor. The complainant reported they were told a staff person that had resigned and was investigated for care related concerns was possibly going to be rehired and work with the same residents again. This caused concern for the complainant and resident. The complainant reported they had been told the management staff could not be accountable for evening care concerns when the management team was not there.

**Findings #6:** The facilities' Incidents and Accidents reports including the neglect allegation and investigation, corrective actions, and interventions were reviewed and found to be appropriate and in compliance. Grievances were reviewed and documented as being dealt with appropriately. A list of current working staff and staffing assignments was reviewed and revealed no staff member under investigation to be scheduled or working. Residents, families, and staff including management staff were interviewed about abuse and neglect situations and how and who to report these allegations and there were no identified concerns. The facility's Policy and Procedures regarding Abuse and Neglect were reviewed.

This allegation was unsubstantiated based on lack of sufficient evidence.

**Conclusion #6:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #7:** The complainant reports the facility is understaffed and the staff have been told not to tell anyone they are understaffed.

**Findings #7:** Call lights and response times were observed to be appropriate during the survey process. Staffing numbers and hours for August 23 to September 12, 2015 were determined to be within acceptable regulatory standards. Residents, family members, and staff interviews did not reveal a consistent day or time of any delay in call light response times. Review of residents' medical records did not reveal any adverse resident outcomes related to deficient care (such as any pressure ulcers, lack of hygiene, increase in falls, etc.). Resident Council meeting minutes did not document an issue with understaffing. Grievances did not document a concern regarding staffing issues.

This complaint was unable to be substantiated based on lack of evidence to support that the facility was understaffed.
Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The complainant stated a licensed nurse had given the wrong medication at the wrong time. Another licensed nurse administered bowel medications even when residents had no need for a laxative, then the licensed nurse refused to help toilet the residents.

Findings #8: Call lights and response times were observed to be appropriate. Medication Pass observations were observed to be performed correctly. Observations of residents and licensed nursing staff interactions did not reveal any concerns. Residents' medical records which included Physician's orders, medication administration, and bowel sheets were reviewed and documentation supported the Physicians' orders were followed and medications were administered appropriately. The residents interviewed did not express any concerns about medication administration nor the licensed nursing staff.

This complaint was unsubstantiated based on insufficient evidence of any deficient practices.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: The complainant reported the staff do not consistently wash their hands or use the hand sanitizer. The hand sanitizer dispensers in the hallway are not cleaned on a regular basis. The complainant reported the evening shift used a trash bag for the soiled briefs and drug it down the hallway from room to room as the staff changed each resident's brief.

Findings #9: Infection Control observations which included proper staff hand hygiene and contaminated waste disposal were completed on September 15 to September 17, 2015 with no issues. The interviews with residents, families, and staff conducted regarding infection control procedures and any infection control concerns revealed no issues. Grievances were reviewed and did not reveal any concerns. The facility's Infection Control Policy and Procedures addressed proper infection control measures and also documentation of staff training with handwashing audits performed. The facility had installed new disposable and readily accessible hand sanitizers for residents, staff, and visitors to use.

This complaint was unsubstantiated based on lack of sufficient evidence.

Conclusion #9: Unsubstantiated. Lack of sufficient evidence.

Allegation #10: The complainant reported evening shift staff had borrowed and taken residents' personal belongings without permission.

Findings #10: Grievances and residents' medical records were reviewed regarding borrowed, stolen, and/or personal belongings. Interviews with residents and staff, which included the evening shift staff were completed September 15, 2015 to September 17, 2015.
Based on the information obtained which included an interview with the identified resident with the missing items, this complaint is unsubstantiated based on lack of sufficient evidence.

**Conclusion #10:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #11:** The complainant stated that once a resident is in bed for the night, they are told they can’t get up to use the bathroom until morning.

**Findings #11:** Evening observations, call light observations, review of grievances, review of resident council minutes, interviews with residents and families, and review of medical records did not reveal any concerns or problems that residents could not use the bathroom during the night. The identified resident was interviewed regarding the ability to get up at night to use the bathroom. The resident took sleeping medications and had no desire to be woke up at night, could use the call light and could have help when and if they wanted to go to the bathroom. Other residents stated they would get up at night to use the bathroom and did receive the needed assistance.

This complaint was unsubstantiated due to the lack of sufficient evidence.

**Conclusion #11:** Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt