



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 28, 2016

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

Provider #: 135102

Dear Mr. Chinchurreta:

On **July 14, 2016**, a survey was conducted at Sunny Ridge 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

G. David Chinchurreta, Administrator
July 28, 2016
Page 2 of 4

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 **August 8, 2016**. Failure to submit an acceptable PoC by **August 8, 2016**, may result in the imposition of penalties by **September 1, 2016**.

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 **August 18, 2016 (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 **October 12, 2016**. A change in the seriousness of the deficiencies on **August 28, 2016**, may result in a change in the remedy.

G. David Chinchurreta, Administrator
July 28, 2016
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **October 12, 2016** includes the following:

Denial of payment for new admissions effective **October 12, 2016**. [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 **January 10, 2017**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, 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 **October 12, 2016** 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:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

G. David Chinchurreta, Administrator
July 28, 2016
Page 4 of 4

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 **August 8, 2016**. If your request for informal dispute resolution is received after **August 8, 2016**, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 the federal recertification survey of your facility. The surveyors conducting the survey were: Evelyn Floyd, JD, MS, RN, Team Coordinator Linda Kelly, RN Abbreviations: ADL= Activities of Daily Living BOS = Business Office Staff CMO = Clinical Manager of Operations CNA= Certified Nursing Assistant CNE = Center Nurse Educator DA = Dietary Aide DC = Discontinued LN = Licensed Nurse MAR = Medication Administration Record mcg = micrograms MDS = Minimum Data Set assessment NPE = Nurse Practice Educator NSD = Nutritional Services Director P&P = Policies and Procedures PRN= As needed QAA = Quality Assessment and Assurance SNF = Skilled Nursing Facility TI = Therapeutic Interchange	F 000			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		8/15/16	

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

TITLE

(X6) DATE

Electronically Signed

08/03/2016

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.

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 1</p> <p>of residents or misappropriation of their property; and report any knowledge it 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 to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of facility investigations, and staff interviews, it was determined the facility failed to ensure thorough</p>	F 225	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Sunny</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 2</p> <p>investigations of misappropriation of residents' controlled substance medications and implementation of measures to prevent future misappropriations or drug diversions. This was true for 4 of 10 sampled residents (#1, #8, #9, and #10) and 9 random residents (#13- #21) whose controlled substance MARs were reviewed. The deficient practice had the potential to affect all residents receiving controlled substance medications. This resulted in diversion of residents' medications and the potential for residents to experience increased pain due to a lack pain medication. Findings include:</p> <p>The facility's Controlled Drugs Management policy, reviewed 4/15/16 and revised 5/1/16, documented the following:</p> <p>*Ongoing Inventory: "A complete count of all Schedule II-IV controlled drugs is required at the change of shifts per state regulation or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses.."</p> <p>*Destruction: "Two licensed professionals are required to destroy and document destruction of controlled drugs."</p> <p>*Discrepancies at any step in the process will be reported to appropriate persons as defined by the policy.</p> <p>*The Controlled Substance Book, for ongoing tracking of all controlled drugs will be used on each medication cart. "A separate bound book will be used for tracking drugs that are held for destruction. Both books must be maintained for</p>	F 225	<p>Ridge does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements,, facts, and conclusions that form the basis for the deficiency.</p> <p>F225 Residents Identified to be Affected Residents #1, 8,9,13, 19 and 21 will be assessed for pain by the Center Nurse Executive or designee and for any negative psychosocial impact by the Licensed Social worker or designee on or before 8-5-16. Follow up will be completed as indicated by assessment. Residents #10, 14, 15,16,17,18, and 20 discharged from Sunny Ridge Center prior to 8/1/2016. Other Residents with the Potential to be Affected Review of state reportable events that have occurred in the last 30 days was instituted by the Executive Director for thoroughness of investigation on 8-2-16. Follow-up investigation will be completed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 3 10 years."</p> <p>The facility's Disposal/Destruction of Refused, Discontinued, and Expired Medications, dated 3/1/11, documented that refused or dropped medications were documented on the resident's MAR and disposed of immediately. Outdated and discontinued medications in packages from pharmacy were to be stored in a double-locked area until destruction could occur. Staff were to complete a destruction form which was retained by the facility.</p> <p>The facility's Summary of Investigation Abuse Allegation documented a controlled substance drug diversion occurred between 2/24/16 and 4/4/16. The Summary of Investigation documented the following:</p> <ul style="list-style-type: none"> * Identity of the affected residents and the associated controlled substance pages in the Controlled Substance Book and the identified drug diversions for each resident; * Resident's identification information, MARs and assessments; * Identity, interview and statement from the suspected responsible LN;and * Statements from 10 LN's. <p>The investigation did not contain the police report or the dismissal of the suspected LN. Both documents were obtain during the survey process.</p> <p>The identified Controlled Substance Book narcotic pages contained the following documentation:</p>	F 225	<p>by the Administrator or designee on or before 8-3-16.</p> <p>A count of current controlled substances within the center was completed by the Center Nurse Executive on 8-2-16 with all controlled medications accounted for and no noted discrepancies.</p> <p>Systematic Changes and Education Licensed Nurses were re-educated on controlled substance management by the nurse practice educator on or before 8-5-16 to include education on controlled substance, receipt, storage, and disposal. Licensed Nurses will complete a controlled substance management post test administered by the Center Nurse Executive or designee on or before 8-5-16 to validate competency with controlled substance management. Beginning 8-2-16 state reportable investigations will be reviewed by the center executive director and the center nurse executive to ensure that components of the investigation are complete.</p> <p>On or before 8-8-16, the pharmacist will review the center's controlled drug management monthly to validate compliance with center policy. The Center Executive Director and Center Nurse Executive will be educated on completing a thorough investigation including ensuring that statements and interviews are complete, and that all appropriate documentation is received and filed prior to closing the investigation, by the Regional Vice President on or before 8-15-16.</p>		

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 4</p> <p>* Pages N30, N27, N8, N7, N32, N12, N13, N14, and N15 were initialed and documented as transferred to another narcotic page. The transfers were undated and did not denote the reasoning for the transfers. The LN's initials for signing in, and for the transfers, appeared to be the same unidentified initial, which was unlike the suspected LN's signature or initial.</p> <p>* Pages N65, N71, N68, N52, N49, N66, N12, N14, N15, N78 and N79 were initialed and documented as destroyed. Destruction documentation either contained only one signature/initial or two signatures/initials of the same person, which was identified as the suspected LN. Seven of these 11 destructions pages were not dated. One page that was dated had a destruction date prior to the date the medication was signed in.</p> <p>The statement from the suspected LN documented the LN's statement was submitted in "reference to misappropriation of narcotics on different levels, different dates and times by myself and other RN's at this facility on various dates as noted...Some take it as serious however due to the lax nature of some of the other nurses at said facility I also took short cuts to get tasks completed in a timely manner...I take full responsibility in this as this is my license on the line... I don't want these narcotics, I don't take them and I don't sell them as was insinuated as a possibility yesterday." The LN was not questioned regarding transfers of narcotic medication cards. The investigation did not identify which narcotic pages were reviewed with the suspected LN during the interview.</p>	F 225	<p>Performance Monitoring Beginning the week of 8-2-16 the administrator or designee will review a reportable investigation to ensure that all components of the investigation are complete. The center nurse executive will audit the controlled substance management in the center including validation of accurate documentation in the controlled substance log, as well as a count of current controlled medications. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled and reported to the QAPI committee by the Center Executive Director for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The center executive director is responsible for monitoring and follow-up.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 5</p> <p>Four of the 10 LNs statements documented when they identified issues and/or the process of counting narcotic medication cards. The statements were signed, however, the signatures were illegible. The statements were not dated.</p> <p>The remaining 6 LNs statements consisted of the following formatted set statements for the nurse to attest to:</p> <ol style="list-style-type: none"> 1. "I do not recognize the second signature on the narc[otic] sheets shown to me."; 2. "I do recognize (suspected LN's name) signature."; 3. "I have not taken narcotics from this facility for personal use."; and 4. "I have no knowledge of where the missing narcotics are." <p>Five of the LN statements were signed, however, the LNs signing the statements could not be identified as the signatures were illegible. The sixth statement was initialed and did not contain further identifying documentation. Three of the statements were not dated.</p> <p>The drug diversion investigation did not identify the specific narcotic page signatures which were shown to the LNs to identify, or indicate the LNs were asked to identify their own signatures on the narcotic pages.</p> <p>The facility's Substance Abuse and Alcohol Misuse Prevention and Testing policy, dated 6/1/13, documented, "1. Drug testing will be performed under specific circumstances for full time, part time, casual, and temporary employees; students; and agency staff. 1.1</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 6 Pre-employment; 1.2 Reasonable suspicion;..."</p> <p>The facility's new employee and hiring packet contained an Acknowledgement of Receipt of Substance Abuse and Alcohol Misuse Prevention and Testing Policy and Consent to Testing. The consent documented receipt of the policy and signed and dated consent to drug testing per the Substance Abuse and Alcohol Misuse Prevention and Testing policy.</p> <p>On 7/14/16 at 7:00 am, the CNE stated the facility was not currently conducting controlled substance audits or any random audits. The CNE stated pharmacy staff came in once a month and looked at the narcotic book. The CNE stated the narcotics were diverted by documenting either the transfer of the narcotic to another page or destruction of the narcotic. She stated the transferring page did not correspond with the page transferred. She stated the suspected LN had worked at the facility for approximately 3 month and was later dismissed. The CNE was not aware of any resident not receiving their medications. The CNE stated she was unaware of any system changes other than nurses now keeping a running total of the narcotic cards in the front of the Controlled Substance Book. The CNE stated the previous CNE had conducted the investigation. The CNE stated the facility did not use a destruction or wasted log book. At this time, the Administrator stated drug testing of the suspected LN or the other LNs were not initiated.</p> <p>On 7/14/16 at 11:05 am, during an interview with the Administrator, CNE, CMO and pharmacy consultant, the CNE stated the LNs counted only the narcotic medication cards on the cart. If a</p>	F 225			

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	<p>Continued From page 7</p> <p>narcotic card was documented as destroyed or transferred, the page was crossed out and therefore the counting LNs disregarded the entire page. The facility believed the responsible LN was documenting PRN controlled substances as either transferred to another page or destroyed and then taking the medication. The suspected LN had signed twice for the required two signatures to destroy a medication. The CNE stated a shift count of total cards was initiated after the incident however, ongoing or random audits were not being conducted.</p> <p>The pharmacist consultant stated he reviewed residents' medications monthly and would "scan" the Controlled Substance Medication Log Book each month. The pharmacist consultant stated that pharmacy did not have a system in place that would necessarily track transferred or destroyed narcotic medication cards. since once the medications leave the pharmacy then the facility assumes responsibility. He stated he "monitored the facility's monitoring system."</p> <p>On 7/14/16 at 2:45 pm, the Administrator stated the QAA committee had not identified the drug diversion of multiple residents' controlled substances as an issue for the committee. The Administrator stated the committee looked at "broken systems" and did not consider the drug diversion as a system issue, but a personnel issue. The Administrator stated he put the diversion in the hands of the experts such as, pharmacy, human resources and medical who were better equipped to handle the issue. He stated he thought the person responsible had been identified, and all the other nurses were handling controlled substances correctly,</p>	F 225			

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 225	Continued From page 8 however he did not have past or current audits confirming the process had been corrected to verify other LNs were not diverting narcotic medications. The Administrator stated drug testing of the LNs had not been conducted and he had let Human Resources make that decision. He stated there was no need to perform drug testing on the suspected LN since she had confessed. The Administrator confirmed a secure system could have identified the diversion issue sooner and limited the extent of the problem. On 7/19/16 at 1:20 pm, the CNE confirmed the facility did not use a separate destruction log; the Controlled Substance Book recorded the destruction of narcotics; the facility did not use a destruction form as per policy; and initials of licensed staff sufficed for documentation since the initials were backed up by a signature log. The CNE stated she was unsure whether the pharmacy was aware of the facility's policy requirements. The failure to thoroughly investigate diversion of controlled substance medications directly impacted Residents #1, #8, #9, #10, and #13-#21 whose controlled substance MARs were reviewed.	F 225			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		8/15/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 226	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of personnel files and staff interviews, it was determined the facility failed to ensure information from previous employers was obtained for 1 of 5 new employees (A) before or upon hire. The failure created the potential for increased risk of abuse and neglect for 9 of 9 sample residents (#1- #9) and other residents under the CNA's care. Findings included:</p> <p>Five new employee personnel files were reviewed on 7/14/16. Employee A, a CNA, was hired on 5/6/16, but information from 2 previous employers was not obtained until 5/9/16.</p> <p>On 7/14/16 at 9:20 am, BOS #1 said the previous employer checks were done 3 days after Employee A started work.</p> <p>On 7/14/16 at 9:35 am, BOS #1 said the facility recently changed to a "large company" to do their previous employer checks.</p> <p>On 7/14/16 at 9:55 am, regarding Employee A's previous employer checks, BOS #1 indicated employer checks for Employee A had not been completed.</p>	F 226	<p>F226</p> <p>Residents Identified to be Affected Residents #1-9 and other residents had the potential to be affected by this deficient practice. The previous employer checks received indicated no prior issues of abuse or neglect with Employee A.</p> <p>Other Residents with the Potential to be Affected Residents receiving care from Employee A had the potential to be affected by this deficient practice. The facility received Employee A's reference and checks from the previous employer and, although 3 days late, there were no issues of abuse or neglect and therefore the residents under Employee A's care were not affected. Current employee files were reviewed for completed reference checks by the Center Executive Director or designee on or before August 5 with no additional missing checks noted.</p> <p>Systemic Changes and Education</p> <p>The facility payroll/HR staff has been re-educated on 8-3-16 by the Center Executive Director to properly process an employees' employment application to include receiving an employee's reference checks prior to being fully hired and working. An audit will be instituted starting August 8, 2016, to show all new employees have their proper reference</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 226	Continued From page 10	F 226	checks and this will be completed by the facility payroll/HR staff and monitored by the Center Executive Director. Performance Monitoring On or before the week of August 8, 2016, the Center Executive Director or designee will audit 3 employee files for timely completed reference checks for any new staff hired and/ or current staff. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be complied by the center executive director or designee and reported to the QAPI committee for review and remedial intervention for 3 months or until substantial compliance is achieved. The Center executive director is responsible for monitoring and follow-up.		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, it was determined the facility failed to ensure noise from laundry tubs being wheeled up and down the hallway did not disturb residents. This was true for 5 of 10 residents in a group interview who were awakened in the morning from the noise created by the laundry tubs. This created the potential for psychosocial and/or	F 258	F258 Residents Identified to be Affected New quiet laundry tubs were ordered by the executive director on July 26. A resident council meeting will be held the next day, after the delivery of the new tubs, by the director of housekeeping to	8/15/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 258	<p>Continued From page 11</p> <p>physical harm to residents due to ongoing stress and lack of sleep. Findings include:</p> <p>On 7/12/16 at 1:30 pm, during a group interview, 5 of the 10 attending residents stated the laundry tubs being wheeled down the hallway in mornings were so loud, the noise woke them up. When asked if the residents had reported the noise to the facility, the residents stated they were unsure if anyone had mentioned the noise to staff, but thought the noise was so obvious they should not need to report it.</p> <p>On 7/13/16 at 9:20 am, a laundry tub was observed being wheeled from the hallway dirty laundry room to the laundry. The laundry tub rolling down the hallway on the hard floor created a loud and disturbing noise.</p> <p>On 7/14/16 at 6:25 am, a laundry tub was observed being wheeled from the hallway dirty laundry room to the laundry. The laundry tub rolling down the hallway on the hard floor created a loud and disturbing noise. Residents were still sleeping at this time. During an interview with Housekeeper #1 at this time, she stated she started laundry at 5:00 am.</p>	F 258	<p>ensure that the change in cart resolved resident concerns with early morning noise levels.</p> <p>Other Residents with the Potential to be Affected Center residents who are able to be interviewed were interviewed about any noise related concerns in the center by the Executive director or designee on or before August 8. Follow-up interventions were implemented as indicated by resident response.</p> <p>Systemic Changes and Education Laundry staff, maintenance department and the Laundry Director will be monitoring the new laundry tubs to assure that they remain quiet and not disturb residents wishing to sleep. Residents at the facility Resident Council Meeting will be asked if the new quiet tubs have abated the morning noise from the laundry tubs.</p> <p>Performance Monitoring Beginning August 15, 5 random residents will be interviewed weekly to assure that the noise level caused by the noisy laundry tubs has been abated by the new laundry tubs. This audit will continue weekly for four weeks, then monthly for two months. Results of the audits will be discussed at the facility Performance Improvement Committee for three months or until substantial compliance is achieved. The center Laundry Director is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 258	Continued From page 12	F 258	responsible for monitoring and follow-up.		
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interviews, it was determined the facility failed to ensure licensed nursing staff adhered to professional standards of practice. This was true for 3 of 10 residents (#4, #8, and #12) sampled for narcotic therapies, and for 5 of 5 residents (#s1 - 5) reviewed for falls. This deficient practice created the potential for diversion of a narcotic medication, for residents to be harmed by receiving medication at the incorrect time, and by receiving medications that differed from those ordered by the physician. The failure to meet professional standards of practice also created the potential for more than minimal harm if there was a delay in recognizing and reporting a deterioration in the neurological status of residents experiencing accidents in which there was potential head injuries. Findings include:</p> <p>According to Potter, Perry & Ostendorf (2014), Clinical Nursing Skills & Techniques, 8th ed. Elsevier: St. Louis, 488-489, safe medication preparation and administration is obtained in accordance with Nursing: Scope and Standards of Practice (ANA, 2010), to prevent medication errors follow the six rights of medication administration: right medication; right dose; right</p>	F 281	<p>F281 Residents Identified to be Affected Resident # 12 discharged from Center on 7/28/16. Resident #8-MD was contacted by Center Nurse Executive (CNE) on 8/1/16 related to inconsistent time of administration of Levothyroxine and a new order was received to allow for medication administration of Levothyroxine to be given per her preference on 8-1-16 and the medical record was updated by the licensed nurse to include documentation of medication administration time. Resident #8 was assessed by Center Nurse Executive on 8/1/16 for any adverse reaction related to inconsistent medication administration. Resident #4-Center Nurse Executive verified placement and accuracy of Fentanyl patches on 8/1/16. Resident's pain assessed on 7/20/16 LN with no new onset of pain and resident is satisfied with current level of pain. Residents #1-5 were assessed on or before 8/1/16 with no neurological issues noted. Other Residents with the Potential to be</p>	8/15/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 13</p> <p>patient; right route; right time; and right documentation. Compare at least three times the information on the MAR corresponds exactly with the prescriber's written order and with the medication label. Guidelines for Safe Narcotic Administration and Control include: "An inventory record is used each time a narcotic is dispensed...and provide an accurate ongoing account of the narcotics used, wasted, and remaining...A second nurse witnesses disposal of the unused portion, and the record is signed by both nurses..." This policy was not followed. Examples include:</p> <p>1. Resident #8 was admitted on 4/5/15 with diagnoses which included hypothyroidism. Resident #8's MDS, dated 5/9/16, documented she was cognitively intact. Review of Resident #8's MAR documented she received Levothyroxine (hypothyroid medication) 25 mcg at 6:00 am.</p> <p>On 7/12/16 at 4:30 pm, Resident #8 stated she took her thyroid medication around 1:00 am when she woke up to go to the bathroom.</p> <p>The facility's Medication Administration policy, dated 3/15/16, stated licensed nurses would follow state regulations and accepted standards of practice.</p> <p>Review of Resident #8's MARs for April, May, June and July 2016 documented Levothyroxine was administered at 6:00 am. Resident #8's nursing notes and care plan did not contain documentation that Resident #8 received or requested medications at unscheduled times.</p>	F 281	<p>Affected</p> <p>Interview-able residents will be interviewed regarding satisfaction with current administration times of medications on or before 8/9/16 and follow up will be completed as indicated. Review of the medication administration record, including the Fentanyl destruction log for the last 30 days starting on 7/31/16 for any missed documentation of Fentanyl destruction. Any identified resident with missed Fentanyl destruction had a pain assessment completed by Center Nurse Executive or designee on or before 7/31/16 with no increase of pain noted. A medication administration record to medications cart audit was completed on or before August 8, 2016. Any discrepancies found will be addressed immediately with the physician and pharmacy.</p> <p>Residents with falls over the last 30 days on 7/19/16 were reviewed for complete neurological evaluations. Those resident□s identified with incomplete neurological evaluations had a follow up assessment completed by Center Nurse Executive on 7/19/16 with no neurological issues noted.</p> <p>Systemic Changes and Education</p> <p>Licensed staff will be educated by Nurse Practice Educator or designee on or before August 5, 2016, regarding medication pass times and MD notifications regarding any medications requested to be given outside of scheduled medications times, process for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 14</p> <p>On 7/13/16 at 9:40 am, the NPE stated medications could be given an hour before or an hour after the scheduled times. The NPE stated that if a medication was given at an unscheduled time, it should be documented on the MAR and in the Nursing Notes. The NPE stated if the resident was requesting medication at unscheduled times the physician should be called before giving the medication and it should be documented in Nurses' Notes and on the resident's care plan. The NPE stated the night LN gave the 6:00 am medications.</p> <p>On 7/14/16 at 5:45 am, LN #4, stated if a medication was given at a time other than the scheduled time, the actual time of administration was documented on the MAR. LN #4 state Resident #8 periodically woke up in the night and requested her thyroid medication. LN #4 stated night shift staff gave all the scheduled 6:00 am medications.</p> <p>On 7/14/16 at 9:05 am, Resident #8 stated she routinely took her thyroid medication around 1:00 am, and had taken it around 1:00 am that morning.</p> <p>Resident #8's MAR did not accurately document the time the levothyroxine was administered.</p> <p>2. Resident #4 was admitted to the facility in 2013 with multiple diagnoses, including spinal stenosis and chronic pain syndrome.</p> <p>Resident #4's current physician orders included Fentanyl 12 mcg and Fentanyl 25 mcg patches every 72 hours. The dosage of Fentanyl was</p>	F 281	<p>controlled substance destruction, six rights of administration medication, therapeutic interchange and completing Neurological checks per policy. Beginning on or before 8/5/16, during regularly scheduled quarterly care conferences, residents will be asked by Center Nurse Executive or designee if they are satisfied with their current medication administration times. Follow up will be completed immediately following the care conference with any noted concerns.</p> <p>On 7/21/16, Center Nurse Executive updated the MAR to include the destruction of Fentanyl patches by two nurses eliminating the separate Fentanyl destruction log in the MAR. Licensed staff will have medication administration competencies completed on or before August 15, 2016 by the NPE or designee, including Fentanyl destruction competencies. Beginning 8/8/16, during morning clinical meeting, neurological assessments will be reviewed by Center Nurse Executive or designee, for completion. Performance Monitoring Beginning the week of August 15, 2016 the Center Nurse Executive or designee will review 5 new medication orders to ensure that medications are administered per physician's orders. The Center Nurse Executive or designee will audit 3 random residents with Fentanyl patches to ensure appropriate destruction has occurred. The Center Nurse Executive or designee</p>		

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 15 increased to 37 mcg on 4/29/16.</p> <p>Resident #4's MARs for June and July 2016 documented the 12 mcg and 25 mcg fentanyl patches were changed every 3 days.</p> <p>There were gaps in the documentation on Resident #4's Used Fentanyl Patch Disposal Log, dated 4/1/16 to 7/10/16. The gaps were as follows: 6 days between 5/17/16 to 5/23/16, 6 days between 5/23/16 and 5/29/16, 7 days between 5/29/16 and 6/7/16, 6 days between 6/13/16 and 6/19/16, 9 days between 6/19/16 and 6/28/16, and 12 days between 6/28/16 and 7/10/16. The disposal of the used Fentanyl patches was not consistently documented.</p> <p>Additionally, one nurse's signature was documented on the Used Fentanyl Patch Disposal Log when the controlled medication was wasted/destroyed on 4/7/16, 4/13/16, and 6/19/16, instead of the signatures of two LNs.</p> <p>Resident #4's Progress Notes, dated 12/15/15 through 7/12/16 did not mention the disposal of the used Fentanyl patches.</p> <p>The facility's policy and procedure for management of controlled drugs, revised 5/1/16, documented a single dose of a controlled drug must be destroyed by the person who removed the used transdermal patch, witnessed by another nurse, and both of their signatures must be entered in the space with the documentation of the destruction.</p> <p>On 7/14/16 at 12:30 pm, the CNE said there were "gaps" in the documentation and that 2</p>	F 281	<p>will review 3 residents with falls to ensure neuro assessment is completed per policy.</p> <p>These audits will be completed weekly X4 weeks, monthly X2 months. The results of these audits will be complied by the Center Nurse Executive and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and follow up.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 16</p> <p>nurses did not always sign when the used Fentanyl patches were disposed.</p> <p>3. During a medication pass observation on 7/13/16 at 9:45 am, LN #2 administered 7 medications to Resident #12, including brimonidine tartrate solution 0.2%, 1 drop in both eyes. The pharmacy label on the brimonidine documented, "Brimonidine tartrate 0.2% drops...Instill 1 drop into both eye [sic] twice daily."</p> <p>On 7/13/16 at 10:00 am, a discrepancy between Resident #12's physician's order and the pharmacy label for the brimonidine tartrate eye drops was noted. The physician's order, dated 6/6/16, documented, "Alphagan P Solution 0.1% (Brimonidine Tartrate) Instill 1 drop in both eyes two times a day for glaucoma."</p> <p>Resident #12's current physician's orders also documented, "Generic substitution is authorized unless otherwise indicated. Center may participate in therapeutic interchange program..." It was dated 6/3/16.</p> <p>Resident #12's July 2016 MAR also documented Alphagan P Solution 0.1% (Brimonidine Tartrate) 1 drop in both eyes twice a day.</p> <p>On 7/13/16 at 10:05 am, LN #2 said she had not noticed that Resident #12's brimonidine tartrate pharmacy label and bottle did not match the MAR.</p> <p>On 7/13/16 at 10:30 am, the CNE stated that a Therapeutic Interchange (TI) from Alphagan P 0.1% to brimonidine tartrate 0.2% was done in</p>	F 281			

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 17</p> <p>June 2016. The CNE said Resident #12's orders and MARs continued to document Alphagan P solution 0.1 % rather than brimonidine tartrate solution 0.2% because the pharmacy had not communicated with the facility or provided documentation about the TI. The CNE provided a Therapeutic Interchange, dated 6/6/16, faxed to the facility on 7/13/16. The TI documented, "DC: Alphagan P 0.1% drops when the current supply of medication is exhausted. New order: brimonidine tartrate 0.2% drops. Instill 1 drop into both eyes twice daily ***TI***." A note on the TI documented, "Interchange per physician authorization according to interchange Policies and Procedures applicable to the state in which the resident resides."</p> <p>The pharmacy label for brimonidine tartrate differed from the physician's order for Alphagan and the MARs.</p> <p>4. Review of the facility's Fall Management policy, dated 3/15/16, documented when a patient falls, the Fall Response Protocol was utilized, which included a Neurological Assessment for all unwitnessed falls and witnessed falls with head injury. The Neurological Assessment was to be performed: every 30 minutes for 2 hours; then every hour for 4 hours; then every 4 hours for 24 hours. This policy was not followed. Examples include:</p> <p>Resident #3 was admitted on 5/6/16 with diagnoses which included dementia, osteoarthritis, and history of a hip fracture.</p> <p>On 5/16/16, Resident #3 had an unwitnessed fall. The Neurological Assessment Flow Sheet for the</p>	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 18</p> <p>fall did not contain neurological assessment documentation, only vital sign documentation.</p> <p>On 6/18/16, Resident #3 had an unwitnessed fall and sustained a head injury. Review of Resident #3's medical record did not contain documentation of neurological assessments.</p> <p>5. Resident #2 was admitted on 3/5/16 with diagnoses which included Alzheimers, and a history of falling.</p> <p>On 3/22/16, Resident #2 had an unwitnessed fall. The Neurological Assessment Flow Sheet for the fall did not contain neurological assessment documentation, only vital sign documentation.</p> <p>On 4/4/16 at 7:25 pm, Resident #2 had an unwitnessed fall. The Neurological Assessment Flow Sheet for the fall was initiated 2 hours after the fall, then documented 4 hourly assessments, and only 1 assessment 4 hours after that.</p> <p>On 7/8/16 at 4:30 pm, Resident #2 had an unwitnessed fall. The Neurological Flow Sheet for the fall contained neurological assessment documentation per protocol until 7/9/16 at 9 am. However, only 5 of the 16 documented assessments were signed.</p> <p>6. Resident #5 was admitted on 4/3/14 with diagnoses which included Parkinson's disease.</p> <p>On 4/4/16 at 8:30 pm, Resident #5 had an unwitnessed fall and sustained a wrist fracture. The Neurological Assessment Flow Sheet for the fall documented the initiation of the assessment and the transfer of Resident #5 to the hospital</p>	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	<p>Continued From page 19 emergency room. On 4/5/16 at 1:30 am, Resident #5 returned to the facility. Neurological assessments were not resumed after the resident's return.</p> <p>On 7/16/16, Resident #5 had an unwitnessed fall. Documentation of a Neurological Assessment Flow Sheet or neurological assessments per the fall protocol was not found in Resident #5's medical record.</p> <p>7. Resident #1 was admitted to the facility on 1/23/16 with multiple diagnoses, including congestive heart failure, left arm/wrist fracture, and failure to thrive.</p> <p>On 2/11/16 at 2:15 pm, Resident #1 had an unwitnessed fall. The Neurological Assessment Flow Sheet for the fall documented the neurological assessments stopped after the 4th hourly check and that the every 4 hours for 24 hours neurological assessments were not done.</p> <p>On 3/19/16 at 10:30 pm, Resident #1 had another unwitnessed fall. The Neurological Assessment Flow Sheet for the fall documented the neurological assessments stopped after 1 hourly check and that the remaining neurological assessments were not done.</p> <p>8. Resident #4 was admitted to the facility in 2013 with multiple diagnoses, including spinal stenosis and chronic pain syndrome.</p> <p>On 3/15/16 at 8:30 pm, Resident #4 had an unwitnessed fall. Neurological assessments related to the unwitnessed fall were not found in Resident #4's medical record, and the facility did</p>	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 281	Continued From page 20 not provide neurological assessment documentation related to the fall.	F 281			
F 371 SS=F	On 7/14/16 at 4:00 pm, the CNE stated she was aware there were problems with the neurological assessments not being done or not completed. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure the can opener blade was clean and staff performed proper hand hygiene. The failures had the potential to place 9 of 9 sample residents (#1 - #9), and all other residents who ate food served from the facility's kitchen, at risk for more than minimal harm from food-borne illness. Findings include: 1. On 7/11/16 at 9:45 am, during the initial tour of the SNF kitchen with DA #1 in attendance, a red substance, approximately 1/4 inch long, was observed on the blade of the can opener. The substance was sticky to the touch. DA #1 said the can opener had not been used that morning.	F 371	F371 Residents Identified to be Affected Diet aid #1 was re-educated by the dietary manager on infection control and dietary sanitation including handwashing, handwashing procedure, and cleaning of the can-opener. The can opener was placed into the dishwasher for cleaning by Diet aid #1 on July 11. Residents who ate food served from the kitchen had the potential to be affected by this deficient practice. The 24-Hour Nursing Report was reviewed by Food Service Supervisor from July 11 through July 18 for any residents with indication of	8/15/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 371	<p>Continued From page 21</p> <p>The DA immediately removed the can opener and placed it to be washed.</p> <p>2. a. On 7/12/16 at 11:25 am, DA #1 was observed plating food for residents from the steam table in the SNF kitchen. At 11:30 am, the telephone rang and DA #1 answered it with her bare hand. After the phone call, DA #1 did not wash her hands before she resumed plating food for residents. When the DA plated food onto 1 plate she was asked about hand hygiene after handling the telephone. DA #1 stopped and washed her hands after that. However, when the DA washed her hands, she applied soap then immediately rinsed her hands under running water while she applied friction and rubbed her hands together for 12 seconds.</p> <p>b. On 7/13/16 at 8:00 am, DA #1 was observed as she washed her hands 5 times during the plating of the breakfast meals for residents in the main dining room. Each time the DA washed her hands, she applied soap then immediately rinsed her hands under running water while she applied friction and rubbed her hands together for 10 to 12 seconds.</p> <p>On 7/14/16 at 5:30 pm, the NSD provided the Food and Nutrition Services P&P on handwashing which referred to the Infection Control hand hygiene P&P. The Infection Control hand hygiene P&P documented the proper technique to wash hands with soap and water as follows, "Wet hands with warm (not hot) water, apply soap to hands, and rub hands vigorously for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel.</p>	F 371	<p>GI symptoms related to any food-borne illnesses. None have shown any evidence of food-borne illness.</p> <p>Other Residents with the Potential to be Affected A dietary sanitation review was completed by the dietary manager on August 5 and any identified concerns were followed up immediately.</p> <p>Systemic Changes and Education All dietary staff has been re-education in the proper procedure for handwashing by the Dietary Supervisor on or before August 5, 2016. Staff will be audited per shift weekly by Food Service Director to assure proper handwashing technique. The can opener will be cleaned at the end of each shift and included into the shift-end kitchen closeout list. List will include signature of staff cleaning the can opener.</p> <p>Dietary staff will complete a hand washing competency on or before 8-5-16, administered by the food service manager or designee. Food Service Supervisor will conduct an audit 2x week on tray line to assure appropriate handwashing techniques.</p> <p>The can opener will be cleaned at the end of each shift and included into the shift-end kitchen closeout list. List will include signature of staff cleaning the can opener.</p>		

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 371	Continued From page 22 DA #1 did allow sufficient time to lather and wash before she rinsed her hands.	F 371	The can opener cleaning, including documentation of the staff that cleaned the can-opener, was added to the end of shift-end kitchen closeout list by the food service manager on 8-5-16. Performance Monitoring Beginning the week of 8-8-16, the Food Service Director will check the can opener daily and will review the shift-end closeout list for compliance as well check staff is complying with proper hand washing techniques. This will be done weekly for 4 weeks then monthly for 2 months. Results of the audits will be reported to the center QAPI committee for review and remedial intervention for 3 months or until substantial compliance is achieved. The center food service director is responsible for monitoring and follow-up		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		8/15/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 431	<p>Continued From page 23 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure used fentanyl patches were not diverted. This was true for 1 of 2 residents (#4) with orders for fentanyl patches. Inconsistent documentation of controlled medication wasting and lack of 2 nurses to witness the wasting increased the potential for diversion of the controlled pain medication and created the potential for resident experience increased pain. The facility also failed to ensure 2 of 25 medication pharmacy labels reflected the current physician's order for 2 of 9 residents (#11 & #12) during medication pass observations. The failures created the potential for suboptimal benefit and adverse reactions if the medications were not administered as</p>	F 431	<p>F431 Residents Identified to be Affected Residents #4-Center Nurse Executive (CNE) verified placement and accuracy of Fentanyl patches on 8/1/16. Resident's pain assessed on 7/20/16 by LN with no new onset of pain and resident is satisfied with current level of pain. Resident # 12 discharged from Sunny Ridge on 7/28/16. Resident #11 received new box of medication on 7/12/16 with correct label per MD order to accurately match the medication administration record. Other Residents with the Potential to be Affected</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 431	<p>Continued From page 24 ordered. Findings include:</p> <p>1. Resident #4 was admitted to the facility in 2013 with multiple diagnoses, including spinal stenosis and chronic pain syndrome.</p> <p>Resident #4's current physician orders included 2 fentanyl patches, a 12 mcg and a 25 mcg patch every 72 hours (3 days). The dose of fentanyl was increased to 37 mcg on 4/29/16 and the resident's MARs for June and July 2016 documented the 2 fentanyl patches were changed every 3 days.</p> <p>There were several gaps in Resident #4's Used Fentanyl Patch Disposal Log documentation, dated 4/1/16 to 7/10/16. The gaps were as follows: 6 days between 5/17/16 to 5/23/16, 6 days between 5/23/16 and 5/29/16, 7 days between 5/29/16 and 6/7/16, 6 days between 6/13/16 and 6/19/16, 9 days between 6/19/16 and 6/28/16, and 12 days between 6/28/16 and 7/10/16. In addition, there was only 1 nurse's signature when the controlled medication was wasted on 4/7/16, 4/13/16, and 6/19/16.</p> <p>Progress Notes, dated 12/15/15 through 7/12/16, did not contain documentation of the disposal of Resident #4's used fentanyl patches.</p> <p>On 7/14/16 at 12:20 pm, the Consultant Pharmacist said he did a "random" review of the facility's drug destruction documentation monthly. He said he asked staff if 2 nurses sign when used fentanyl patches were wasted but that he did not review Used Fentanyl Patch Disposal Logs. He said, "Guess I should look at these [Used Fentanyl Patch Disposal Logs]".</p>	F 431	<p>All medication administration records and medications on the medication cart were reviewed for accuracy to ensure medication labels and the Medication Administration Record are correct. Audit was completed on or before August 8, 2016. Any discrepancies will be followed up immediately with the physician and pharmacy.</p> <p>Review of the medication administration record, including the Fentanyl destruction log for the last 30 days starting on 7/31/16 for any missed documentation of Fentanyl destruction. Any identified resident with missed Fentanyl destruction had a pain assessment completed by Center Nurse Executive or designee on or before 7/31/16 with no increase pain noted. Systemic Changes and Education</p> <p>Licensed staff will be educated by NPE or designee on or before August 8, 2016 on the process for controlled substance destruction and the six rights of administration medication.</p> <p>On 7/21/16, Center Nurse Executive updated the MAR to include the destruction of Fentanyl patches by two nurses eliminating the separate Fentanyl destruction log sheet in the MAR. Licensed staff will have medication administration competencies completed on or before August 15, 2016 by the NPE or designee, including Fentanyl destruction competencies.</p> <p>Performance Monitoring Beginning the week of August 15, 2016, the CNE or designee will audit 3 random</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 431	<p>Continued From page 25</p> <p>On 7/14/16 at 12:30 pm, the CNE said there were "gaps" in Resident #4's Used Fentanyl Patch Disposal Logs and that 2 nurses did not consistently sign when used fentanyl patches were wasted.</p> <p>2. During a medication pass observation on 7/12/16 at 1:25 pm, LN #1 administered an Albuterol nebulizer treatment for Resident #11. The LN said it was a routine Albuterol treatment. The pharmacy label on the box of Albuterol documented, "Use 1 vial via nebulizer twice daily for wheezing and use 1 vial via nebulizer every 6 - 8 hours as needed".</p> <p>On 7/12/16 at 1:40 pm, a discrepancy between Resident #11's physician's order for Albuterol nebulizer treatments and the Albuterol pharmacy label was noted. A 1/14/16 order increased the routine Albuterol treatments to 3 times a day while an 8/11/15 order documented the prn Albuterol treatments as every 6 hours as needed.</p> <p>Immediately afterward, LN #1 said the routine Albuterol treatments were increased to 3 times a day in May 2016.</p> <p>The pharmacy label did not reflect the current orders for Resident #11's Albuterol nebulizer treatments.</p> <p>3. During a medication pass observation on 7/13/16 at 9:45 am, LN #2 administered 7 medications to Resident #12, including brimonidine tartrate solution 0.2%, 1 drop in both eyes. The pharmacy label on the brimonidine documented, "Brimonidine tartrate 0.2%</p>	F 431	<p>residents with Fentanyl patches to ensure appropriate destruction. Beginning the week of August 15, 2016, the Center Nurse Executive or designee will review 5 new medication orders to ensure that medications are administered per physician's orders. These audits will be completed weekly X4 weeks, monthly X2 months. The results of these audits will be compiled by the CNE and reported to the QA/PI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved. The CNE is responsible for monitoring and follow up. On or before 8-8-16, the pharmacist will review the center's controlled drug management monthly to validate compliance with center policy. The IDT will be re-educated on completing a thorough investigation by the regional vice president on or before 8-15-16. Beginning the week of 8-8-16, the administrator or designee will review a reportable investigation to ensure that all components of the investigation are complete. The center nurse executive will audit the controlled substance management in the center including validation of accurate documentation in the controlled substance log, as well as a count of current controlled medications. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled and reported to the QAPI committee by the Center Executive Director for review</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 431	<p>Continued From page 26 drops...Instill 1 drop into both eye [sic] twice daily."</p> <p>On 7/13/16 at 10:00 am, a discrepancy between Resident #12's physician's order and the pharmacy label for the brimonidine tartrate eye drops was noted. The physician's order, dated 6/6/16, documented, "Alphagan P Solution 0.1% (Brimonidine Tartrate) Instill 1 drop in both eyes two times a day for glaucoma."</p> <p>Resident #12's current physician's orders also documented, "Generic substitution is authorized unless otherwise indicated. Center may participate in therapeutic interchange program..." It was dated 6/3/16.</p> <p>Resident #12's July 2016 MAR also documented Alphagan P Solution 0.1% (Brimonidine Tartrate) 1 drop in both eyes twice a day.</p> <p>On 7/13/16 at 10:05 am, LN #2 said Resident #12's brimonidine tartrate pharmacy label did not match the physician's order.</p> <p>On 7/13/16 at 10:30 am, the CNE said the pharmacy made a Therapeutic Interchange (TI) from Alphagan P 0.1% to brimonidine tartrate 0.2% in June 2016 but did not communicate the change or provide the TI documentation to the facility until 7/13/16. The CNE said that was why Resident #12's orders and MARs continued to document Alphagan P solution 0.1 % rather than brimonidine tartrate solution 0.2%. The CNE provided a 6/6/16 TI faxed from the pharmacy to the facility that day. The TI documented that the Alphagan was to be discontinued when the current supply was exhausted and changed to</p>	F 431	<p>and remedial intervention monthly X3 months or until substantial compliance is achieved. The center executive director is responsible for monitoring and follow-up.</p>		

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

PRINTED: 08/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
(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 431	Continued From page 27 brimonidine tartrate 0.2%, 1 drop into both eyes twice daily. The TI also documented, "Interchange per physician authorization according to interchange Policies and Procedures applicable to the state in which the resident resides."	F 431			