



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 4018

July 8, 2014

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

Provider #: 135102

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Chinchurreta:

On **June 23, 2014**, a Facility Fire Safety and Construction survey was conducted at **Sunny Ridge** by the Department of Health & Welfare, 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 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 and a similar State Form 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

G. David Chinchurreta, Administrator
July 8, 2014
Page 2 of 4

Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 21, 2014**. Failure to submit an acceptable PoC by **July 21, 2014**, may result in the imposition of civil monetary penalties by **August 10, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **July 28, 2014**, (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 **July 28, 2014**. A change in the seriousness of the deficiencies on **July 28, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 28, 2014**, includes the following:

G. David Chinchurreta, Administrator
July 8, 2014
Page 3 of 4

Denial of payment for new admissions effective **September 23, 2014**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **December 23, 2014**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (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 **June 23, 2014**, 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 8, 2014
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 **July 21, 2014**. If your request for informal dispute resolution is received after **July 21, 2014**, 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, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 07/02/2014
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME	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
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V(111) building with a two-hour rated separation between the common walls of the nursing and assisted living/retirement facilities. The building was constructed in 1989 and has sprinkler/smoke detection coverage. The kitchen is located in the attached retirement building. Currently the facility is licensed for 46 SNF/NF beds</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 23, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required. By submitting this Plan of Correction, Sunny Ridge Center does not admit that the deficiencies 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>This Plan of Correction constitutes our Credible Allegation of Compliance.</p>	
K 018 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>P. D. Churchurra, Administrator</i>	TITLE	(X6) DATE 7-18-14
---	-------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 018	Continued From page 1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors equipped with self-closing devices were not blocked. Failure to ensure that self-closing corridor doors close completely would allow dangerous gases and smoke to enter the corridor affecting egress during a fire event. This deficient practice affected 25 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey. Findings include: During the facility tour conducted on June 23, 2014 between 1:30 PM and 2:00 PM, observation of the Activities Room door revealed it was wedged open with a crushed paper cup. When asked, the Maintenance Director stated this deficient practice was problematic during the times the Activities Room was in use due to residents preferring to keep the door open. This finding was acknowledged at the exit conference conducted with the Administrator and Maintenance Director on June 23, 2014 at 3:50 PM. Actual NFPA standard: 19.3.6.3 Corridor Doors.	K 018	K018 1. Any and all items wedging the door open have been removed and the door now closes unhindered. 2. Residents attending meetings or eating meals in the indicated room have the potential to be affected by the same deficient practice. 3. The door now has a magnet connected to the fire alarm system which automatically closes should the fire alarm system activate. 4. The maintenance director will monitor the door weekly for one month then monthly for two months. Results will be reported to the Performance Improvement Committee monthly for three months. 5. Date completed 7/8/14.	
	19.3.6.3.3* Hold-open devices that release when the door is			

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

Printed: 07/02/2014
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 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014	
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 018	Continued From page 2 pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that smoke compartment doors fully closed and latched when activated. Failure to ensure closure of smoke compartment doors would allow smoke and dangerous gases to pass freely between smoke compartments during a fire event. This deficient	K 021		

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

Printed: 07/02/2014
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 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 021	<p>Continued From page 3</p> <p>practice affected all residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 23, 2014 between 12:45 PM and 1:30 PM, testing of the fire doors between resident rooms 207 and 209 revealed they would not close completely leaving a gap of approximately 1/2 inch. Further testing revealed that the installed latching device would not latch. When asked, the Maintenance Director stated the doors had been having problems since the installation of new flooring had occurred in this area.</p> <p>Actual NFPA standard:</p> <p>19.2.2.2.6*</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>7.2.1.8.2</p> <p>In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <p>(1) Upon release of the hold-open mechanism, the door becomes self-closing.</p>	K 021	<p>K021</p> <ol style="list-style-type: none"> The cited fire door has been adjusted and fixed by a local door company and now closes completely with no gaps. Residents in 2 of 2 smoke compartments have the potential to be affected by the same deficient practice. Maintenance director will monitor and check the cited fire doors periodically to assure that the doors meet NFPA standards. Maintenance director will monitor the cited fire doors weekly for one month then monthly for two months. He will report to the Performance Improvement Committee monthly for three months. Completed 7/8/14 	

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

Printed: 07/02/2014
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 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 021	Continued From page 4 (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 021		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors in hazardous areas would allow passage of smoke and dangerous gases during a fire event into	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 029	Continued From page 5 adjacent areas affecting egress. This deficient practice affected 13 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey. Findings include: During the facility tour conducted on June 23, 2014 between 12:45 PM and 1:30 PM, operational testing of the door to the Medical Records office/storage room located directly across from resident room #205 revealed that the door would not self-close. The room measured approximately eight feet by ten feet (80 ft ²) and storing files and papers creating a combustible greater than that of the general occupancy. When asked, the Maintenance Director stated he was not aware that this room constituted a hazardous area and required that the door be self-closing. Actual NFPA standard: 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²)	K 029	K029 1. The door hinges have been replaced and door is now self-closing. 2. Residents in 1 of 2 smoke compartments have the potential to be affected by the same deficient practice. 3. The door hinges have been replaced which automatically closes the door. The door now has a magnet connected to the fire alarm system which automatically closes should the fire alarm system activate. 4. The maintenance director will monitor the door weekly for one month then monthly for two months. Results will be reported to the Performance Improvement Committee monthly for three months. 5. Date completed 7/8/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME			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	
K 029	Continued From page 6 (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.	K 029			
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the maintenance of smoke detection devices. Failure to ensure smoke detection devices are properly maintained would result in equipment not functioning as designed	K 054			

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

Printed: 07/02/2014
FORM APPROVAL
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 054	Continued From page 7 during a fire event. This deficient practice affected 1 resident, staff and visitors in 1 of 2 smoke compartments. The facility is currently licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey. Findings include: During the facility tour conducted on June 23, 2014 between 1:30 PM and 2:00 PM, observation by the surveyor and the Maintenance Director of the smoke detection device in resident room #218 revealed that the device was askew at the ceiling and missing the protective cover for the bottom of the sensing unit. When asked about the condition of the device, the Maintenance Director stated he was not aware of this problem. Actual NFPA standard: 19.7.6 Maintenance and Testing. (See 4.6.12.) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 054	K054 1. The cited smoke detector device protective cover has been replaced to the bottom of the cited sensing unit. 2. Residents in 1 of 2 smoke compartments have the potential to be affected by the same deficient practice. The protective cover has been replaced. 3. Maintenance director will monitor the cited smoke detector for any subsequent repairs needed. 4. Maintenance director will monitor smoke detectors in resident rooms weekly for one month then monthly for two months and will report to the Performance Improvement Committee monthly for three months. 5. Completed 7/8/14	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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)
K 062	<p>Continued From page 8</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler systems were maintained per NFPA 25. Failure to ensure sprinkler systems are maintained would result in lack of sufficient suppression during a fire event. This deficient practice affected 38 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 23, 2014 between 1:00 PM and 1:15 PM, observation of the sprinkler head in resident room #204 revealed it was wrapped with masking tape. When asked if he was aware this sprinkler was obstructed, the Maintenance Director stated he was not. He further stated this had been done during recent remodeling in this room.</p> <p>2) During the facility tour conducted on June 23, 2014 between 1:30 PM and 2:00 PM, observation of the sprinkler in resident room #214 revealed it was missing the trim escutcheon. When asked if he was aware this sprinkler was missing an integral component, the Maintenance Director stated he was not aware it was missing.</p> <p>3) During the facility tour conducted on June 23, 2014 between 2:45 PM and 3:30 PM, observation of the sprinklers located in the service corridor hallway and the staff lounge bathroom revealed the trim escutcheons for these two sprinklers were dislodged from the ceiling area and hanging down approximately 1 inch. When asked if he was aware of this condition, the Maintenance</p>	K 062	<p>K062</p> <ol style="list-style-type: none"> The three cited sprinklers have all been repaired as required. Residents in rooms #204 and #214 and residents in the service corridor hallway cited have the potential to be affected by the same deficient practice. Maintenance director will periodically monitor the sprinkler heads to assure that they are maintained as required per NFPA 25. Maintenance Director will monitor the sprinkler heads weekly for one month then monthly for two months. Results will be reported to the Performance Improvement Committee for three months. Completed 7/8/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 062	Continued From page 9 Director stated he was not.	K 062		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure means of egress were continually free of obstacles. Failure to provide clear means of egress would prohibit the safe and orderly evacuation of occupants during an emergency. This deficient practice affected 25 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey. Findings include: 1) During the initial building tour conducted on June 23, 2014 at 9:45 AM, a med pass cart was observed by the surveyor parked in the corridor at the nurses station located between resident room #211 and #210. This cart was immobile and continually stationed in this location as the initial tour ended at 10:15 AM. 2) During the facility tour conducted on June 23, 2014 between 12:45 PM and 3:00 PM, the med pass cart seen during the initial facility tour was again observed by the surveyor and the Maintenance Director parked in the same location at 12:45 PM, 1:15 PM, 2:30 PM and 3:00 PM.	K 072	K072 1. Medication Cart is on wheels, is mobile and is being moved at least every 30 minutes. The Med Cart is also being stationed in a location that does not obstruct exits or egress of same. 2. Residents located in area cited have the potential to be affected by this deficient practice. 3. Nurse Practice Educator and Maintenance Director will periodically monitor the Medication Cart to assure that it is mobile as required and that it does not obstruct exits or egress of same. 4. Monitoring will be done weekly for one month then monthly for two months. Results will be reported to the Performance Improvement Committee monthly for three months. 5. Completed 7/8/14	

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

Printed: 07/02/2014
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 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME			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	
K 072	Continued From page 10 When asked about policy regarding this cart, the Maintenance Director stated that it was usually in use and not stored in the path of egress. Actual NFPA standard: 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072			
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that soiled linen exceeding 32 gal. was properly stored. Failure to ensure hazardous material storage is located in an approved location would result in the passage of smoke and dangerous gases to adjacent areas affecting egress during a fire event. This deficient practice affected 13 residents, staff and visitors in 1 of 2 smoke compartments. The facility is	K 075			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 075	Continued From page 11 licensed for 46 SNF/NF beds and had a census of 36 on the day of the survey. Findings include: During the facility tour conducted on June 23, 2014 between 3:00 PM and 3:45 PM, the service hallway between the laundry room and the staff lounge area had a 64 gallon soiled linen cart stored in it. Interview of laundry staff revealed this linen cart was full of soiled linen. When asked if this storage was a normal practice, the Maintenance Director stated that normally soiled linen carts were stored inside the laundry. Actual NFPA standard: 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft ² (20.4 L/m ²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075	K075 1. The laundry cart cited was moved from the hallway into the laundry room where it is normally stored. 2. 13 residents in 1 of 2 smoke compartments have the potential of being affected by this deficient practice. Staff has been re-trained to keep the laundry cart in the laundry room and not the hallway. 3. Laundry supervisor will monitor the laundry workers on their proper placement of the laundry carts. 4. Laundry supervisor will monitor each week for one month and then monthly for two months. Results will be submitted to the Performance Improvement Committee. 5. Completed 7/8/14	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		
This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical connections were done				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME		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
K 147	<p>Continued From page 12</p> <p>in accordance with NFPA 70. Failure to ensure that patient care equipment and large appliances are plugged directly into a main power supply would result in a possible fire from overheated wiring or electrical shock. This deficient practice affected 13 residents, staff and visitors in 1 of 2 smoke compartments in the Skilled Nursing section and all residents, staff and visitors occupying the kitchen and main dining area of the retirement center. The facility is licensed for 46 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on June 23, 2014 between 2:45 PM and 3:00 PM, observation of resident room #205 revealed an oxygen concentrator was plugged into a relocatable power tap. When asked, the Maintenance Director stated he was aware that patient care equipment must be plugged directly into a main power supply.</p> <p>2) During the facility tour conducted on June 23, 2014 between 3:00 PM and 3:30 PM, observation of the kitchen area located in the retirement section of the facility revealed a commercial blender was plugged into a relocatable power tap. When questioned, the Maintenance Director stated he was not aware of why this appliance was not plugged directly into the outlet available.</p> <p>Actual NFPA Standard: NFPA 70 ARTICLE 400 Flexible Cords and Cables 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a</p>	K 147	<p>F147</p> <ol style="list-style-type: none"> 1. The oxygen concentrator in resident room #205 has been taken off the relocatable power tap and plugged directly into the main power supply. 2. Residents using oxygen concentrators have the potential to be affected by this deficient practice. These residents will be checked to assure that their concentrators are plugged directly into the main power supply. 3. Staff will be re-educated to plug oxygen concentrators directly into the main power supply. 4. Nurse Practice Educator and Maintenance Director will monitor this issue weekly for one month then monthly for two months. Results will be taken to the Performance Improvement Committee monthly for three months. 5. Completed 7/8/14

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

Printed: 07/02/2014
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 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREME	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
--------------------	--	---------------	---	----------------------

K 147	Continued From page 13 structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREMENT C		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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story type V(111) building with a two-hour rated separation between the common walls of the nursing and assisted living/retirement facilities. The building was constructed in 1989 and has sprinkler/smoke detection coverage. The kitchen is located in the attached retirement building. Currently the facility is licensed for 46 SNF/NF beds The following deficiencies were cited during the annual fire/life safety survey conducted on June 23, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.	C 226		

RECEIVED
JUL 21 2014
FACILITY STANDARDS

Idaho form

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

B. D. Chinchuruta, Administrator

TITLE

(X6) DATE

7-18-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135102	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2014
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE REHABILITATION & RETIREMENT C		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) COMPLETE DATE
C 226	Continued From Page 1 This Rule is not met as evidenced by: Please refer to federal form 2567 following "K" tags: K 018 - Corridor doors K 021 - Smoke doors K 029 - Hazardous area K 054 - Smoke Detection K 062 - Sprinkler Maintenance K 072 - Door impediments K 075 - Soiled linen storage K 147 - Electrical requirements	C 226	Refer to K018 Refer to K021 Refer to K029 Refer to K054 Refer to K062 Refer to K072 Refer to K075 Refer to K147	7/8/14

Idaho form