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May 19, 2017

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

Provider #: 135102

Dear Mr. Chinchurreta:

On **March 14, 2017**, an unannounced on-site complaint survey was conducted at Sunny Ridge.

Call light placement, call light response times, and water availability were observed throughout the survey. Residents were observed for signs and symptoms of being overly medicated and/or not adequately medicated, dehydration, and oral hygiene. Staff were observed assisting residents with their meals.

The clinical record of the identified resident and three other residents' records were reviewed for Quality of Care concerns. The facility's Grievance file from June 2016 to March 2017 was reviewed, as well as Resident Council minutes from June 2016 to March 2017, the facility's Allegation of Abuse reports from June 2016 to March 2017, and the facility's Incident and Accident reports for January and February 2016.

Several residents and staff, including the Center Executive Nurse, were interviewed regarding Quality of Care concerns, call light placement, medication administration, hydration, oral hygiene, and meal assistance.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007391

ALLEGATION #1:

The Reporting Party said an identified resident was moved to a smaller room and the resident had problems adjusting to the room due to claustrophobia.

FINDINGS #1:

The identified resident no longer resided in the facility at the time the complaint was investigated.

The identified semi-private and private rooms were measured and no concerns were identified.

The identified resident's clinical record did not document a concern with the identified room. The facility's Grievance file from June 2016 to March 2017 was reviewed, as well as Resident Council minutes from June 2016 to March 2017, and the facility's Allegation of Abuse reports from June 2016 to March 2017 - no concerns were identified regarding room assignments.

The resident who occupied the identified room during survey had no concerns with the size of the room. The Center Executive Nurse said the identified room was the only private room in the facility and residents also had the option to pay for both spaces in a semi-private room for a bigger room.

Based on observations, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident sustained an avoidable weight loss due to a room change.

FINDINGS #2:

One other resident was observed for weight loss and meal assistance with two meals and no concerns were identified.

The clinical records of the identified resident and one other resident were reviewed for weight loss and no concerns were identified.

The Center Executive Nurse said the identified resident received appropriate weight loss prevention interventions.

Based on observations, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified resident was forced to get up from bed to eat and was forced to eat when he/she was tired, which increased the risk of choking on food.

FINDINGS #3:

Several residents were observed receiving assistance eating during two meals and no concerns were identified.

The clinical records of the identified resident and one other resident were reviewed for nutritional concerns and none were identified. The facility's Grievance file from June 2016 to March 2017 and the facility's Allegation of Abuse reports from June 2016 to March 2017 did not document a concern with forced feeding.

Several residents said there were no concerns with eating assistance and they were not forced to get up from bed or forced to eat. Several Certified Nursing Aides (CNAs) and nurses said residents were not forced to get up for meals or force-fed meals. If such a thing were to occur, these staff said they would put an immediate halt to such a practice and promptly report it to administration. The Center Executive Nurse said if residents were not awake during meals, staff would try to wake them and if they would not wake, the resident would be taken back to bed if they so wanted.

Based on observations, record review and staff interview, it was determined the allegation could not be substantiated.

ALLEGATION #4:

An identified resident received either inadequate or excessive anti-anxiety medication, excessive antidepressant medication, and insufficient pain medication to adequately control pain.

FINDINGS #4:

Several residents were observed throughout the survey for anxiety and pain control and no concerns were identified. Several nursing staff were observed offering pain medication when residents needed it.

The clinical records of the identified resident and two other residents were reviewed for psychotropic and pain medication administration and effectiveness and no concerns were identified. The facility's Grievance file from June 2016 to March 2017 was reviewed, as well as Resident Council minutes from June 2016 to March 2017, and the facility's Allegation of Abuse reports from June 2016 to March 2017 and no concerns regarding medication administration and/or effectiveness were identified.

Several residents said there were no concerns with their medications, including the timely administration and dosages of pain medications. Several nurses stated they monitored residents for pain, anxiety and over-sedation, and would either use non-pharmacological approaches based on residents' care plans and/or administer the appropriate medication at the appropriate time. The Center Executive Nurse said the identified resident's medications were managed appropriately, changed when indicated, and the facility worked with the resident's physician and family to ensure the resident received the appropriate medications.

Based on observations, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

An identified resident did not receive adequate hydration or oral hygiene and had dried and cracked lips, foul breath, and dirty teeth.

FINDINGS #5:

Several residents were observed throughout the survey for dehydration and oral care and no concerns were identified. Many of the residents' rooms were observed for water availability and no concerns were identified. Water/ice pass was observed and no concerns were identified. The clinical records of the identified resident and three other residents were reviewed for dehydration and oral care and no concerns were identified. The facility ' s Grievance file from June 2016 to March 2017 was reviewed, as well as Resident Council minutes from June 2016 to

March 2017, and the facility's Allegation of Abuse reports from June 2016 to March 2017 and no concerns were identified regarding hydration or oral care hygiene.

Several residents said they had no concerns regarding hydration or oral care. Several CNAs and nurses said they ensured residents were well hydrated and proper oral care was provided. The Center Executive Nurse said the identified resident received hydration during meals, at bedside, and during medication pass, and that appropriate oral care was provided to the resident.

Based on observations, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

An identified resident's call light was never within reach and as a result the resident fell and sustained a fractured leg.

FINDINGS #6:

Many of the residents' rooms were observed and call lights were accessible to residents. Call light response times were observed and were answered in a timely manner.

The clinical record of the identified resident and one other resident's record were reviewed for fall prevention and no concerns were identified. The facility's Grievance file from June 2016 to March 2017 was reviewed, as well as Resident Council minutes from June 2016 to March 2017, and the facility's Incident and Accident reports for January and February 2016 and no concerns were identified.

Several residents said staff ensured their call lights were within reach when they left their rooms and had no concerns regarding call lights. Several staff members said prior to leaving a resident's room all items the resident might need, including call lights, were placed where the resident could reach them. The Center Executive Nurse said the identified resident's fall was not due to call light placement and appropriate fall preventions were in place at the time.

Based on observations, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

David Scott, R.N., Supervisor
Long Term Care

DS/lj