

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

PRINTED: 04/13/2018
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 R 04/11/2018
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}	<p>INITIAL COMMENTS</p> <p>On April 10, 2018 to April 11, 2018, an onsite revisit survey of your facility was conducted to verify correction of deficiencies noted during the survey of February 23, 2018. Sunny Ridge was found to be in substantial compliance with federal health care regulations as of March 20, 2018.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW Presie Billington, RN</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

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.

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F 000	<p>INITIAL COMMENTS</p> <p>On April 10, 2018 and April 11, 218 a complaint investigation survey of your facility was conducted. Sunny Ridge was found to be in substantial compliance with federal health care regulations on April 11,2018 and no deficiencies were cited.</p> <p>Surveyors conducting the survey were: Brad Perry, LSW Presie Billington, RN</p>	F 000			

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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January 16, 2019

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

Provider #: 135102

Dear Mr. Chinchurreta:

On **April 11, 2018**, an unannounced on-site complaint survey was conducted at Sunny Ridge. The complaint was investigated in conjunction with the facility's on-site Recertification follow-up survey conducted April 10, 2018 through April 11, 2018. The complaint allegations, findings and conclusions are as follows:

Call lights were observed throughout the survey. Mechanical lift transfers were observed. Meals were observed for supervision, staff assistance, and weight loss concerns. Residents' dental care and oral hygiene were observed. Staff and resident interactions were observed.

An identified resident's clinical record and five other residents' records were reviewed for Quality of Care concerns. The facility's Grievance file was reviewed, as well as its Incident and Accident reports, allegation reports of abuse and neglect, staffing records, and mechanical lift training documents.

Several residents, CNAs, and nurses were interviewed regarding various Quality of Care issues. The local Ombudsman was interviewed regarding the identified resident. The Practice Development Specialist, a Physical Therapist, the Resident Service Director, and the Director of Nursing were interviewed regarding various issues.

Complaint #ID00007793

ALLEGATION #1:

An identified resident was not allowed to use a sit-to-stand mechanical lift and was made to use a Hoyer mechanical lift, while other weaker residents were allowed to use the sit-to-stand device.

FINDINGS #1:

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

Multiple mechanical lift transfers were observed for several residents and were appropriate for the residents' abilities and safety.

An identified resident's clinical record and three other residents' records were reviewed for mechanical lift assessments and each documented the lifts used were appropriate for their ability and safety during transfers.

Three residents, who used mechanical lifts, expressed no concerns with the type of lifts used. Several CNAs, the Practice Development Specialist, a Physical Therapist, the Director of Nursing, and the local Ombudsman said an identified resident had trouble using the sit-to-stand lift appropriately and was no longer safe to use that lift.

A Physical Therapist said an identified resident could not perform and maintain the correct lifting movements to be safe in the sit-to-stand, even after being placed in therapy for several weeks.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident was afraid to use a Hoyer mechanical lift, which resulted in a decline in wanting to live, had increased depression and lost weight due to refusing to eat.

FINDINGS #2:

Several Hoyer lift transfers were observed for two residents and they did not express fear or depression during the observations. Four residents' meals were observed for potential weight loss and increased depression and no concerns were identified.

The identified Resident's clinical record did not document the resident had expressed a decreased desire to live, had increased depression or weight loss. Four other residents' records were reviewed for increased depression and weight loss and no concerns were identified. An allegation of neglect for the identified Resident was reviewed for issues regarding mechanical lift changes and no concerns were identified.

Two residents, who used Hoyer lifts, expressed no concerns with the lifts and denied increased depression or weight loss. Several CNAs said the identified Resident had not expressed fear, increased depression, or weight loss. The Resident Service Director said the Resident was observed to be happy and was evaluated

for depression shortly after the Hoyer lift was put into place and the Resident's depression did not increase and the Resident's food intake did not decline. The Director of Nursing said the Resident understood the need to remain safe while using the Hoyer lift and did not express a decline in the desire to live and did not refuse meals.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified staff member threatened a family member that the identified Resident was going to be left in bed and/or would be involuntarily be discharged if the resident refused to use a Hoyer lift.

FINDINGS #3:

Staff and resident interactions were observed throughout the survey and no concerns of threats were identified.

The identified Resident's clinical record and three other residents' records were reviewed for abuse concerns and no concerns were identified. The facility's allegation reports of abuse and neglect did not document a concern of abuse by the identified staff member.

Several residents said all the staff were very respectful and had not been threatened by staff. Several CNAs and nurses said they treated residents with respect and would report any threats to their supervisor immediately. The Director of Nursing said there were never any threats made to the identified Resident or family members.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

CNAs were transferring residents with mechanical lifts by themselves instead of using two staff members. An identified resident was transferred with a Hoyer lift by one identified staff member and the resident was partially naked with the window blinds opened.

FINDINGS #4:

Multiple mechanical lifts were observed to be completed by two staff members and window blinds were closed and privacy curtains were pulled during the transfers.

The identified Resident's clinical record and three other residents' records did not document a concern with mechanical lift or privacy issues. The facility's Grievance file did not document concerns with mechanical lift transfers and privacy during those transfers. The facility's Incident and Accident reports and allegation reports of abuse and neglect did not document a concern with mechanical lift transfers or privacy concerns. The facility's mechanical lift training records documented staff received appropriate education regarding mechanical lift transfers.

Residents said staff always used two staff members to complete mechanical lift transfers and made sure their privacy was protected by closing curtains and blinds. Several CNAs, nurses, and the Director of Nursing said mechanical lift transfers were performed with two staff members. The Practice Development Specialist said staff received ongoing training for mechanical lift transfers and received training again whenever there was a change to a resident's type of lift. An identified staff member said he/she did not transfer the identified Resident by themselves and always closed the curtain and window blinds.

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

ALLEGATION #5:

There is only one staff member assisting to feed 10 residents in the assisted dining room.

FINDINGS #5:

Three meals were observed for supervision, staff assistance, and weight loss concerns. The assisted dining room had at least two or three staff members physically assisting two or three residents who needed that level of assistance. The other six to eight residents in the dining room ate independently and no concerns regarding assistance or weight loss were identified. The restorative dining room was also observed to have at least one or two staff members for two to three residents who only required cueing and occasional physical assistance and no assistance or weight loss concerns were identified. One other resident who ate in his/her room was observed to receive physical assistance of a staff member and no concerns were identified.

The clinical record of three residents who needed staff assistance for meals did not document a concern regarding weight loss.

Several residents said there were enough staff to help with meals. Several CNAs and nurses said there were enough staff to meet the residents' needs. The Director of Nursing said there were enough staff to meet the residents' needs.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

There is not enough supervision at night.

FINDINGS #6:

Call lights were observed throughout the survey and no concerns were identified.

Staffing records documented the facility had enough staff each shift, including nights. The facility's Grievance file did not document concerns of lack of supervision or staffing at night.

Several residents said there were enough staff to help with their needs at night. Several CNAs and nurses said there were enough staff to meet the residents' needs on all shifts and there was always a charge nurse at night. The Director of Nursing said there were enough staff to meet the residents' needs and she was always available to provide supervision at all times of the day and night.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Staff did not brush the teeth of an identified resident.

FINDINGS #7:

Three residents' teeth were observed and no concerns were identified. Oral hygiene for several residents were observed and no concerns were identified.

The identified Resident's clinical record documented oral hygiene was complete and a dental hygienist record did not document any oral care concerns. Three other residents' records did not document a concern with oral care.

G. David Chinchurreta, Administrator
January 16, 2019
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Several residents said staff assisted them with oral hygiene and brushing their teeth. Several CNAs and nurses said oral hygiene was provided and the identified Resident's family member would offer to brush the resident's teeth when he/she was in the facility. The Resident Service Director and the Director of Nursing said the facility had a mobile hygienist and dentist who came in regularly to clean and take care of residents' teeth. The Director of Nursing said staff provided the residents with good oral care.

Based on observation, record review, resident 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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj