IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK– ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

November 19, 2018

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 **November 8, 2018**, 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. 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. Please provide ONLY ONE

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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 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of civil monetary penalties by **December 24, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 13, 2018**, (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 **February 6, 2019**. A change in the seriousness of the deficiencies on **December 23, 2018**, may result in a change in the remedy.

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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. 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 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of civil monetary penalties by **December 24, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 13, 2018**, (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 **February 6, 2019**. A change in the seriousness of the deficiencies on **December 23, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 13, 2018**, includes the following:

Denial of payment for new admissions effective **February 8, 2019**.
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 **May 8, 2019**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **November 8, 2018**, 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

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 **December 3, 2018**. If your request for informal dispute resolution is received after **December 3, 2018**, 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, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED
	135102		11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY RIDGE	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	INITIAL COMMENTS The facility is a single-story type V (111) construction with a two-hour rated separation between the nursing home, independent living apartments and assisted living. The building was constructed in 1989 and has sprinkler/smoke detection coverage throughout. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. Kitchen and Laundry services are located in the independent living section of the building. Currently the facility is licensed for 43 SNF/NF beds and had a census of 35 on the dates of the survey. The following deficiencies were cited during the annual life safety code survey conducted on November 7 - 8, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED DEC 07 2018 FACILITY STANDARDS	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	K 911		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

B. D. Chinchurreta, Executive Director — 11/30/18

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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K 911	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station in accordance with NFPA 110. Failure to provide a remote manual stop station has the potential to prevent shutdown of the emergency generator during a system malfunction, or unintentional operation. This deficient practice affected 35 residents, staff and visitors on the dates of the survey. Findings include: During the facility tour on November 8, 2018 from approximately 10:45 AM to 12:30 PM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Director stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) NFPA 110 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.	K 911	K 911 1. A new remote manual stop station for the EES generator has been equipped as per NFPA requirements. 2. All residents residing in the skilled nursing unit have the potential to be affected by the same deficient practice. A new remote manual stop station has been equipped. 3. The maintenance director and facility Executive Director are now apprised of the requirement of the remote manual stop and will assure it is operational going forward. 4. The remote manual stop will be tested annually as required. Results will be reviewed at next QAPI Committee Meeting. 5. Completion by 11/25/18	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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SUNNY RIDGE	2609 SUNNYBROOK DRIVE NAMPA, ID 83686

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K 918	Continued From page 2 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Power Supply	K 918	K 918 1. The facility Emergency Power Supply has been tested with a four-hour load test on 11/30/18. 2. All residents residing in the skilled nursing unit have the potential to be affected by the same deficient practice. The four-hour load test, as required, has been completed. 3. The maintenance director is now apprised of the requirement of the three-year, four-hour load test and will assure it is implemented every three years going forward. 4. The required load testing will be tested every three years, as required. Results will be reviewed at next QAPI Committee Meeting. 5. Completion by 11/30/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED
	135102		11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY RIDGE	2609 SUNNYBROOK DRIVE NAMPA, ID 83686

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K 918	Continued From page 3 Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect and test EPSS under load could result in a lack of system reliability during a power loss. This deficient practice affected 35 residents, staff and visitors on the dates of the survey. Findings include: During review of the EPSS inspection and load testing documentation provided on November 7, 2018, from approximately 1:00 PM to 3:00 PM, no documentation could be produced for a three-year, four-hour load test. When asked about the four-hour load bank being performed tri-annually, the Maintenance Director stated the facility was not aware of this standard. Actual NFPA standard: NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSs, or initiated by opening all switches or breakers supplying normal power to all ATSs that are part of the EPSS being tested.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ENTIRE BUILDING** B. WING _____	(X3) DATE SURVEY COMPLETED
	135102		**11/08/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY RIDGE	**2609 SUNNYBROOK DRIVE** **NAMPA, ID 83686**

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K 918	Continued From page 4 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.	K 918		

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November 19, 2018

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

Provider #: 135102

RE: **EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Chinchurreta:

On **November 8, 2018**, an Emergency Preparedness 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 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. 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 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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of civil monetary penalties by **December 24, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 13, 2018**, (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 . A change in the seriousness of the deficiencies on **January 3, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 13, 2018**, includes the following:

Denial of payment for new admissions effective **February 8, 2019**.
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 **May 8, 2019**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **November 8, 2018**, 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

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

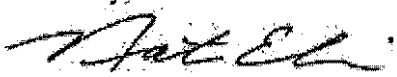
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 3, 2018**. If your request for informal dispute resolution is received after **December 3, 2018**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 11/16/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135102		11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNY RIDGE	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
E 000	Initial Comments	E 000		
	The facility is a single-story type V (111) construction with a two-hour rated separation between the nursing home, independent living apartments and assisted living. The building was constructed in 1989 and has sprinkler/smoke detection coverage throughout. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. Kitchen and Laundry services are located in the Independent living section of the building. Currently the facility is licensed for 43 SNF/NF beds and had a census of 35 on the dates of the survey.		RECEIVED DEC 07 2018 FACILITY STANDARDS	
	The following deficiencies were cited during the initial Emergency Preparedness Survey conducted on November 7 - 8, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.			
	The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction			
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)	E 006		
	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]			
	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

B. D. Chinchuneta, Executive Director — 12-6-18

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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E 006	Continued From page 1 *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct a comprehensive facility-based and community-based risk assessment to include strategies for addressing emergency events identified by the risk assessment. Failure to conduct a facility and community-based risk assessment with strategies for response hinders the facility's ability to respond to disasters and emergencies. This deficient practice affected 35 residents, staff and visitors on the dates of the survey. Findings include: On November 8, 2018, from approximately 8:00	E 006	E 006 1. The EPP committee has reviewed and revised the facility Risk Assessments assuring that the HVA and corresponding strategies address all emergency events as identified. 2. Residents residing in the SNF have the potential to be affected by this deficient practice. Review of HVA and corresponding strategies will be ongoing by the EPP committee. 3. The HVA and strategies will be reviewed at least annually by the EPP committee. Maintenance Director will be responsible. 4. Review results of the HVA and strategies will be presented to the QAPI Committee by the maintenance director. 5. Completion date: 12-7-18	

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E 006	Continued From page 2 AM to 10:30 AM, review of the provided emergency preparedness plan, including the facility Hazard Vulnerability Assessment (HVA) revealed some of the hazards identified on the HVA did not have strategies for response. They were; Snowfall, Blizzard, Ice Storm, Extreme Temperatures, Drought, Wild Fire, Volcano, Generator Failure, Transportation Failure, Fuel and Natural Gas Failure, Sewer Failure, Information System, Hazmat, Internal, Mass Casualty - Trauma, Mass Casualty - Medical, Mass Casualty - Hazmat, Labor Action, Workplace Violence, Building Break-in, Auto Break-in, Medication theft, Assaults (outside) and Kidnapping. Additionally, some strategies for response were in the EP plan, but not listed on the HVA. They were; Armed Intruder, Dam Failure, Loss of Water Supply, Nuclear/Radiation Fallout and Pandemic/Epidemic. When asked, the Maintenance Director stated the facility was not aware of the discrepancies on the HVA. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006		
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		

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E 007	Continued From page 3 *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency plan that addressed the resident population, including persons at risk and the type of services the facility would be able to provide in an emergency. Failure to provide information on the resident population served within the facility, their unique vulnerabilities in the event of a disaster, and services the facility could provide in an emergency, could potentially hinder evacuation, continuation of resident care and a community integrated response during an emergency. This deficient practice affected 35 residents, staff and visitors on the dates of the survey. Findings include: On November 8, 2018, from approximately 8:00 AM to 10:30 AM, review of the provided emergency preparedness plan revealed the resident population, including persons at risk was not addressed in the plan. Additionally, the facility had not identified the types of services they could provide in an emergency. When asked, the Maintenance Director stated the facility was unaware of this requirement. Reference: 42 CFR 483.73 (a) (3)	E 007	E 007 1. The maintenance director has contacted Zach Ward of the Healthcare Coalition in order to set up a mutual time in which to conduct a comprehensive facility-based and community-based assessment for addressing emergency events. 2. All residents living in the SNF have the potential to be affected by this deficient practice. Coordination of necessary collaboration of assessments will be followed through as event(s) are coordinated with all required parties. 3. Regularly scheduled community events will be held as directed by the maintenance director and the participating outside agency. 4. Maintenance director will report to the QAPI committee results and outcomes of the planned emergency events. 5. Completion date: ~~2-15-19~~ 12-15-18	
E 009 SS=D	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4)	E 009		

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E 009	Continued From page 4 [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility had not implemented a method for collaboration with local, tribal, regional, State and Federal emergency response officials to promote an integrated response to emergency events. This deficient practice had the potential to affect 35 residents, staff and visitors	E 009	E009 The facility is now connected with Northwest Healthcare Response Network for local emergency preparedness officials to coordinate an integrated response drill to emergent situations as of 11/07/2018. The center will continue with monthly follow up and participate in integrated drills. The Emergency Preparedness Plan (EPP) will be updated to reflect the efforts mentioned above. The EPP will be reviewed by the Center Executive Director (CED) and other key members of the Interdisciplinary Team (IDT) for completeness as required annually. The CED will report the updates to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations. The CED shall be responsible for compliance. Compliance date 12/9/2018	

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E 009	Continued From page 5 on the dates of the survey. Findings include: Review of the facility emergency plan on November 8, 2016, from approximately 8:00 AM to 10:30 AM, revealed the facility failed to collaborate with local, tribal, regional, State, and Federal officials to maintain an integrated response in the event of a disaster. When asked, the Maintenance Director stated that to his knowledge, the facility had not yet reached out to any of these organizations or participated in any of the planning or training they provide. Reference: 42 CFR 483.73 (a) (4)	E 009		
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.	E 018		

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E 018	Continued From page 6 *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and	E 018	E 0018 1. A tracking system has been documented as part of the emergency plan policies and procedures. 2. Residents residing in the SNF have the potential to be affected by this deficient practice. A tracking system has been added to the facility EPP. 3. Facility will continue to update and monitor the EPP on a regular throughout the year. Staff will be educated on the tracking system by the maintenance director. 4. Tracking system will be reviewed with the Quality Assurance Performance Improvement Committee and will be monitored periodically annually. Maintenance Director is responsible. 5. Completion date 12-7-18	

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E 018	Continued From page 7 procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a current policy for tracking on-duty staff during an emergency, to include the specific name and location of receiving facility or other location in the event they are relocated with residents during an emergency. Lack of a tracking policy has the potential to hinder the facility's ability to provide care and continuation of services during an emergency. This deficient practice had the potential to affect 35 residents, staff and visitors on the dates of the survey. Findings include: On November 8, 2018, from approximately 8:00 AM to 10:30 AM, review of the provided records, policies and procedures failed to demonstrate the facility had in place a system to track the location of on-duty staff during an emergency. When asked, the Maintenance Director stated the facility was unaware of the requirement to track on-duty staff during an emergency. Reference: 42 CFR 483.73 (b) (2)	E 018		

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E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a current policy and procedure for sheltering in place which can subsequently be reviewed annually. Lack of a current policy and procedure for sheltering in place has the potential to leave residents and staff without resources to continue care during an emergency. This deficient practice affected 35 residents, staff and visitors on the dates of the survey.	E 022	E 022 1. The facility Emergency Preparedness Plan has been updated to include policies and procedures on how our residents will shelter in place for patients, staff and volunteers who remain in our facility. 2. Residents living in the SNF have the potential to be affected by this deficient practice. A Shelter-in-Place policy and procedure has been included in our facility EPP. 3. A review of this policy and procedure will occur at annually by the maintenance director and Executive Director of the facility 4. The Shelter-in-Place policy will be submitted to the facility Quality Assurance and Performance Improvement Committee by the maintenance director. Policy will be reviewed at least annually. 5. Completion date: 12-7-18	

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E 022	Continued From page 9 Findings include: On November 8, 2018, from approximately 8:00 AM to 10:30 AM, review of the provided emergency preparedness plan failed to demonstrate current and annually reviewed policies and procedures for sheltering in place. Records provided indicated a plan to "Take Cover" but did not include strategies for sheltering in place. When asked, the Maintenance Director stated the facility was unaware of the shelter in place requirement. Reference: 42 CFR 483.73 (b) (4)	E 022		
E 026 SS=D	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026		

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E 026	Continued From page 10 *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for the facility role under an 1135 waiver as declared by the Secretary and the provisions of care at an alternate site if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice could potentially affect 35 residents, staff and visitors on the dates of the survey. Findings include: On November 8, 2018, from approximately 8:00 AM to 10:30 AM, review of the provided policies and procedures revealed the facility did not have a current policy or procedure that addressed the facility role during a disaster event. When asked, the Maintenance Director stated the facility was unaware of this requirement. Reference: 42 CFR 483.73 (b) (8)	E 026	E026 Sunny Ridge Center has a policy in place by Genesis Healthcare that meets the requirement for providing care and treatment of patients at alternate care sites under 1135 waiver. The CED re-educated the maintenance director and staff on the current written emergency preparedness plan and location where to find the 1135 waiver. This information will be reviewed annually and as needed. The policy will be reviewed at the next QAPI meeting. Recommended changes, if any, will be addressed at this time. The CED shall be responsible for compliance. Compliance date 12/07/2018	
E 034 SS=D	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an	E 034		

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E 034	Continued From page 11 emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to document a current plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder an integrated response and continuation of care. This deficient practice could potentially affect 35 residents, staff and visitors on the dates of the survey.	E 034	F 034 1. The EPP committee has reviewed and revised the facility Risk Assessments assuring that the HVA and corresponding strategies address all emergency events as identified. 2. Residents residing in the SNF have the potential to be affected by this deficient practice. 3. The HVA and strategies will be reviewed at least annually by the EPP committee. Maintenance Director will be responsible. 4. Review results of the HVA and strategies will be presented to the QAPI Committee by the maintenance director. 5. Completion date: 12-7-18	

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(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
E 034	Continued From page 12 Findings include: On November 8, 2018, from approximately 8:00 AM to 10:30 AM, review of the facility emergency plan revealed no indication the facility had shared or had a written method to share information on its needs or capabilities with emergency management officials. When asked, the Maintenance Director stated the facility was unaware of this requirement. Reference: 42 CFR 483.73 (c) (7)	E 034		
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide current information on the facility emergency preparedness plan with residents, families and their representatives. Not sharing information with residents, families and their representatives on the EP plan, has the potential to create confusion	E 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135102		11/08/2018

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E 035	Continued From page 13 and lack of understanding of the facility's response during a disaster. This deficient practice could potentially affect 35 residents, staff and visitors on the dates of the survey. Findings include: On November 8, 2018, from approximately 8:00 AM to 10:30 AM, review of the facility emergency preparedness plan and related documents revealed the facility had not yet shared relative information with residents, families and their representatives on the emergency preparedness plan. When asked, the Maintenance Director stated the facility was unaware of this requirement. Reference: 42 CFR 483.73 (c) (8)	E 035	E 035 1. The residents, and families will be informed that the facility has a Emergency Preparedness Plan manual This will be accomplished by having an insert in the new admission packets, informing the Resident Council and sending a mailing to the resident's families. 2. All residents living in the SNF have the potential to be affected by this deficient practice. 3. Center Executive Director will review new admission packets randomly throughout the year to assure that they contain an insert describing the EPP manual. 4. CED report will be reviewed with the QAPI committee. 5. Completion date: 12-7-18	