



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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June 7, 2019

Corrected Letter

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

Provider #: 135102

Dear Mr. Chinchurreta:

On **May 24, 2019**, a survey was conducted at Sunny Ridge by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 17, 2019**. Failure to submit an acceptable PoC by **June 17, 2019**, may result in the imposition of penalties by **July 10, 2019**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 28, 2019 (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 **August 24, 2019**. A change in the seriousness of the deficiencies on **July 8, 2019**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 24, 2019** includes the following:

Denial of payment for new admissions effective **August 24, 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 non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 24, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **August 24, 2019** 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:

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<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 **June 17, 2019**. If your request for informal dispute resolution is received after **June 17, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

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

PRINTED: 06/27/2019
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 05/24/2019
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NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686
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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
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from May 20, 2019 to May 24, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Suzy Devereaux, RN	F 000		
F 575 SS=F	Survey Abbreviations: DON = Director of Nursing LPN = Licensed Practical Nurse Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part	F 575		6/21/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/13/2019
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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 575	<p>Continued From page 1</p> <p>489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, it was determined the facility failed to post Medicare and Medicaid contact information in an area accessible for residents, resident representatives, and visitors to view. This was true for 1 of 7 residents (Resident #11) in the Resident Group interview and had the potential to affect the remaining 31 residents in the facility. This had the potential for more than minimal harm if residents required assistance from any of these agencies, but did not know how to contact an agency representative. Findings include:</p> <p>On 5/20/19 at 7:00 AM and 1:52 PM and on 5/20/19 at 8:53 AM, the posting for Medicare and Medicaid information was hung on the bulletin board in the main hallway near the nurses' station. The information was printed on regular sized paper (8 1/2 X 11 inches) and posted with push pins which were 5 feet 11 inches from the ground. If a resident was in a wheelchair, the posting would be difficult to reach or see due to the height of the posting.</p> <p>On 5/21/19 at 2:03 PM, during the Resident Group interview and on 5/22/19 at 9:22 AM, Resident #11 said since she was in a wheelchair and had poor vision, it was difficult to reach and read the postings on the bulletin board because the information was too high.</p> <p>On 5/22/19 at 9:36 AM, the DON said the Medicare and Medicaid postings were too high for someone in a wheelchair, someone who had</p>	F 575	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, this Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F575 Facility postings were lowered and posted to new a display board. Resident #11 has been escorted to the facility postings location to ensure they could read the posted documents.</p> <p>Current cognitively capable residents will be interviewed to determine if they can read the document postings. New document posting board has been installed to allow for wheelchair height document postings for all residents.</p> <p>Department Directors have been re-educated to ensure facility postings are at wheelchair accessible height by Center Executive Director or designee on or before 6/21/19.</p>		

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F 575	Continued From page 2 trouble reaching, or those with poor vision.	F 575	Any new facility postings will be reviewed for placement in morning management meeting. Center Executive Director or designee will randomly audit 3 residents to ensure Facility Postings are viewable. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved. Center Executive Director or designee will be responsible.		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		6/21/19	

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F 582	<p>Continued From page 3</p> <p>periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with an Advanced Beneficiary Notice at the initiation, reduction, or termination of their Medicare Part A</p>	F 582	<p>F582 Resident #19 was provided an Advanced Beneficiary Notice (ABN) and a chance to ask questions.</p>		

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F 582	Continued From page 4 benefits. This was true for 1 of 3 residents (Resident #19) reviewed for Advance Beneficiary Notice (ABN). This failure created the potential for residents to experience financial and psychological distress when residents were not informed of their potential liability for payment. Findings include: The facility's Advanced Beneficiary Notice policy, dated 3/30/18, directed facility staff to issue an ABN before services were delivered to inform the Medicare beneficiary or their responsible party that they were financially liable for the services. This policy was not followed. Resident #19 was admitted to the facility on 3/28/19, with multiple diagnoses including type 2 diabetes. Resident #19's census record documented his Medicare Part A benefits ended on 4/12/19 and he remained in the facility. His record did not include an ABN. On 5/23/19 at 7:51 AM, the Administrator Designee said Resident #19 was not given an ABN and said he expected staff to issue ABNs before Medicare coverage ended.	F 582	Current residents will be audited to determine if they require an upcoming ABN and one will be provided if needed. Department Directors will be re-educated on required Advanced Beneficiary Notice resident notification by Center Executive Director or designee on or before 6/21/19. Discussion of upcoming residents requiring an ABN will be conducted during morning Department Director meeting. Center Executive Director or designee will audit 3 residents to identify any residents requiring an Advanced Beneficiary Notification. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved. Center Executive Director or designee will be responsible.		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		6/21/19	

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F 623	<p>Continued From page 5</p> <p>language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p>	F 623			

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F 623	<p>Continued From page 6</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure</p>	F 623			

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F 623	<p>Continued From page 7</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a notice of transfer was provided in writing to residents and/or residents' representatives when residents were transferred to the hospital. This was true for 2 of 2 residents (#13 and #35) reviewed for transfer to the hospital. This failed practice had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's Discharge and Transfer policy, dated 2/1/19, documented when a resident was transferred or discharged from the facility, the resident and resident representative must be notified in writing and in a language and manner they understand.</p> <p>This policy was not followed.</p> <p>a. Resident #13 was admitted to the facility on 3/12/19, with multiple diagnoses, including hepatic (liver) failure.</p> <p>A transfer notice to the hospital, dated 3/2/19, documented Resident #13 was transferred to the</p>	F 623	<p>F623 Residents #13 and #35 received a written transfer notice.</p> <p>Cognitively capable Residents will be interviewed regarding the written transfer notice requirement and given opportunity to ask questions. Resident transfers for the past 30 days will be audited to ensure written notification was provided.</p> <p>Department Directors will be re-educated on written discharge and transfer notice requirements by Center Executive Director or designee on or before 6/21/19.</p> <p>Discharge and Transfer notices will be discussed and controlled during morning Department Director meeting.</p> <p>Center Executive Director or designee will audit 3 residents written discharge and transfer notice requirements. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance improvement committee</p>		

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F 623	Continued From page 8 hospital. The notice did not document the reason for the transfer and was not signed by the resident or the resident's representative. On 5/20/19 at 9:35 AM, Resident #13 stated she had been hospitalized in March or April because of a fall due to her ammonia levels. On 5/21/19 at 2:35 PM, the DON stated there was no proof the resident or resident representative received a written transfer notice. b. Resident #35 was admitted to the facility on 4/5/19, with multiple diagnoses, including neoplasm (mass of tissue) of the cecum (part of the large intestine). Resident #35's Progress Notes, dated 4/10/19, documented he was transferred to the hospital on 4/10/19 due to abdominal tenderness and liquid stool. Resident #35's record did not document he or his representative received a written transfer notice. On 5/24/19 at 8:34 AM, LPN #1 stated she called families about transfers but did not provide a written notification of transfers.	F 623	monthly X3 months or until substantial compliance is achieved. Center Executive Director or designee will be responsible.		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		6/21/19	

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F 625	<p>Continued From page 9</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a resident and/or a resident's representative was provided a bed hold notice when transferred to the hospital. This was true for 1 of 2 residents (Resident #35) reviewed for transfers. This failed practice created the potential for harm if residents were not informed of their right to return to their former room at the facility within a specific time and may cause psychosocial distress if not informed they may be charged to reserve their room. Findings include:</p> <p>The facility's Bed Hold policy, dated 1/1/19, directed staff to provide a bed hold notice to the resident and/or the resident's representative,</p>	F 625	<p>F625 Resident #35 has been provided with the bed hold notification documentation.</p> <p>Cognitively capable Residents have been interviewed about the Bed Hold policy and have had a chance to ask questions.</p> <p>The center nurse executive or designee reviewed the last 14 days of transfer/discharges for bed hold written notification. Residents identified as not having been notified will be provided written notification.</p> <p>Department Directors will be re-educated</p>		

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F 625	Continued From page 10 when transferred to the hospital. Resident #35 was admitted to the facility on 4/5/19, with multiple diagnoses, including neoplasm (mass of tissue) of the cecum (part of the large intestine). Resident #35's Progress Notes, dated 4/10/19, documented he was transferred to the hospital on 4/10/19 due to abdominal tenderness and liquid stool. Resident #35's record did not document he or his representative received a written bed hold notice. On 5/23/19 at 10:50 AM, the Medical Records Director stated she could not find documentation a bed hold notice was provided to Resident #35 or his representative. On 5/24/19 at 8:34 AM, the Social Services Designee stated she did not mail out a bed hold notice to Resident #35 or his family.	F 625	on Bed Hold policy notification requirements by Center Executive Director or designee on or before 6/21/19. In morning clinical meeting the director of social services will review residents pending discharge with the interdisciplinary team to ensure they were notified in writing. Center Executive Director or designee will audit 3 residents written bed hold notification documentation. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved. Center Executive Director or designee will be responsible.		
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 637		6/21/19	

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F 637	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, it was determined the facility failed to ensure a significant change of status assessment (SCSA) was completed within 14 days after a hospice revocation. This was true for 1 of 2 residents (Resident #13) reviewed for hospice. This had the potential for harm if facility staff did not recognize changes in the resident's health status and needs. Findings include:</p> <p>The October 2018 Resident Assessment Instrument Manual, page 2-23, documented, "A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD [assessment reference date] must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill."</p> <p>Resident #13 was admitted to the facility on 3/12/19, with multiple diagnoses, including encephalopathy (range of conditions that change brain function or structure).</p> <p>Resident #13's record documented an Admission Mimimum Data Set (MDS) assessment was completed on 3/19/19.</p> <p>Resident #13's Progress Notes, dated 4/3/19,</p>	F 637	<p>F637 Resident #13 had a significant change status assessment completed on 5/22/19.</p> <p>A review of all center residents was completed by Center Nurse Executive on 6/10/19 to ensure that any residents either placed on hospice services or removed from hospice services over the last 30 days had a significant change in status assessment completed within 14 days. Any residents found without a significant change in status assessment during this review will have one completed.</p> <p>The previous Clinical Reimbursement Coordinator is no longer with the company/facility. The New Clinical Reimbursement Coordinator was educated on completing a significant change in status assessment within 14 days of any residents going on hospice services or coming off hospice services by the Center Nurse Executive or designee on or before 6/21/19.</p> <p>Center Nurse Executive or designee will audit 3 residents to ensure that a significant change of status assessment was completed within 14 days on any residents that were started on hospice services or removed from hospice services. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be</p>		

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F 637	Continued From page 12 documented she was discharged from hospice services. Her record did not document a SCSA was completed. On 5/20/19 at 9:41 AM, Resident #13 stated she had been on hospice but had been discharged over a month ago. On 5/21/19 at 3:10 PM, the DON stated Resident #13 was discharged from hospice on 4/3/19. On 5/23/19 at 3:22 PM, the MDS Coordinator stated that a SCSA was not completed within 14 days of the date Resident #13 was discharged from hospice.	F 637	reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved. The Center Nurse Execute or designee is responsible for monitoring and oversight.		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		6/21/19	

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F 732	<p>Continued From page 13</p> <p>(ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident and staff interview, it was determined the facility failed to post the nursing staff information in an area accessible for residents, resident representatives, and visitors to view. This was true for 1 of 7 residents (Resident #11) in the Resident Group interview and had the potential to affect the remaining 31 residents in the facility. Findings include: The facility's Posting Staffing policy, revised 9/1/13, directed staff to display the information which was accessible to residents. This policy was not followed. On 5/20/19 at 7:00 AM and 1:52 PM and on 5/20/19 at 8:53 AM, the nursing staff posting information was hung on the bulletin board in the main hallway near the nurses' station. The</p>	F 732	<p>F732 Facility postings were lowered and posted to new a display board. Resident #11 has been escorted to view Posted Nurse Staffing info on the bulletin board to ensure they can adequately see the information.</p> <p>Cognitively capable Residents will be interviewed and informed about the Nurse Staff posting requirements and availability.</p> <p>Department Directors will be re-educated on the Nurse Staff posting requirements by Center Executive Director or designee on or before 6/21/19.</p> <p>New Nurse Staffing postings and Facility postings will be discussed and controlled</p>		

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F 732	Continued From page 14 information was printed on regular sized paper (8 1/2 X 11 inches) and posted with push pins which were 5 feet 11 inches from the ground. If a resident was in a wheelchair, the posting would be difficult to reach or see due to the height of the posting. On 5/21/19 at 2:03 PM, during the Resident Group interview and on 5/22/19 at 9:22 AM, Resident #11 said since she was in a wheelchair and had poor vision, it was difficult to reach and read the postings on the bulletin board because the information was too high. On 5/22/19 at 9:36 AM, the DON said the nursing staff posting was too high for someone in a wheelchair, someone who had trouble reaching, or those with poor vision.	F 732	during morning management meeting. Center Executive Director or designee will audit 3 residents to ensure Posted Nurse Staffing is viewable. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved. Center Executive Director or designee will be responsible.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		6/21/19	

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F 758	<p>Continued From page 15</p> <p>specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents behaviors were accurately monitored while receiving psychotropic medications. This was true for 1 of 12 residents (Resident #32) whose records were reviewed for psychotropic medications. This failure created</p>	F 758	<p>F758 Resident #32 was assessed by Center Nurse Executive or designee for adverse side effects from psychotropic medications on 6/10/19 with no adverse side effects noted.</p>		

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F 758	<p>Continued From page 16</p> <p>the potential for harm should residents experience adverse reactions or lack of efficacy from psychotropic medications. Findings include:</p> <p>The facility's Nursing Documentation policy, revised 3/1/16, documented nursing documentation was to be clear, pertinent, and accurate to communicate the patient's status and provide accurate accounting of care and monitoring provided.</p> <p>Resident #32 was admitted to the facility on 10/15/15, with multiple diagnoses, including dementia with psychosis.</p> <p>Resident #32's physician order, dated 4/16/18, documented she received Risperdal (antipsychotic medication) 0.25 mg (milligrams) three times a day (TID) for dementia with psychotic symptoms (mental illness characterized by a loss of contact with reality).</p> <p>Resident #32's monthly behavior monitoring sheets for July and August 2018 were blank. Her monthly behavior monitoring sheets documented two incidents of distressing delusions in September 2018 and two incidents of distressing delusions in October 2018.</p> <p>Resident #32's Psychiatric Progress Notes, dated 10/3/18, documented the physician was asked to see the resident to consider a gradual dose reduction of her order for Risperdal. The physician documented:</p> <p>* The resident continued to experience symptoms of irritability, agitation at times, and delusional thinking.</p>	F 758	<p>A review of center residents with psychotropic medications requiring behavior monitoring was completed by Center Nurse Executive or designee to ensure and behavior monitor documentation was accurate. Any residents found with discrepancies in their documentation will be assessed for adverse side effects from psychotropic medications and MD will be updated for any further follow up needed.</p> <p>Facility is stopping the practice of documenting behavior symptoms by exception only. Behavior documentation will to be done every shift.</p> <p>Staff responsible for behavior monitoring documentation will be educated on the requirements for documentation accuracy by the Practice Development Specialist or designee on or before 6/21/19.</p> <p>Staff responsible for communicating pertinent resident information regarding behavior monitoring to the MD will be educated on the requirements for accuracy per behavior monitor documentation by the Practice Development Specialist or designee on or before 6/21/19.</p> <p>Practice Development Specialist or designee will review behavior management monitoring policy with Medical Director and facility Psychiatrist on or before 6/21/19.</p>		

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F 758	<p>Continued From page 17</p> <p>* The resident had dementia with significant psychotic symptoms with ongoing periods of delusional thinking and distress related to those symptoms.</p> <p>* Dose reduction of Risperdal was clinically contraindicated due to the risk of decompensation of the resident's wellbeing.</p> <p>Resident #32's monthly behavior monitoring sheets from November 2018 through April 2019 were blank.</p> <p>Resident #32's Psychiatric Progress Notes, dated 2/11/19, documented, the physician was asked to see the resident to consider a gradual dose reduction of her order for Risperdal. The physician documented:</p> <p>* The resident continued to have periods of significant mood symptoms, irritability, anxiety, and approached the staff more than 40-50 times.</p> <p>* Dose reduction of Risperdal was clinically contraindicated due to the risk of exacerbation of her psychotic symptoms and the resident was still distressed by these symptoms.</p> <p>* The benefits of the Risperdal outweighed the risks.</p> <p>On 5/22/19 at 4:14 PM, LPN #2 stated the nursing staff documented behaviors monitored throughout their shift on the behavior monitor sheets.</p> <p>On 5/22/19 at 4:21 PM, LPN #3 stated the nursing staff documented the number of behavior episodes during the shift and any interventions tried for the target behaviors on the behavior monitoring sheets. LPN #3 stated if there were no target behaviors the sheet was left</p>	F 758	<p>Center Nurse Executive or designee will audit 5 residents to ensure the behavior monitors are accurate. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved.</p> <p>The Center Nurse Executive or designee is responsible for monitoring and oversight.</p>		

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F 758	Continued From page 18 blank. On 5/23/19 at 8:11 AM, the DON stated the facility staff charted behaviors by exception. If there were no behaviors, then she did not expect anything to be written down. On 5/24/19 at 8:18 AM, MD #1 (Medical Doctor) stated he did not generally look at residents' behavior monitoring sheets for accuracy. He said he relied on behavior symptom information verbally provided by the nurses and expected the staff to know what Resident #32's behaviors were like. On 5/24/19 at 9:37 AM, the DON stated she was not aware MD #1 only received verbal reports from nursing staff and did not review the behavior monitor sheets. The DON stated the nurses' verbal report to MD #1 should match the charting on the behavior monitoring sheets.	F 758			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, review of Resident Council minutes, resident interview, Resident Group interview, test tray evaluation,	F 804	F804 Resident #10, #11, #17, #27, #29 will be assessed by the center registered	6/21/19	

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F 804	<p>Continued From page 19</p> <p>and staff interview, it was determined the facility failed to ensure palatable food was served. This was true for 5 of 16 residents (#10, #11, #17, #27, and #29) reviewed for food and nutrition. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:</p> <p>The facility's Food and Nutrition policy, revised 6/15/18, documented foods were to be served at appropriate temperatures for palatability and have an acceptable taste.</p> <p>Resident Council minutes, dated 1/15/19 and 2/19/19, documented complaints of cold food. Resident Council minutes, dated 4/16/19, documented temperatures had improved and there were new complaints of food palatability.</p> <p>On 5/21/19 at 2:03 PM, during the Resident Group interview, Resident #29 said the food was often dried out and cold. Resident #11 said the vegetables were not flavorful.</p> <p>Residents were interviewed regarding the food served at the facility. Examples include:</p> <p>* On 5/20/19 at 9:30 AM, Resident #10 said the food sometimes did not taste good.</p> <p>* On 5/20/19 at 11:05 AM, Resident #27 said the macaroni and cheese was always dry.</p> <p>* On 5/20/19 at 11:35 AM, Resident #17 said sometimes the food was not very good.</p> <p>On 5/22/19 at 12:12 PM, two test tray lunch meals were evaluated for the regular and</p>	F 804	<p>dietitian or designee for adverse reactions related to food palatability concerns. Follow-up will be completed as indicated by the review.</p> <p>A meal service review and test tray will be completed by the regional dietary manager or designee to evaluate the nutritional value, appearance, and palatability of food. Follow-up will be completed as indicated by the review.</p> <p>A member of management staff will perform random audits of dining services to address any resident concerns including any issues with food palatability, nutritive value, or appearance of food.</p> <p>The dietary staff will be educated on food preparation, following menus, and measures that need to be taken to ensure that food is palatable, nutritious, and is well presented by the regional dietary manager or designee on or before 6/21/19.</p> <p>A monthly dining committee meeting will be held by the center dietary manager or designee and any residents who choose to attend to review meal service concerns including issues with palatability, nutritive value, and appearance, with follow-up completed as determined in the meeting.</p> <p>A dining audit will be completed 3 X a week by the center executive director or designee to ensure that food appearance and nutritive value are provided. 5 test</p>		

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

PRINTED: 06/27/2019
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 05/24/2019
NAME OF PROVIDER OR SUPPLIER SUNNY RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2609 SUNNYBROOK DRIVE NAMPA, ID 83686		
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F 804	<p>Continued From page 20</p> <p>alternate meals. The Food Service Supervisor (FSS) took the meals out of the portable food cart. (The food cart had divided sections of hot and cold chambers where meal tray items would be placed on either the hot or cold side of each tray and the tray would be inserted into the hot and cold chambers of the food cart to keep hot items hot and cold items cold.) The test trays were evaluated by two surveyors along with the FSS. The regular meal included macaroni and cheese which had a temperature of 102.3 degrees F (Fahrenheit) and the gluten free macaroni and cheese was 88.8 degrees F. The alternate meal included potato salad which had a temperature of 59.8 degrees F. The FSS said both samples of the macaroni and cheese were dry and cool, and the potato salad was too warm. The FSS said dietary staff must have placed the test tray in backwards where the hot food had been cooled down and the cold food had been heated up.</p> <p>On 5/23/19 at 8:13 AM, a test tray breakfast meal was requested. The egg and cheese biscuit had already been assembled with the egg and cheese sandwiched between the biscuit halves. The biscuit sandwiches were in a container on the steam table in the serve out kitchen.</p> <p>On 5/23/19 at 8:15 AM, the test tray was evaluated by two surveyors along with the FSS. The breakfast meal included an egg and cheese biscuit which was 117.6 degrees F. The FSS said the egg and cheese was cool and the biscuit was dried out.</p>	F 804	<p>trays will be tested by the center executive director or designee to ensure food palatability. These audits will be completed weekly X4 weeks and then monthly X 2 months. The results of these audits will be reported to the center QAPI committee for review and remedial intervention monthly X3 months or until substantial compliance is achieved.</p> <p>The center executive director or designee is responsible for monitoring.</p>		