



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

January 8, 2020

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 **December 18, 2019**, 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 an isolated 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** 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.

G. David Chinchurreta, Administrator  
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**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 **January 21, 2020**. Failure to submit an acceptable PoC by **January 21, 2020**, may result in the imposition of civil monetary penalties by **February 12, 2020**.

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 **January 22, 2020**, (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 **March 17, 2020**. A change in the seriousness of the deficiencies on **February 1, 2020**, may result in a change in the remedy.

G. David Chinchurreta, Administrator  
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The remedy, which will be recommended if substantial compliance has not been achieved by **January 22, 2020**, includes the following:

Denial of payment for new admissions effective **March 18, 2020**.  
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 **June 18, 2020**, 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 **December 18, 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:

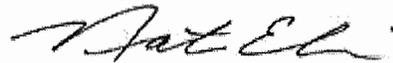
BFS Letters (06/30/11)

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

This request must be received by **January 21, 2020**. If your request for informal dispute resolution is received after **January 21, 2020**, 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: 12/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>SUNNY RIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2609 SUNNYBROOK DRIVE NAMPA, ID 83686</b>
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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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single-story type V (111) structure, originally constructed in 1989. There is a two-hour separation between the nursing home and abutting assisted living. The building is fully sprinklered, with an interconnected fire alarm/smoke detection throughout. There is an on-site, spark ignited, Emergency Power Supply System (EPSS) generator generator that provides backup emergency power. Currently the facility is licensed for 43 SNF/NF beds and had a census of 38 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on December 18, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000		
K 321 SS=D	<p><b>Hazardous Areas - Enclosure</b> CFR(s): NFPA 101</p> <p><b>Hazardous Areas - Enclosure</b> Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches</p>	K 321		

**RECEIVED**  
JAN 17 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>S. J. Chirchuneta, CFD</i>	TITLE	(X6) DATE <b>1-17-2020</b>
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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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K 321	<p>Continued From page 1 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms . b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure doors to hazardous areas were maintained to ensure separation of exposure to the corridor. Failure to ensure doors to hazardous areas such as the Laundry room, fully self-close and latch has the potential to allow fire, smoke and dangerous gases to pass into the corridor, affecting egress of the residents. This deficient practice affected 13 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/18/19 from 1:00 - 3:00 PM, observation and operational testing of the door from the corridor into the clean side of the Laundry, revealed the door was de-laminating and obstructed from fully self-closing as required, leaving a gap of approximately 3/8 inches, failing to ensure resistance to the passage of smoke. Interview of</p>	K 321	<p><b>K 321</b></p> <ol style="list-style-type: none"> <li>1. A new, approved fire-rated door has been ordered from Door Service of Idaho and will be installed upon delivery.</li> <li>2. 38 residents in the skilled unit have the potential to be affected by the deficient practice.</li> <li>3. The maintenance director will enter into our TELs system to review all fire rated doors to assure that they meet the fire-rated standard.</li> <li>4. Maintenance director will monitor any all doors on a regular random basis. He will report results to the Quality Assurance Performance Improvement Committee once per month for three months.</li> <li>5. Completion by 12/19/19</li> </ol>	

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K 321	Continued From page 2 the Maintenance Director at approximately 1:45 PM established he was aware of the door not fully self-closing.  Actual NFPA standard:  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. 19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. 19.3.2.1.3 The doors shall be self-closing or automatic-closing.	K 321		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		

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K 353	<p>Continued From page 3</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression system pendants free of obstructions such as paint or corrosion, has the potential to hinder staff response during a fire event. This deficient practice affected staff on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 12/18/19 from 1:00 - 2:00 PM, observation of the Laundry room revealed one (1) corroded fire suppression system pendant above the dryers and one (1) in the mop/chemical closet directly across from the dryers.</p> <p>Actual NFPA standard:</p> <p>5.2* Inspection. 5.2.1 Sprinklers. 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage</p>	K 353	<p><b>K 353</b></p> <ol style="list-style-type: none"> <li>Five affected sprinkler heads have been replaced by Viking Sprinkler Company on 1/13/2020..</li> <li>38 residents have the potential to be affected by the deficient practice.</li> <li>Maintenance director will systematically check all sprinkler heads for corrosion, leaking and other issues. Additionally Viking Sprinkler Company will be checking for these same issues upon their quarterly and annual sprinkler system checks.</li> <li>Maintenance director will monitor all sprinklers on a regular basis. He will report results to the Quality Assurance Performance Improvement Committee once per month for three months.</li> <li>Completion by 12/19/19</li> </ol>	

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K 353	Continued From page 4 (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer 5.2.1.1.3* Any sprinkler that has been installed in the incorrect orientation shall be replaced.	K 353		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101  Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure portable fire extinguishers were maintained in accordance with NFPA 10. Failure to install fire extinguishers at the appropriate height, has the potential to result in damage(s) to the extinguisher and/or hinder staff response during a fire event. This deficient practice affected staff on the date of the survey.  Findings include:  During the facility tour conducted on December 18, 2019 from 1:30 - 2:30 PM, observation of the installed portable fire extinguisher in the main Laundry revealed the top of the extinguisher was mounted at 66 inches when measured from the floor.  Actual NFPA standard:  NFPA 10 6.1.3.8 Installation Height.	K 355	K 355  1. Facility maintenance director has lowered the affected fire extinguisher to the required height of no more than 5 feet (1.53 m) above the floor.  2. 38 Residents have the potential to be affected by this deficient practice.  3. Maintenance director has checked all of the fire extinguishers to assure that they are at the required height.  4. Maintenance director will review and monitor randomly on an annual basis. Report will be given to the QAPI Committee at least annually by the maintenance director.  5. 12-19-19	

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

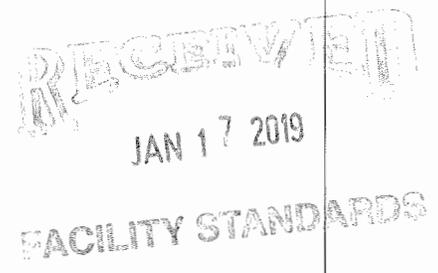
Printed: 12/31/2019  
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K 355	Continued From page 5 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor.  6.1.3.8.2 Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 31.2 ft (1.07 m) above the floor.	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single-story type V (111) structure, originally constructed in 1989. There is a two-hour separation between the nursing home and abutting assisted living. The building is fully sprinklered, with an interconnected fire alarm/smoke detection throughout. There is an on-site, spark ignited, Emergency Power Supply System (EPSS) generator generator that provides backup emergency power. Currently the facility is licensed for 43 SNF/NF beds and had a census of 38 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on December 18, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	C 000		
C 227	<p>02.106,01,a Structurally Sound, Maintained and Equiped</p> <p>01. General Requirements. General requirements for the fire and life safety standards for a health care facility are:</p> <p>a. The facility shall be structurally sound, maintained and equipped to assure the safety of patients/ residents, employees and the</p>	C 227		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *S. D. Chanchuneta, CED* TITLE: \_\_\_\_\_ (X6) DATE: *1-17-2020*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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C 227	Continued From Page 1  public.  This RULE: is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the facility was maintained to assure the safety of residents, employees and the public. Allowing access to areas under mold remediation and repair by residents, employees and the public, has the potential to increase exposure of those hazards to all occupants of the facility. This deficient practice affected 25 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey.  Findings include:  1) During review of provided maintenance and inspection records conducted on 12/18/19 from 8:45 - 11:00 AM, records indicated a mold identification and remediation project in three (3) resident room bathrooms' shower stalls, beginning December 10, 2019. Interview of the Maintenance Director conducted at approximately 11:15 AM established the facility became aware of a leak and problems in the shower stalls approximately one month prior to the date of the survey.  2) During the facility tour conducted on 12/18/19 from 11:00 AM - 3:00 PM, observation of resident room bathrooms revealed the following:  - Inspection of resident rooms 210 and 212 revealed both were directly accessible from the corridor by residents, staff and visitors. Each had active fans being used to dry areas of the bathroom shower stalls and an open wall cavity in the adjoining, separation wall. The open cavity showed direct evidence of a black substance on the back of the drywall and wood framing members.	C 227	C 227  1. Residents in room 215 were moved to another room on 12-19-19. Locks were installed on the main resident doors of rooms 201, 212, 215 to assure no residents, staff or visitors can enter rooms.  2. All residents in the skilled unit have the potential to be affected by the deficient practice.  3. Affected resident rooms will have locks installed to prevent any residents, staff or visitors from entering.  4. Maintenance director will monitor any affected rooms to assure proper locks are installed. He will report results to the Quality Assurance Performance Improvement Committee once per month for three months.  5. Completion by 12/19/19	

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:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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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) COMPLETE DATE
C 227	Continued From Page 2  - Inspection of resident room 215 revealed the shower stall in the shared bathroom, was open and accessible to the two (2) residents housed in the room, with an approximately 18 inch by 18 inch section of tile having fallen off the drywall and evidence of a black substance on the exposed drywall.  Further review of the provided lab testing documentation established all three locations had samples taken from these areas that tested positive for mold at what was documented as "High".  Actual IDAPA standard:  106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. a. The facility shall be structurally sound, maintained and equipped to assure the safety of patients/residents, employees and the public.	C 227		
C 228	02.106,01,b Barriers to Natural/Man-Made Hazards  b. Where natural or man-made hazards are present on the premises, the facility shall provide suitable fences, guards, and/or railings to isolate the hazard from the patient's/resident's environment.  This RULE: is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the facility was maintained to assure the safety of residents,	C 228		

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:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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C 228	Continued From Page 3  employees and the public. Failure to isolate inherent risks associated with mold remediation and repair projects to the resident environment, has the potential to increase exposure of those hazards to all occupants of the facility. This deficient practice affected 25 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey.  Findings include:  During the facility tour conducted on 12/18/19 from 11:00 AM - 3:00 PM, observation of resident room bathrooms revealed the bathrooms located in resident rooms 210, 212 and 215 were under repair for a mold remediation identified on 12/10/19 and were fully accessible by residents, staff and visitors. When asked at approximately 11:15 AM why the rooms had not been secured to prevent access by occupants to the areas under repair, the Maintenance Director stated he was not aware of the requirement to prevent access to these areas.  Actual IDAPA standard:  106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. b. Where natural or man-made hazards are present on the premises, the facility shall provide suitable fences, guards, and/or railings to isolate the hazard from the patient ' s/resident ' s environment.	C 228	C 228  1. 25 residents in the skilled unit had the risk isolated by facility placing locks on the affected resident rooms, including showers. Locks were installed on the main resident doors of rooms 201, 212, 215 to assure no residents, staff or visitors can enter rooms.  2. 25 residents, staff and visitors have the potential to be affected by the deficient practice.  3. Affected resident rooms will have locks installed to prevent any residents, staff or visitors from entering.  4. Maintenance director will monitor any affected rooms to assure proper locks are installed. He will report results to the Quality Assurance Performance Improvement Committee once per month for three months.  5. Completion by 12/19/19	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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

January 8, 2020

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 **December 18, 2019**, 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 an isolated 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 **January 21, 2020**. Failure to submit an acceptable PoC by **January 21, 2020**, may result in the imposition of civil monetary penalties by **February 12, 2020**.

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 **January 22, 2020**, (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 **February 22, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 22, 2020**, includes the following:

Denial of payment for new admissions effective **March 18, 2020**.  
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 **June 18, 2020**, 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 **December 18, 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:

<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

G. David Chinchurreta, Administrator

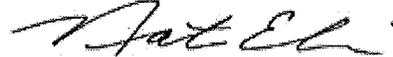
January 8, 2020

Page 4 of 4

This request must be received by **January 21, 2020**. If your request for informal dispute resolution is received after **January 21, 2020**, 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: 12/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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NAME OF PROVIDER OR SUPPLIER <b>SUNNY RIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2609 SUNNYBROOK DRIVE NAMPA, ID 83686</b>
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E 000	Initial Comments  The facility is a single-story type V (111) structure, originally constructed in 1989 and located within a municipal fire district, with both county and state EMS services available. There is a two-hour separation between the nursing home and abutting assisted living. The building is fully sprinklered, with an interconnected fire alarm/smoke detection throughout. There is an on-site, spark ignited, Emergency Power Supply System (EPSS) generator generator that provides backup emergency power. Currently the facility is licensed for 43 SNF/NF beds and had a census of 38 on the dates of the survey.  The following deficiencies were cited during the initial Emergency Preparedness Survey conducted on December 18, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	E 000		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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.*  (2) Include strategies for addressing emergency	E 006		

RECEIVED  
JAN 17 2019  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>S. D. Chenchuneta, CED</i>	TITLE	(X6) DATE <i>1-17-2020</i>
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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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E 006	<p>Continued From page 1 events identified by the risk assessment.</p> <p>*[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC 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, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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. (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.</p>	E 006	<p>E 006</p> <ol style="list-style-type: none"> <li>1. Facility has obtained a copy of the Canyon County Idaho Multi-Jurisdiction All Hazard Mitigation Plan and has used it to review and develop our facility current Hazard Vulnerability Analysis.</li> <li>2. 38 Residents and facility staff have the potential to be hindered in the EP relevant training of the areas identified by county EMS.</li> <li>3. The Canyon County Idaho Multi-Jurisdiction All Hazard Mitigation Plan will be used in developing and reviewing the facility Hazard Vulnerability Analysis during annual review of same.</li> <li>4. Maintenance director will review HVA annually with the assessment team using the Canyon County Idaho Multi-Jurisdiction All Hazard Mitigation Plan. Report will be given to the QAPI Committee at least annually by the maintenance director.</li> <li>5. 12-19-19</li> </ol>	

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E 006	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a Hazard Vulnerability Analysis (HVA) for the EP plan that considered a community based risk assessment such as a county all-hazard mitigation plan. Failure to consider available county hazard considerations when developing the facility EP HVA and relevant policies and procedures, has the potential to hinder the EP relevant training of staff ,by not fully addressing known hazards of the area as identified by county EMS. This deficient practice affected 38 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 12/18/19 from 8:45 - 11:00 AM, review of the provided emergency plan, policies and procedures, revealed the plan did not include documented information as defined under the county all-hazard mitigation plan, or a copy of the county plan. At approximately 11:15 AM, the Maintenance Director was asked if the facility had a copy of the county plan, or if it was used when developing the HVA. The Maintenance Director stated he was unaware if it was consulted and that the assessment was completed internally through facility management and staff.</p> <p>Reference: 42 CFR 483.73 (a) (1) - (2)</p>	E 006		
E 013 SS=D	<p>Development of EP Policies and Procedures CFR(s): 483.73(b)</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this</p>	E 013		

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E 013	<p>Continued From page 3 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 every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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 every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure policies and procedures were aligned with a community-based and facility-based HVA. Failure to develop policies and procedures based on relevant community risks, such as those identified in a county all-hazard mitigation plan, has the potential to confuse staff and result in irrelevant training on hazards that are not</p>	E 013	<p>E 013</p> <ol style="list-style-type: none"> <li>1. Facility has obtained a copy of the Canyon County Idaho Multi-Jurisdiction All Hazard Mitigation Plan and has used it to review and develop our facility emergency plan, policies and procedures.</li> <li>2. 38 Residents, staff and visitors have the potential to be affected by this deficient practice.</li> <li>3. The Canyon County Idaho Multi-Jurisdiction All Hazard Mitigation Plan will be consulted in developing and reviewing facility emergency plan and HVA.</li> <li>4. Maintenance director will review emergency plan and HVA annually with the assessment team using the Canyon County Idaho Multi-Jurisdiction All Hazard Mitigation Plan. Report will be given to the QAPI Committee at least annually by the maintenance director.</li> <li>5. 12-19-19</li> </ol>	

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

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E 013	Continued From page 4 consistent with the facility location. This deficient practice affected 38 residents, staff and visitors on the dates of the survey.  Findings include:  On 12/18/19 from 8:45 - 11:00 AM, review of the provided emergency plan, policies and procedures, failed to demonstrate the facility incorporated or consulted the county all-hazard mitigation plan when developing the required HVA, but used information as generated from internal staff and management team discussions.  Reference: 42 CFR 483.73 (b)  Additional Reference: E - 0006	E 013		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2)  *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]:  (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required	E 039		

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E 039	<p>Continued From page 5</p> <p>community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following</p>	E 039	<p>E 039</p> <p>1. Our facility staff and residents participated in an actual evacuation of the facility during a live fire event on 12/30/19 at 9:44am. The Nampa Fire Department responded with three fire trucks and numerous fire fighters. Brent Hoskins, Deputy Fire Marshal with the Nampa Fire Department, praised the facility staff for a rapid and efficient evacuation of the residents.</p> <p>2. 36 residents had the potential to be affected by this deficient practice.</p> <p>3. Facility will participate <sup>FWC</sup> in a full-scale <del>community-based exercise</del> every 2 years <sup>WITH ADMIN</sup> unless an actual natural or man-made emergency requiring the activation of the emergency plan occurs. <sub>1/27/20</sub></p> <p>4. Monitoring of the required community-based exercises will be accomplished by the maintenance director and he will report the results to the QAPI Committee at least annually.</p> <p>5. 12-30-19</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/18/2019</b>
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E 039	<p>Continued From page 6</p> <p>the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p>	E 039		

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E 039	<p>Continued From page 7</p> <p>(B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that</p>	E 039		

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E 039	<p>Continued From page 8</p> <p>is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem</p>	E 039			

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E 039	<p>Continued From page 9</p> <p>statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop</p>	E 039		

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E 039	<p>Continued From page 10</p> <p>exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, the facility failed to complete two (2) full scale drills as required. Failure to complete two full-scale exercises for the activation of the EP, has the potential to hinder staff performance during an actual emergency. This deficient practice affected 38 residents and staff on the date of the survey.</p> <p>Findings include:</p> <p>During review of the provided facility EP conducted on 12/18/19 from 8:45 - 11:00 AM, records demonstrated the facility had documented participation in 1 of 2 required full-scale events or exercises, that tested the</p>	E 039		

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E 039	Continued From page 11 effectiveness of the EP policies and procedures.  Reference: 42 CFR 483.73 (d) (1)	E 039		