STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36193 Based on observation, residents and staff interviews, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 2 of 14 residents (#94 and #96) observed in the main dining room and 1 of 7 (Resident #30) observed in the assisted dining room. This failure had the potential to cause a decrease in residents' sense of self-worth and psycho-social well-being. Findings include: 1. On 1/6/25, the following were observed in the Main Dining Room: a. Resident #7, Resident #9, and Resident #96 were seated at the same table. Resident #7 and Resident #9 were served their meal tray at 8:10 AM and 8:13 AM respectively and started eating. Resident #96 did not receive her tray until 8:29 AM (19 minutes from when the first meal was delivered to their table). b. Resident #93, Resident #94 and Resident #95 were seated at the same table. Resident #93 and Resident #95 were observed eating their meals at 8:21 AM. Resident #94 did not receive her meal tray. - at 8:50 AM, Resident #94 was heard saying to Resident #93 and Resident #95 Maybe I am getting my lunch. Resident #94 smiled at the surveyor and stated, Maybe they thought I am on a diet. - at 8:57 AM, CNA #1 stated she did not know why Resident #94's meal tray did not arrive. CNA #1 asked LPN #2 to get Resident #94's meal tray because she could not leave the dining room. - at 8:59 Resident #94 was served her meal tray (38 minutes from when Resident #93 and Resident #95 started eating). On 1/6/25 at 2:06 PM, the DON stated residents seated at the same table should be served their trays at the same time. She said there was a confusion in the dining room this morning. The DON stated the kitchen was told Resident #94 was not going to eat her breakfast, I don't know where that information came from. The DON stated she did not know why Resident #96 also did not receive her meal tray at the same time as Resident #7 and Resident #9. The DON stated we have been trying to place the residents' meal tray at the same order as they sat at the table. 50603 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 1/6/25, the following was observed in the Assisted Dining Room: -at 8:07 AM, 6 out of 7 residents were served and already eating their meals. Resident #30 was seated at the same table with Resident #17, had not been served her meal. -at 8:16 AM, Resident #30 received her meal (15 minutes after the meals were handed out to the other residents). On 1/6/25 at 8:58 AM, CNA #2 explained, Resident #30's meal tray was late because she had changed dining rooms over the weekend and the kitchen still had her registered at the Main Dining Room. The meal cart for the Main Dining Room is delivered 15 minutes after the assisted dining meal cart, so Resident #30 would receive her meal later. On 1/8/25 at 12:32 PM, the Dietary Director stated nurses will let the kitchen know when a resident changes dining rooms. The location is input into the residents' chart and the meal tickets are then printed out. If the meal is still going to the Main Dining Room, then the resident's chart has not been updated. On 1/9/25 at 2:51 PM, the Administrator and the Clinical Resource Nurse stated the kitchen was not made aware of the change over the weekend and they should have been input into Resident #30's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review and staff interview, it was determined the facility failed to ensure transfer notices were provided to the ombudsman. This was true for 1 of 2 residents (Resident #6) reviewed for transfers to the hospital. This deficient practice had the potential for harm if residents were not aware of or able to exercise their rights related to transfers. Findings include: The State Operations Manual, Appendix PP, revised on 8/8/24 documented, Before transfers or discharges of a resident, the facility must 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 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. Resident #6 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including end stage renal disease, diabetes, and congestive heart failure (a chronic progressive condition affecting the pumping power of the heart muscle). Resident #6's annual MDS assessment, dated 5/23/24, documented Resident #6 was cognitively intact. A review of Resident #6's medical record documented she had two unplanned hospitalization s on 10/26/24 and 12/14/24. Documentation of Ombudsman notification was not found. On 1/9/25 at 8:00 AM, the surveyor asked for copies of hospital transfer notification to the Ombudsman. On 1/9/25 at 11:23 AM, the Administrator stated the Ombudsman was not notified of Resident #6's transfers to the hospital and she should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to the residents or their representatives upon transfer to the hospital. This was true for 2 of 2 residents (#6 and #40) reviewed for transfer. This deficient practice created the potential for harm if residents were not informed of their rights to return to their former bed/room at the facility within a specified time. Findings include: The facility's Transfer or Discharge policy, dated 10/2022, documented a notice of facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer. 1. Resident #40 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including acute cholecystitis (inflammation of the gallbladder) and diabetes. A nursing progress note, dated 9/23/24 at 8:09 PM, documented Resident #40 complained of on and off abdominal pain for the past three days. Resident #40's representative stated the surgeon told her that if ever Resident #40 had abdominal pain or fever she was to go to the hospital. Resident #40's representative took Resident #40 to the hospital. A nursing progress note, dated 9/24/24 at 8:13 AM, documented Resident #40 was admitted to the hospital. Resident #40's record did not include documentation that a Bed Hold notice was provided to her or to her representative when she was admitted to the hospital. On 1/9/25 at 3:02 PM, the DON stated she was unable to find a Bed Hold notice was provided to Resident #40 or to her representative. When asked if Bed Hold notice should have been provided to Resident #40 or to her representative, the DON stated Yes Bed Hold notice should have been provided to Resident #40 or to her representative. 50603 2. Resident #6 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with multiple diagnoses including end stage renal disease, diabetes, and congestive heart failure (a chronic condition that occurs when the heart cannot pump enough blood to meet the body's needs). Resident #6's annual MDS assessment, dated 5/23/24, documented Resident #6 was cognitively intact. A review of Resident #6's medical record documented she had two unplanned hospitalization s on 10/26/24 and 12/14/24, as follows: a. A nursing progress report, dated 10/26/24, documented Resident #6 complained of increased pain and pressure to the area surrounding the colostomy. Resident #6 stated she felt more weak and shaky, and agreed to go to the ER (emergency room) for further evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospital report, dated 10/26/24, documented Resident #6 had an operation to incise and drain an abdominal wall abscess. b. A nursing progress noted, dated 12/14/24, documented Resident #6 approached facility staff and stated, I need to go to the emergency room , my ostomy site hurts really bad. The ostomy site was assessed and noted to have swelling and redness, tender to the touch. Resident #6 was transported to the hospital. A hospital report for 12/14/24 was not provided to surveyor upon request. There was no documentation Resident #6 or her representative was provided bed hold paperwork. On 1/9/25 at 11:23 AM, the Administrator stated bed hold paperwork was not provided to Resident #6 or her representative for either hospitalization , and it should have been provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 12 residents (Resident #16) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The Resident Assessment Instrument (RAI), revised 10/1/24, documents if a PASARR (Preadmission Screening and Resident Review) Level II determines a resident has a serious mental illness then section A1500 of the MDS should be marked yes. Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including dementia, PTSD (post traumatic stress disorder), and major depressive disorder. Resident #16's medical record documented a PASSAR level II, dated 1/11/22 and 6/17/22, was completed. Resident #16's admission MDS assessment, section A1500, dated 1/18/22, documented Yes, Resident #16 did have a PASSAR level II. Resident #16's annual MDS, section A1500, dated 12/23/22, 12/6/23, and 11/29/24 documented No Resident #16 did not have a completed PASSAR level II. On 1/8/25 at 2:30 PM, the MDS Coordinator stated Resident #16 had a PASSAR level II completed on 1/11/22. However, his PASSAR level II, dated 6/17/22 included an exemption that a level II was no longer needed, as he now only needs a PASSAR level I. The MDS Coordinator stated since Resident #16 no longer needed a PASSAR level II, she would not mark that in the MDS, and his original PASSAR level II would not carry forward. The MDS Coordinator verified Resident #16's admitting diagnoses had not changed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, record review and interview, it was determined the facility failed to ensure residents' medications were administered according to professional standards. This was true for 1 of 5 residents (Resident #17) observed during medication administration. This failed practice created the potential for Resident #17 to experience low or high blood sugar if she receives an incorrect amount of insulin. Findings include: Resident #17 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and stroke. A physician's order, dated 9/16/24 documented Resident #17 was to receive 12 units of Insulin Aspart subcutaneously (under the skin) one time a day related to diabetes. On 1/8/25 at 11:51 AM, LPN #1 took the Insulin Aspart pen, replaced the needle with a new one and dialed the pen to 12 units. LPN #1 then went to Resident #17's room and injected the Insulin Aspart to Resident #17's lower abdomen. LPN #1 was not observed to prime the insulin pen before dialing the prescribed dose of insulin for Resident #17. On 1/8/25 at 12:04 PM, when asked about the preparation of insulin pen injection, LPN #1 stated she did not prime the insulin pen. LPN #1 stated it was a quick pen and it does not need to be primed. The Insulin Aspart website, accessed on 1/14/25 stated, before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing perform an airshot (prime the needle).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review and staff interview, it was determined the facility failed to provide adequate supervision and functioning devices to prevent resident's fall. This was true for 1 of 3 residents (Resident #143) reviewed for accidents and falls. Resident #143 was harmed when he was being transported to the restorative dining room, and sustained a laceration on his head when he fell . Findings include: Resident #143 was admitted to the facility on [DATE] with multiple diagnoses including Parkinson's disease, heart disease, osteoarthritis, cognitive decline, and depression. An MDS significant change assessment, dated 4/16/24, documented Resident #143 was cognitively intact. Resident #143's care plan, initiated 10/12/22, documented Resident #143 was at risk for falls due to impaired mobility, Parkinson's disease, weakness, unsteady gait, medications, and poor safety awareness. Interventions included foot device to wheelchair for positioning, revised 3/21/24. This intervention was not followed. An I&A report, dated 5/2/25, documented Resident #143 was being transported to the restorative dining room. Resident #143 legs were out stretched from a seated position. Resident #143 suddenly dropped his feet to the floor, causing him to fall. His face hit the floor before CNAs were able to catch him. The report documented he was bleeding profusely from his head. EMS (Emergency Medical Services) was called and Resident #143 was transported to the hospital for treatment. A hospital report, dated 5/2/24, documented Resident #143 had a 3.5 centimeter laceration repair to his scalp, closed with 6 staples (a surgical staple used to close a wound), due to a fall from a wheelchair where he fell on to his knees and head. A facility incident investigation report, dated 5/8/24, documented a CNA stated Resident #143 had been transferred to the dining room without his foot pedals before without incident. The CNA stated Resident #143 had refused to use his foot pedals. There was no documentation in Resident #143's record that he had refused to use his foot pedals. On 1/10/25 at 10:26 AM, the Administrator stated Resident #143 had Parkinson's disease, and he did not like the foot pedals due to the jerking which caused him pain in the ankles and potential pressure ulcers. The Administrator stated the facility could have ensured wheelchair safety measures were followed such as going slower or using a wheelchair seatbelt while resident was in motion. The facility took the following actions in order: -The resident was transferred to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	-The State Agency Long Term Care portal was notified. -The physician was notified. -Resident #143's respresentative was notified. -Resident #143 was monitored for his injury. -Staff were interviewed. -The staff were educated regarding wheelchair safety: Proper transfer technique, ensuring proper fit and adjustments, navigating different terrains safely, preventing accidents and injuries, maintaining wheelchair stability, checking for wear and tear, and the importance of regular inspections. -The care plan was updated to ensure Resident #143's feet were on the padded pedals during wheelchair mobility, and if Resident #143 refused, to reapproach and encourage him to use the foot pedals during transport for safety. This finding represents past non-compliance with this regulatory requirement. Resident #143 had no falls since this incident, and no other incidents were found regarding other residents being injuried during transfer. At the time of the survey the facility was in substantial compliance and therefore does not require a plan of correction. There was sufficient evidence the facility corrected the non-compliance as of 6/8/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, review of the Incidents and Accidents (I&As) report, residents and residents' representatives interview, staff interviews, and residents' group interviews, it was determined the facility failed to ensure there were sufficient numbers of staff available at all times to provide nursing and related services to meet the residents' needs. This was true for 3 of 41 residents (#19, #30, and #36) reviewed for staffing concerns and had the potential to affect all residents in the facility. This deficient practice created the potential for physical and psychosocial harm if residents did not receive appropriate care or received delay of care. Findings include: a. Residents and their representatives were interviewed and stated the facility did not have sufficient staff to meet their needs. - On 1/6/25 at 11:16 AM, Resident #144's representative stated, Staff is good and care for residents, but during meal times there are not enough staff to respond to immediate needs and he is waiting for help if he needs it. - On 1/6/25 at 1:29 PM, Resident #34 who was cognitively intact according to her annual MDS assessment, dated 12/7/24, stated, They are short handed to get [her] ready for bed. They also take longer during meal times. - On 1/7/25 at 11:37 PM, Resident #5 who was cognitively intact according to her annual MDS assessment, dated 12/9/24, I don't have anyone come quickly with the call light when I need my depends changed. During meal times when I need help to poop, they won't help me as they need to pass meals. - On 1/7/25 at 2:30 PM, Resident #16's representative stated, I come at lunch and he is ready to get into bed. There is lot of lunch chaos and they aren't able to help [him]until after the lunch rush. - On 1/7/25 at 2:32 PM, Resident #95 stated she pressed her call light and waited. Resident #95 stated she was holding her bladder and when she was unable to hold it she urinated into her bed. b. A Resident Council Meeting was held on 1/7/25 at 9:37 AM. Ten residents attended the meeting. Seven residents stated it took up to an hour before their call lights were answered. One male resident stated, a 10 - 15 minute waiting time was reasonable. The male resident stated, It was so uncomfortable, I needed to be changed. A female resident verified she had to wait up to an hour before getting help. c. I&As documented the following incidents: 1. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including stroke and Parkinson's disease. An MDS assessment, dated quarterly MDS assessment, dated 11/20/24, documented Resident #19 was moderately cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An I&A report, dated 11/17/24 at 10:45 PM, documented Resident #19 was found on the floor of his room. When asked how he ended up on the floor, Resident #19 stated I crawled out of bed to get help. Resident #19 was found to be have been incontinent. An I&A report, dated 12/22/24, documented Resident #19 was found on the floor of his room. Resident #19 stated, I was trying to go to the bathroom. 2. Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including bladder disorder, asthma and bipolar disorder. A quarterly MDS assessment, dated 12/5/24, documented Resident #30 was cognitively intact. An I&A report, dated 12/17/24, documented Resident #30 was found on the floor of her bathroom. Resident #30 stated Had my call light on but nobody came and I was worried I would wet myself. Resident #30 stated she was needing to go to the restroom, but staff was not coming fast enough. 3. Resident #36 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, urinary tract infection and kidney failure. An MDS assessment, dated 11/5/24 documented Resident #36 was cognitively intact. A care plan, initiated 10/29/24, documented Resident #36 required one person assist for toileting. An I&A report, dated 12/22/24 at 7:00 PM, documented Resident #36 was found on the floor in his room. Resident #36 stated he fell when was walking back from the restroom. On 1/10/25 at 9:48 AM, the DON with the Clinical Resource Nurse stated the resident census is stable, so we keep the same number of staff for each of the shifts. We follow the PPD for staffing levels required in the facility. On 1/10/25 at 10:25 AM, the DON with the Clinical Resource Nurse stated she started in the position as DON about three weeks ago. The DON stated Resident #36 kept going to the restroom without using his call light for assistance. She stated the residents' care plan were updated to toilet them after meals and before laying down. When asked if staff were educated regarding residents' toileting program and what was done regarding residents' concerns about their call lights not being responded in a timely manner, the DON stated she would look for the documentation of education provided to the staff. On 1/10/25 at 11:41 AM, the DON with the Clinical Resource Nurse stated she was unable to find documentation staff were educated regarding residents' toileting program as indicated in their care plan. The DON also stated she could not find documentation other residents were interviewed regarding call lights waiting time when Resident #30 stated she had her call light on but nobody came and was worried she would wet herself, and toileted herself to the bathroom and fell . 50603

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and staff interview, it was determined the facility failed to ensure pharmacist recommendations were followed or addressed by the attending physician. This was true for 1 of 5 residents (Resident #31) whose pharmacist recommendation was reviewed. This deficient practice created the potential for Resident #31 to use unnecessary medications. Findings include: The facility's Medication Regimen Reviews (MRR) policy, reviewed 4/2024, documented the Consultant Pharmacist performs MRR for every resident in the facility receiving medication upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated. Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: Resident's Name, Name of Medication, The Identified Irregularity and The pharmacist recommendation. The attending physician documents in the medical record that the irregularity had been reviewed and what action was taken to address it. Resident #31 was admitted to the facility on [DATE], with multiple diagnoses including breast cancer and diabetes. A physician's order, dated 7/28/24, documented Resident #31 was to receive one milliliter of ABHR (Ativan, Benadryl, Haldol and Reglan) cream to her inner wrist three times a day related to anxiety disorder. A Pharmacy Consultation Report, dated 7/1/24 through 9/30/24 and 12/5/24 through 12/6/24, documented, Resident #31 receives an antipsychotic, haloperidol in ABHR, for potentially inappropriate indication: Anxiety. Anxiety is not an appropriate indication to give an antipsychotic in a skilled nursing facility. The Pharmacist requested for clarification for the indication for use or discontinue the use of haloperidol. The Pharmacy Consultation Report had a portion Physician Response with three options listed for the physician to choose from: 1. I accept the recommendation(s) above, please implement as written. 2. I accept the recommendation(s) above with the following modifications: 3. I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: The Pharmacy Consultation Report did not include a response from the physician regarding Resident #31's use of haloperidol in ABHR. On 1/9/25 at 4:09 PM, the DON stated she started in her position as DON about three weeks ago. The DON stated Resident #31 was a hospice resident and the Pharmacist recommendation should have been sent to the Hospice Physician as soon as it was received. She stated she did not know why the Pharmacist recommendation was not addressed by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review, review of facility policies and procedure, review of Incidents and Accidents (I&As), and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 3 of 3 residents (#4, #16, and #145) reviewed for medication administration. This failure created the potential for harm if the resident's medications were not administered according to the physician's order. Findings include: The facility's Administering Medications policy, revised 2/24, documented: -The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. -Medications are administered in accordance with prescriber orders, including any required time frame. The facility's Medication and Treatment Orders policy, revised 7/16, documented: -Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. 1. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including fibromyalgia (a chronic condition that causes widespread pain and tenderness in the muscles and soft tissues of the body), pain in the left shoulder, atherosclerosis (a hardening of the arteries), chronic fatigue, and hypothyroidism. A physician's order, dated 3/15/24, directed staff to give Oxycontin (opioid pain medication) ER (extended release) 80 mg two times per day. An I&A report, dated 4/9/24, documented Resident #4 accidentally received a second dose of Oxycontin on 4/8/24 after she had already taken her prescribed dosage. Resident #4 was monitored for signs and symptoms of overdose. The physician and family were notified. A nursing progress noted, dated 4/8/24 at 3:49 PM, documented Resident #4 had slight slow and slurred speech, but could response to questions appropriately. On 4/18/24, a competency assessment for the nurse who provided the second dose was completed. On 1/10/25 at 10:04 AM, the DON acknowledged the incident did happen, but she was not the DON at the time. She stated the two nurses involved in the incident were no longer employed in the facility. 2. Resident #145 was admitted to the facility on [DATE], with multiple diagnoses including COPD (chronic obstructive pulmonary disease), respiratory failure with hypoxia (low levels of oxygen in the body's tissues), and chronic kidney disease with heart failure. A physician's order, 3/29/24, documented Resident #145 was to receive the following medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Miralax 17 grams every day - Culterelle daily - Citracal/D3 - Vitamin C two times per day An I&A, dated 4/5/24, documented the facility did not administer Resident #145's Miralax, Culterelle, Citracal/D3, and Vitamin C as ordered by her physician. An undated handwritten note documented Hospice informed the facility on Tuesday Resident #145 did not receive her Miralax daily or three of her supplements. Hospice had faxed the orders to the facility, which were found in the staff's email from Monday. The orders were printed out and provided to the nurse who was directed to input the orders into Resident #145's record. On 4/4/24, physician orders for Miralax 17 grams every day, Culterelle daily, Citracal/D3, and Vitamin C two times per day were placed into Resident #145's medication orders. The I&A documented a staff inservice, dated 4/9/24, was provided regarding the facility's Medication and Treatment Order policy. On 1/10/25 at 10:00 AM, after reviewing the record with the DON, she stated Resident #145 did not receive the above medications as ordered. The DON stated she was not the DON at the time. She stated the nurse involved was no longer employed at the facility. 3. Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including dementia, PTSD (post traumatic stress disorder), and major depressive disorder. A physician's order, dated 10/7/24, directed staff to administer Resident #16 Clindamycin (antibiotic) HCL (hydrocloride) 300 mg four times per day for 10 days. An I&A, dated 10/8/24, documented the day shift nurse missed giving two doses of Clindamycin HCL 300 mg on 10/7/24, the physician was notified of the error. The nurse involved had their clinical competencies reviewed on 10/19/24. On 1/10/25 at 10:07 AM, the DON verified the error in medication administration for Resident #16 did happen, and due to the multiple medication errors , the nurse was no longer employed at the facility. The facility did the following: -Notified the residents' physician and/or representatives of the medication errors. -Corrected the error and monitored the residents' signs and symptoms. -Provided competency evaluations for the nurses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provided in-service trainings. -The staff involved were no longer employed at the facility. This finding represents past non-compliance with this regulatory requirement. Resident #4, #16, and #145 had no further medication errors since this incident. At the time of the survey the facility was in substantial compliance and therefore does not require a plan of correction. There was sufficient evidence the facility corrected the non-compliance as of 11/19/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on observation, policy review, Food Code review, and staff interview, it was determined the facility failed to ensure the kitchen equipment and environment was maintained, clean, and food was stored in a safe and sanitary manner. These deficiencies had the potential to affect the 41 residents who consumed food prepared by the facility. This placed residents at risk for potential food contamination and adverse health outcomes, including food-borne illnesses. Findings include: 1. Food Receiving and Storage: The FDA Food Code Section ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food documented, Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. The FDA Food Code Section ,d+[DATE].17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, documented, Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. The Facility's Food Receiving and Storage policy, dated 2001, documented: . -Staff to label and date (use by date) dry foods that are removed from original packaging and stored in bins. -All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). -Functioning of the refrigeration and food temperatures are monitored daily, and at designated intervals throughout the day by the food and nutrition services manager or designee, and documented according to the state-specific requirements. -Refrigerators must have working thermometers and are monitored documented for temperature according to state-specific guidelines. On [DATE] at 7:35 AM, the following was observed with the Dietary Director: -The temperature log on the resident snack and personal refrigerator and freezer was incorrectly dated and did not have daily temperatures recorded. -The following items were opened and undated in the dry storage area: mashed potato flakes, steel cut oats, Panko breadcrumbs, packaged rice, corn starch, Oreo cookie crumbles, and grape juice mix. -Spices were expired: hot sauce (expired [DATE]), dry pepper (expired [DATE]), poultry seasoning ([DATE]). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Large plastic bins containing white substances were not labeled with item or use by date. -Mixed vegetables in the refrigerator were opened and undated. On [DATE] at 7:45 AM, the Dietary Director stated she was unaware why there were opened, undated, and expired packages of food and spices in the dry food pantry. She stated food labels and dates are normally placed on the plastic food bins. The Dietary Director stated her staff was trained to label and date opened food items, and she did not know why they were not doing it. On [DATE] at 3:15 PM, a follow-up kitchen inspection was conducted with the Dietary Director. The following was observed: -Expired spices were stored in the food preparation station: cloves (expired [DATE]), pepper (expired [DATE]), white pepper (expired [DATE]), chicken flavor (expired [DATE]), and thyme (no date). -Opened, undated, and an iced covered package of hot dogs on the shelve directly under the freezer condenser. -Breaded chicken patties were opened and undated. -Ranch dressing, salad mix, and mixed vegetables in the refrigerator were opened and undated. -The temperature log on the resident snack and personal refrigerator and freezer was incorrectly dated and did not have daily temperatures recorded. On [DATE] at 3:30 PM, the Dietary Director stated she was unaware why there were expired spices in the cook's area, or why the foods were not dated and labeled. She stated all staff receive food services training and should know how to date food and throw away expired spices. At 3:50 PM, in a joint interview with the DON and Dietary Director, neither could verify who was supposed to be recording the temperatures on the resident refrigerator, but acknowledged someone should be doing it. 2. Cleaning, Sanitation, and Food Shelves: The FDA Food Code Section ,d+[DATE].12 documented packaged food may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, or container or its positioning in the ice or water. The FDA Food Code Section ,d+[DATE].11(A) documented food should be protected from contamination and stored in a clean, dry location where it was not exposed to splash, dust, or other contamination; and at least 6 inches above the floor. The FDA Food Code Section ,d+[DATE].12 Cleaning, Frequency and Restrictions, documented cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The FDA Food Code Section ,d+[DATE].14 (A) documented cleaning ventilation systems intake and exhaust air ducts shall be cleaned so they are not a source of contamination by dust, dirt, and other materials. The facility's Sanitization policy, revised [DATE], documented all equipment, food contact services and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. When cleaning fixed equipment (which cannot be immersed in water), the removeable parts are washed, sanitized, and non-removable parts cleaned with detergent and hot water, rinsed, air-dried, and sprayed with a sanitizing solution (at the effective concentration). The facility's Food Receiving and Storage policy, dated 2001, directed staff to: -Food in dry storage areas must be kept at least 6 inches off the floor. On [DATE] at 7:35 AM, an initial kitchen inspection was conducted with the Dietary Director. The following was observed: -Ice build-up from condensation in the freezer created water droplets that covered two boxes of unopened sausages. -Dust build-up, with large particles, were accumulated on the refrigerator fan covers. On [DATE] at 3:15 PM, a follow-up kitchen inspection was conducted with the Dietary Director. The following was observed: -Dish cloth sanitization buckets located in the ware washing room were noted to be less than 50 parts per million. -Dust was accumulated on the shelves near the oven where dried cooking sheets were stored. -Dust build-up, with large particles, were accumulated on the refrigerator fan covers. -Ice build-up from condensation in the freezer created water droplets that covered two boxes of unopened pork sausages. -Opened, iced covered package of hot dogs on the shelve directly under the freezer condenser. -A shelf in the dry food pantry, storing various dried foods, measured 4 inches from the floor. -Resident snack refrigerator had a burnt-out light bulb, and the door shelf was cracked. The handle to the refrigerator door was missing. On [DATE] at 3:15 PM, Dietary Aid #1 stated he changes the dish sanitization buckets every shift, and he was unaware it needed to be done more frequently. The Dietary Director clarified sanitation buckets are normally monitored and changed at least every three hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:30 PM, the Dietary Director stated equipment storage shelves are deep cleaned at least one time per month. She did not have a record when the shelves had last been cleaned. Additionally, the Dietary Director stated the condenser fans in the freezer and refrigerator are cleaned and maintained by Maintenance. She was not sure when they had last serviced them but believed it to be within the previous month. The Dietary Director verified the shelf in the food pantry should be at least 6 inches off the floor. On [DATE] at 10:37 AM, the Administrator stated there were no maintenance requests for the freezer fan cleaning, or freezer, and resident fridge repairs. The facility was not aware of when the freezer and refrigerator fans were last cleaned. At 11:47 AM, the Administrator and Dietary Director provided the temperature logs for [DATE], but were unable to find additional temperature logs for the previous months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review, observation, and staff interview, it was determined the facility failed to ensure infection control prevention were maintained to provide a safe and sanitary environment. This was true for 1 of 1 resident (Resident #144) observed for infection control. This failure created had the potential to impact all residents in the facility by placing them at risk of infection. Findings include: The CDC (Center for Disease Control and Prevention) website, updated 7/12/22 and accessed on 1/14/24 stated, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices regardless of MDRO (Multiple Drug Resistant Organism) colonization status. Resident #144 was admitted to the facility on [DATE] with multiple diagnoses including stroke. An EBP signage was observed outside Resident #144's door directing provider and staff to wear gloves and gown during device care or use: central line, urinary catheter, feeding tube and tracheostomy (a surgical procedure that involves creating an opening in the neck to access the trachea or windpipe). A physician's order documented Resident #144 was on NPO (nothing per mouth). Resident #144's care plan, initiated 12/19/24, documented he had an enteral feeding tube (a way to deliver liquid nutrition through a flexible tube to your digestive system). On 1/9/25 at 8:51 AM, RN #1 was observed to administer Resident #144's crushed medication one at a time via Resident #144's enteral tube with gloves on. RN #1 was not wearing a protective gown while administering Resident #144's medications. On 1/9/25 at 10:18 AM, RN #1 stated she did not wear a protective gown when she administered Resident #144's medications and she should wear one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135102	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Ridge	2609 Sunnybrook Drive Nampa, ID 83686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on record review and interview, the facility failed to ensure influenza vaccine was administered to a resident who consented to receive the vaccine. This was true for 1 of 5 residents (Resident #39) reviewed for immunizations. This deficient practice created the potential for harm should Resident #39 acquire, transmit, or experience complications from influenza. The facility's Infection Prevention and Control Program (IPCP) policy, revised 2018, documented an IPCP was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy stated immunization was a form of primary prevention and widespread of use of influenza vaccine in the nursing facility was strongly encouraged. Resident #39 was admitted to the facility on [DATE], with multiple diagnoses including hypertension and osteoporosis (a condition that causes bones to gradually thin and weaken). Resident #39's Immunizations record, documented she received the Influenza vaccine on 9/8/22. An Immunization Consent, dated 12/9/24, documented Resident #39 consented to the administration of the Influenza vaccine. On 1/8/25 at 12:13 PM, the DON, who was also the Infection Preventionist, stated the vaccinations were offered to the resident upon their admission to the facility. The DON stated she did not know why the Influenza vaccine was not administered to Resident #39.