NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Sunny Ridge	RC-1260	2609 SUNNYBROOK DR	208-467-7298
Administrator	City	Zip Code	Survey Date
Victoria Ellis	NAMPA	83686	07/03/2024
Survey Team Leader	Survey Type		Response Due
McClenathan, Teresa	health care licensure and follow-up		08/02/2024

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of four employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. Upon interview with the administrator and human resources director, it was confirmed the Department Criminal History and Background Check was not completed.
2	.009.06.c. Use of Previous Criminal History and Background Check.	One of one employees, whose files were reviewed and required an Idaho State Police background check, did not have the check completed prior to working alone with residents. The facility administrator and human resources director confirmed the Idaho State Police background check result was still pending at the time of survey, and the employee had been working alone with residents.
3	.215.01. Administrator Responsibility.	The administrator did not ensure all facility policies were developed to fulfill IDAPA16.03.22. The facility's abuse/neglect/exploitation policy did not include how allegations of abuse, neglect or exploitation would be reported. The policy did not include definitions of abuse, neglect nor exploitation as outlined in IDAPA rule; how residents, family, outside services or other visitors will be educated on how to identify abuse, neglect and exploitation; how residents, family, outside services and others will be

		educated to report abuse, neglect and exploitation nor directions for reporting in the event the administrator/designee is the alleged perpetrator. The policy did not include directions for the administrator and/or mandatory reporter to immediately report all allegations to adult protection and include the number to local adult protection office; direction to contact law enforcement within 4 hours in the event the alleged abused includes; sexual assault or results in serious physical injury, which the jeopardizes the life, health or safety of the resident with the phone number to local law enforcement and to call 911 immediately in the event of an emergency. The policy did not include how the facility would document allegations. For example, reports of abuse; notification of law enforcement; steps taken to investigate the allegation; measures to prevent recurrence nor how all documentation related to complete the investigation will be stored. The policy did not include how allegations of abuse, neglect or exploitation would be investigated. For example, the steps the administrator would take such as interviewing the victim and witnesses, how others with knowledge might be identified nor describing the various conclusions the administrator may reach. The policy also did not describe specific steps the facility would take to restrict access of the perpetrator being a staff/resident/visitor to any alleged victim and other potential victims during an investigation, steps that would be taken to restrict access if the perpetrator is a visitor nor what interventions would be taken to reduce the likelihood of future similar events from occurring. The facility was previously given technical assistance on the abuse policy on October 7, 2022.
4	.250.09. Plumbing.	The facility's water temperatures were not consistently maintained between 105 and 120 degrees F. On 7/1/24 and 7/2/24, the water temperature in several resident rooms, located in all hallways of the facility, were observed to range

		from 131 degrees F to 137 degrees F. The maintenance person stated he was unaware the water temperatures were this high.
5	.260.06. Housekeeping and Maintenance Services.	The facility was not maintained in a clean, safe and orderly manner. For example: The tile around the shower room door jamb was observed to be cracked and chipped; the countertops of the nurse's station was observed to be chipped and missing areas of laminate, with a large gouge along the wall. Two corners of baseboards were observed to be separating, and there was a strong odor of urine was evident in a resident's room, which could be smelled throughout the hallway. All three exit doors were observed to be scratched and gouged.
6	.319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.	Resident #2 did not have a comprehensive assessment, including a nursing assessment, completed prior to being admitted to the facility on 3/2/23. The administrator stated the comprehensive assessment was not completed for this resident.