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	01/23/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to help in developing an advance directive for health care decisions. This was true for 1 of 7 residents (Resident #18) reviewed for advance directives. This deficient practice created the potential for harm if residents' instructions for their healthcare were not followed in the event of a life-threatening outcome. Findings include:Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including right side paralysis following a heart attack, Parkinson's Disease, cognitive communication deficit, depression, and anxiety. A Comprehensive MDS assessment dated [DATE] documented Resident #18 was cognitively intact.A record review of Resident #18's Progress Notes did not document he was offered the opportunity to create an advanced directive.Resident #18's IDT Care Conferences dated 4/17/25, 5/15/25, 7/28/25, 9/17/25, and 12/16/25 did not document that Resident #18 was offered information to formulate an adavanced directiveOn 1/22/26 at 11:22 AM, the Administrator confirmed there was no documentation Resident #18 was provided information to formulate an advanced directive.

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.

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

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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** Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected resident's status. This was true for 2 of 13 residents (#3 and #6) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if the resident was not assessed and/or monitored due to inaccurate assessments. Findings include:1. Resident #3 was initially admitted to the facility on [DATE] and readmitted on [DATE] after a short hospital stay with multiple diagnoses including schizophrenia - bipolar type and anxiety.Resident #3's Significant Change MDS assessment dated [DATE], documented under A1500 in Section A, no for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? However, there was a PASRR level II documented in her electronic medical record, dated 9/14/25.On 1/21/26 at 3:24 PM, the MDS Coordinator #2 stated Resident #3's Significant Change MDS assessment was coded that the resident did not receive a PASRR Level II, and it should have been coded yes.2. Resident #6 was admitted to the facility on [DATE] with multiple diagnoses including end stage renal disease with dependence on dialysis.Resident #6's Quarterly MDS assessment dated [DATE], documented under section H-A, a response of yes for the question, Indwelling catheter. On 1/20/26 at 10:40 AM, observed Resident #6 in her room and she did not have a foley catheter. On 1/21/26 at 3:20 PM, the MDS coordinator #2 stated Resident #6's Quarterly MDS dated [DATE] was coded that she had a foley catheter in error.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure comprehensive resident centered care plan included the care and services for their toenails. This was true for 1 of 13 residents (Resident #32) whose comprehensive care plan was reviewed. This deficient practice created the potential for Resident #32 to receive inadequate or inappropriate care. Findings include: Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including stroke with hemiplegia and hemiparesis (paralysis and weakness on one side on the body).A Comprehensive MDS assessment dated [DATE], documented Resident #32 was dependent on staff for her activities of daily living.Resident #32's ADLs care plan, revised 12/15/25 did not include care for her toenails.On 1/21/26 at 9:44 AM, Resident #32's toenails were observed with the ADON. The ADON was asked to describe Resident #32's toenails. The ADON stated it looked like Resident #32 might have fungal infection on her toenails, brittle, thick and of off color. When asked what he meant of off color, the ADON stated it was brownish in color.On 1/21/26 at 9:56 AM, the ADON reviewed Resident #32's care plan and stated he did not see the condition of her toenails were addressed in her care plan. The ADON stated Resident #32's care plan should have included the care for her toenails.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, it was determined the facility failed to ensure residents who were dependent on staff for activities of daily living assistance received services for their toenails. This was true for 1 of 1 resident (Resident #32) reviewed for nail care. This placed Resident #32 at risk of embarrassment which could affect her socially due to the appearance of her toenails. Findings include: Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including stroke with hemiplegia and hemiparesis (paralysis and weakness on one side on the body).A Comprehensive MDS assessment dated [DATE], documented Resident #32 was dependent on staff for her activities of daily living. On 1/20/26 at 3:34 PM with CNA #1 present, Resident #32's toenails were observed to be thick and whitish to yellowish in color.On 1/21/26 at 9:44 AM, Resident #32's toenails were observed with the ADON. The ADON was asked to describe Resident #32's toenails. The ADON stated it looked like Resident #32 might have fungal infection on her toenails, brittle, thick and of off color. When asked what he meant of off color, the ADON stated it was brownish in color. The ADON stated a Podiatrist visits the facility to look after the residents' toenails. When asked if Resident #32 was seen by the Podiatrist, the ADON stated he would find out and let the Surveyor know.On 1/21/26 at 12:42 PM, the ADON stated the Podiatrist visits the facility every three months and was last at the facility on 11/6/25. When asked if Resident #32 was seen by the Podiatrist, the ADON stated she was not seen by the Podiatrist. When asked why Resident #32 was not referred to the Podiatrist, the ADON was unable to provide an answer. When asked if Resident #32 should have seen by the Podiatrist, the ADON stated, Yes, she should have been referred to the Podiatrist.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 13 residents (Resident #49) reviewed for standards of practice. Resident #49's psychotropic medication was not clarified for its indication of use. These practices had the potential to adversely affect or harm residents whose care and services were not delivered to accepted standards of clinical practice. Findings include:Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, protein calorie malnutrition, and dysphagia (difficulty swallowing).A Hospital Progress Note dated 12/12/25, documented Resident #49 underwent a procedure for gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach, used to provide nutrition) placement.A Hospital Discharge Summary Note dated 12/19/25, documented Concerned lack of sleep and depression as cause as [Resident #49] has increased stress and sleep difficulties with ongoing medical issues. Psychiatry was consulted, [Resident #49] was started on Mirtazapine (antidepressant) nightly.Resident #49's January 2026 MAR, documented she received Mirtazapine 7.5 mg via her G-tube at bedtime for appetite stimulant.On 1/21/26 at 1:10 PM, the DON reviewed Resident #49's hospital progress notes and stated Resident #49's Mirtazapine was for her insomnia and depression.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined the facility failed to ensure residents were adequately assessed for their dietary needs and provided their nutritional needs as ordered by the physician. This was true for 1 of 4 residents (Resident #32) reviewed for weight loss. Resident #32 had the potential for harm when she experienced a 5% weight loss in 30 days. Findings include: Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including stroke with hemiplegia and hemiparesis (paralysis and weakness on one side on the body), dysphagia (difficulty swallowing), hepatitis C and alcohol abuse.A physician's order dated 12/31/25, documented Resident #32 was to be served with regular diet: mechanical soft texture, regular consistency, no plain eggs, bacon or milk products, extra gravy, sauces, yogurt to breakfast tray, ice cream to lunch or dinner tray.A Dietary Profile dated 10/2/25, documented Resident #32's preferred orange juice for her beverage. The dietary profile did not document what she likes and dislikes to eat.A Skin & Weight Note dated 10/30/25, documented Resident #32 had significant weight loss of 5% since her admission to the facility. Her oral intake was 26 -75%. The physician and dietitian were notified of Resident #32's weight loss. The dietitian recommended to add strawberry health shake two times a day to Resident #32's lunch and dinner trays, appetite stimulant was increased on 10/21/25.A Skin & Weight Note dated 11/6/25, documented Resident #32 had significant weight loss of 5% in 30 days. The physician and dietitian were notified of Resident #32's weight loss. The Skin & Weight Note documented the following interventions: regular diet, pureed texture with extra gravy and sauces. Add yogurt to breakfast tray and ice cream to lunch or dinner tray, health shake two times a day strawberry, appetite stimulant increased on 10/21/25.A Skin & Weight Note dated 12/18/25, documented Resident #32 had significant weight loss of 6% in one month. Resident #32 weight continued to drop which was unavoidable due to her disease progression. Her intake was poor to fair but does usually drink a health shake. Resident #32's representative declined for her to have an enteral nutritional support and would like to do comfort measures at this time. Weight was stable since last review.Resident #32 was observed eating in the Restorative Dining Room on:1/20/26 at 12:16 PM, there was no ice cream or health shake observed on her lunch tray.1/22/26 at 8:15 AM, there was no yogurt or health shake observed on breakfast tray.On 1/22/26 at 11:00 AM, Resident #32 was lying in her bed, when asked what she likes to eat, she stated she likes peanut butter. When asked what else she would like to eat, Resident #32 closed her eyes.On 1/22/26 at 1:24 PM, the DM stated Resident #32 used to be served with milk shakes, yogurt and ice cream, but on 12/31/25 she received a communication note from the Speech Language Therapist which documented no eggs, no bacon, no milk products. The DM stated they were told Resident #32 had diarrhea with milk products. The DM stated Resident #32 was not served with health shake as it was milk based. When asked if the facility had non-dairy products supplements for their residents who required it, the DM stated, No. When asked if she informed her supervisor regarding the unavailability of non-dairy products in the facility, the DM stated she did not inform the Administrator. When asked if she should have informed the Administrator regarding the unavailability of non-dairy products in the facility, the DM stated, Yes, I should have informed the Administrator.The DM was also asked regarding Resident #32's Dietary Profile dated 10/2/25, which did not document Resident #32's likes and dislikes to eat. The DM stated sometimes residents were unable to give an answer. When asked if she asked Resident #32's representatives of her likes and dislikes to eat. The DM stated she did not ask Resident #32's representative.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were not expired and kept in a temperature-controlled environment; this was true for 2 of 2 medication carts and 1 storage room observed. This failure created the potential for residents to receive medications with decreased efficacy. Findings include:The facility's Medication Labeling and Storage policy revised 2/2023, documented: If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.1. On 1/22/26 at 8:00 AM, the East Hall medication cart was inspected with LPN #1 present. The following medications were observed:One tube of Glucose Gel 15 mg, expired 4/25One bottle of Aspirin 81 mg, expired 10/25One bottle of Fexofenadine HCl 60 mg, expired 11/25One bottle of TUMS, expired 12/25One bottle of Vitamin D 1,000 (10mcg), expired 12/25One bottle of Aspirin 325 mg, expired 12/25One bottle of Gen-dryl (diphenhydramine) 25 mg, expired 12/25On 1/22/26 at 8:05 AM, LPN #1 stated, she did not know who was responsible for making sure medications were not expired in her medication cart. 2. On 1/22/2026 at 8:10 AM, the [NAME] Hall medication cart was inspected with RN #1 present. The following medications were observed:One bottle of Zinc 50 mg, expired 11/25One bottle of Aspirin 325 mg, expired 12/25One bottle of Vitamin E 180 mg, expired 12/25On 1/22/2026 at 8:20 AM, RN #1 stated he was unsure of who was responsible for ensuring the medications were not expired in his medication cart.3) On 1/22/26 at 8:30 AM, the facility's medication storage room was inspected with RN #1 present. One bottle of Zinc 50 mg was observed expired 11/25.On 1/23/26 at 1:05 PM, the DON stated the expired medications in the medication carts and the medication storage room should have been removed by the nursing staff.4) On 1/22/26 at 8:35 AM, the facility's medication storage room was inspected with the ADON present. The following refrigerator temperature logs had not been updated since 1/18/26 morning shift:specimen refrigeratorvaccine refrigeratormedication refrigeratorOn 1/22/26 at 8:40 AM, the ADON confirmed the temperatures had not been checked since the morning of 1/18/25. The ADON also stated the temperature logs for the refrigerators are the responsibility of the cart nurse to check and record every shift.

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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. Based on observation, the SOM Appendix PP, review of the FDA Food Code, and staff interview it was determined the facility failed to provide a clean and sanitary environment required for food safety, as well as cleaning and sanitizing dishes used by facility residents. This was true for 31 of 32 residents who received food prepared by the facilities kitchen. These deficient practices created the potential for harm by placing residents at risk for potential foodborne illnesses and adverse health outcomes. Findings include:1. The FDA Food Code Section 2-402.11 Effectiveness documented, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens.On 1/20/26 at 8:15 AM, during an initial observation of the facility kitchen Dietary Aide #1 was observed walking through the kitchen without wearing a hair net.On 1/20/26 at 8:18 AM, Dietary Aide #1 stated he should have been wearing a hair net while walking through the kitchen.2. The FDA Food Code Section 3-401.11 Raw Animal Foods, documented raw animal foods such as eggs shall be cooked to heat all parts of the food to a temperature of 145 degrees F for 15 seconds for raw eggs that are broken and prepared for immediate service.The FDA Food Code Section 3-501.19 Time as a Public Health Control, documented a food establishment serving a highly susceptible population may not use time for hot holding foods for 4 hours as the public health control for raw eggs.On 1/22/26 at 7:36 AM, [NAME] #1 was observed frying eggs on the griddle, removing them without checking a temperature, with visibly runny yolks.On 1/22/26 at 8:10 AM, [NAME] #1 confirmed he was using unpasteurized eggs to make over easy eggs, stating yolks are served runny.On 1/22/26 at 8:12 AM, the DM stated eggs should not be served over easy.At 8:54 AM, the last of the resident's breakfast food trays were delivered. The over easy eggs were not served for immediate service.3. The FDA Food Code Section 4-302.12 Food Temperature Measuring Devices documented the presence and accessibility of food temperature measuring devices is critical to the effective monitoring of food temperatures. Proper use of such devices provides the operator or person in charge with important information with which to determine if temperatures should be adjusted or if foods should be discarded.On 1/22/26 from 7:15 AM through 8:45 AM, food temperatures for the steamtable foods were not observed being taken or recorded, when [NAME] #1 added more hashbrowns to the serving line.On 1/22/26 at 7:50 AM, [NAME] #1 stated he recorded the temperatures and kept the measurements in his mind, recording them at the end of tray line service.On 1/22/26 at 7:52 AM, the DM stated temperatures should be taken and recorded prior to tray line service.4. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented surfaces of equipment contacting food that is not time/temperature controlled for food shall be cleaned. On 1/22/26 at 8:12 AM, [NAME] #1 was observed using a dry-cleaning cloth from on top of the food cutting board to wipe the edge of a resident's plate and then set the cleaning cloth back on the cutting board he had used to cut the breakfast sandwiches.On 1/22/26 at 8:14 AM, [NAME] #1 moved the cleaning cloth off the cutting board into a newly made sanitation bucket. [NAME] #1 was not observed getting a new cutting board.On 1/22/26 at 8:20 AM, [NAME] #1 chopped breakfast meat on the cutting board.On 1/22/26 at 8:28 AM, [NAME] #1 stated the cleaning cloths should have been placed in the sanitation bucket prior to tray line service starting.5. The FDA Food Code Section 3-304.15 Glove, Use Limitation documented single-use gloves shall be used for only one task, used for no other purpose, and discarded when damaged, soiled, or when interruptions occur in the operation.From 7:35 AM through 8:24 AM, [NAME] #1 grabbed egg sandwiches with his gloved hands, placing the sandwiches on resident's plates. He was observed grabbing resident's plates, plating the food, using a sanitation cloth (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to wipe the edge of residents plates, and touching the diet paper slips without changing gloves.At 7:47 AM, after removing the over easy eggs from the griddle onto a plate, [NAME] #1 picked up an over easy egg with his gloved hands and placed it on a resident's plate.At 8:25 AM, [NAME] #1 grabbed a hashbrown with his gloved hand and placed it on a resident's plate.On 1/22/26 at 8:28 AM, [NAME] #1 stated he should have used tongs to grab the egg sandwiches and hashbrowns. He stated gloves are changed between tasks like after he cracked the eggs for cooking.6. The FDA Food Code Section 4-501.12 Cutting Surfaces documented cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms (organisms that cause diseases like bacteria, viruses, and fungi) transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.On 1/23/25 at 1:37 PM, the clean cutting boards were observed with residue in the scratched and scored areas.On 1/23/25 at 1:39 PM, the DM stated the cutting boards should be replaced when residue cannot be cleaned.7. The FDA Food Code Section 4-501.114 Manual Chemical Sanitization - Temperature, pH, and Concentration documented sanitizing solution should have a concentration as indicated by the manufacturer's use directions included in the labeling.On 1/23/26 at 1:13 PM, the sanitation bucket used to clean surfaces after lunch tray line tested for less than 200 parts per million (ppm).On 1/23/26 at 1:15 PM, Dietary Aide #2 stated she had made the sanitation bucket 20 minutes before and it had not registered at the required 200 ppm, but she continued to use the sanitation bucket to clean the surfaces of the kitchen. Dietary Aide #2 stated she should have made a new sanitation bucket with at least 200 ppm or more prior to use.8. The SOM Appendix PP revised 7/23/25, documented equipment can become contaminated in various ways including improper sanitation.a. 0n 1/23/26 at 1:23 PM, the ice machine was observed to have a thin line of black residue on the interior white separation plate.On 1/23/26 at 1:25 PM, the DM confirmed there was black residue in the ice machine and that maintenance had cleaned the ice machine two months prior. She stated more frequent cleaning should be done if the ice machine needed it.b. On 1/23/26 at 1:35 PM, dirty dishes were observed stacked on a kitchen preparation table above the clean cutting boards used for food preparation.On 1/23/26 at 1:40 PM, the DM and Dietary Aide #1, explained dirty dishes are taken through the clean side of the dish room and washed appropriately, before being put away. The DM stated she did not believe the dishwashing procedure to get dirty dishes through the clean side to the dirty side was incorrect as dirty dishes should not be taken through a clean kitchen.c. On 1/23/26 at 1:45 PM, cooking skillets were observed with the coating scratched and visibly peeling in the interior portion where food would be cooked.On 1/23/26 at 1:48 PM, the DM stated these skillets should have been replaced and not used for cooking.

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(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** Based on observation, CDC guidance, interview, and record review, it was determined the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the transmission of communicable diseases and infections when the facility failed to perform hand hygiene and don gloves during medication administration, and Resident #49's graduated cylinder and syringe were not changed as ordered by the physician. These failures increased the risk of infection and its associated complications. Findings include: The Centers for Disease Control and Prevention (CDC) web page titled, Clinical Safety: Hand Hygiene for Healthcare Workers, updated 2/27/24 accessed on 1/27/26, documented hand hygiene should be performed: Immediately before touching a patient. Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal. The following was observed for hand hygiene and Personal Protective equipment (PPE): 1) On 1/22/26 at 7:12 AM, LPN #1 was observed preparing a resident's insulin and transdermal patches at the medication cart. She picked up the resident's insulin pen and patches and walked to his room, knocked on the door and entered the room. No hand hygiene or donning of gloves was observed. LPN #1 placed the insulin pen on the bedside table next to a bedside urinal with no barrier between the insulin pen and the table. She then opened the transdermal pain patch and applied it to the resident, rubbing the patch onto his skin with her ungloved hand. LPN #1 then donned gloves without performing hand hygiene and proceeded to administer the resident's insulin injection. She removed her gloves, performed hand hygiene and applied the transdermal nicotine patch to the resident with an ungloved hand. On 1/22/26 at 7:40 AM, LPN #1 stated she was not aware she needed to place a barrier between the insulin pen and the bedside table. When asked about performing hand hygiene when entering a patient's room and prior to donning gloves, LPN #1 chose to remain silent. 2) On 1/22/26 at 8:46 AM, RN #1 was observed preparing a resident's oral medications at the medication cart. He picked up the resident's cup of oral medications and walked to her room, knocked on the door and entered the room. No hand hygiene or donning of gloves was observed. RN #1 handed the resident her medications cup with a cup of water and observed her swallow them. On 1/22/26 at 11:00 AM, the DON stated the expectation for her nurses would be that they perform (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	01/23/2026

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	hand hygiene upon entering a resident's room and donning gloves prior to administering insulin or transdermal patches of any kind. 3) Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including diabetes, protein calorie malnutrition, and dysphagia (difficulty swallowing). A Hospital Progress Note dated 12/12/25, documented Resident #49 underwent a procedure for gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach, used to provide nutrition) placement. A Physician's order dated 1/12/26, directed staff to change and date Resident #49's syringe and graduated cylinder every night shift. On 1/21/26 at 3:15 PM, Resident #49's graduated cylinder and syringe were observed on top of her dresser. The graduated cylinder was dated 1/18/26 and the syringe was undated. On 1/21/26 at 3:20 PM, the Surveyor and ADON went to Resident #49's room to look at her graduated cylinder and syringe. The ADON stated the graduated cylinder and syringe should be change every night and dated. On 1/22/26 at 10:23 AM, the DON stated the graduated cylinder and syringe were ordered to be changed every night for infection control purposes.

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	01/23/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, CDC guidance, and staff interview, it was determined the facility failed to ensure COVID-19 vaccinations were administered to the residents. This was true for 1 of 5 residents (Resident #32) whose COVID-19 vaccination was reviewed. This deficient practice placed residents at risk of severe illness, hospitalization, and death due to SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus - the virus that causes the COVID-19 illness) and had the potential to affect all residents in the facility. Findings include: The CDC website article titled: Staying Up to Date with COVID-19 Vaccines dated 11/19/25 and accessed on 1/26/26 documented:Protection from COVID-19 vaccine decreases over time.Immunity after COVID-19 infection decreases with time.The 2025-2026 vaccine is especially important if you: a. Never received a COVID-19 vaccine, b. Are ages 65 years and older c. Are at high risk for severe COVID-19 d. Are living in a long-term care facility.Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including systemic lupus erythematosus (a chronic autoimmune disease where the immune system mistakenly attacks healthy tissue). Resident #32 was over the age of 65 at the time of admission.Resident #32's COVID-19 Vaccination consent form dated 9/30/25, documented her POA signed an informed consent for her to receive the COVID-19 vaccine.A Progress Note dated 10/25/25 at 1:33 PM, documented the COVID-19 vaccine was not available and pharmacy contacted.Resident #32's record did not include documentation the COVID-19 vaccine was administered.On 1/22/26 at 3:26 PM, the DON and the Regional Resource Nurse reviewed Resident #32's record and did not find documentation the COVID-19 vaccine was administered. The DON stated the Progress Note documented the vaccine was not available and could not see that the vaccine had been rescheduled.