



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 28, 2016

Tami Malone, Administrator
Independent Living Services Summerwind
P.O. Box 6395
Boise, ID 83711

RE: Independent Living Services Summerwind, Provider #13G013

Dear Ms. Malone:

This is to advise you of the findings of the Medicaid/Licensure survey of Independent Living Services Summerwind, which was conducted on January 27, 2016.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures

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

PRINTED: 01/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2016
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NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING SERVICES SUMMERWIND	STREET ADDRESS, CITY, STATE, ZIP CODE 10349 SUMMERWIND DRIVE BOISE, ID 83704
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>Independent Living Services - Summerwind is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for the annual recertification survey conducted from 1/25/16 to 1/27/16.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD Team Lead Michael Case, LSW, QIDP</p>	W 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2016
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NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING SERVICES SUMMERWI	STREET ADDRESS, CITY, STATE, ZIP CODE 10349 SUMMERWIND DRIVE BOISE, ID 83704
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M 000	<p>16.03.11 Initial Comments</p> <p>Independent Living Services - Summerwind is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID)" for the licensure survey conducted from 1/25/16 to 1/27/16.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD Team Lead Michael Case, LSW, QIDP</p>	M 000		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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