

C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

June 2, 2010

Lorraine Transtrum, Administrator Summer Wind, A Retirement & Assisted Living Community 3131 Elliott Avenue, Suite 500 Seattle, WA 98121

Dear Ms. Transtrum:

On May 5, 2010, a complaint investigation survey was conducted at Summer Wind, A Retirement & Assisted Living Community. The survey was conducted by Donna Henscheid, LSW; and Polly Watt-Geier, LSW. This report outlines the findings of our investigation.

## Complaint # ID00004465

Allegation #1: Staff were not watching residents take medications and medications were found on the

floor or in residents' laps.

Findings #1: On May 4, 2010, between 12:30 p.m. and 4:45 p.m., the residents' and their rooms were

inspected. No medications were observed on the floors or in residents' laps. Medication

aides were also observed to watch the residents take their medications when they

assisted them with medications.

On May 4, 2010, between 12:30 p.m. and 4:45 p.m., two caregivers stated that when

they assisted residents with medications, they would observed them swallow the

medications.

Unsubstantiated. Although the allegation may have occurred, it could not be verified

during the complaint investigation.

Allegation #2: Snacks were not offered to residents.

Findings #2: Between May 4 and May 5, 2010, caregivers were observed offering snacks between

meal times from a snack cart to residents in their rooms and in the common areas.

On May 4, 2010, between 12:30 p.m. and 4:45 p.m., six residents were interviewed and

they stated they received snacks in their rooms.

Lorraine Transtru June 2, 2010 Page 2 of 4	m, Administrator			
	On May 4, 2010, between 12:37 p.m. and 2:02 p.m., three staff members were interviewed and stated snacks were offered between meal times and at night. They also stated a snack cart passed fluids and snack foods to residents in their rooms in the morning and afternoon. Additionally, they stated snacks were always sitting out and available in the common area.			
	Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation.			
Allegation #3:	The facility did not offer activities to engage residents who had been diagnosed with dementia.			
Findings #3:	The facility's December 2009 through May 2010 activity calendars were reviewed. They contained a variety of activities to meet the varied needs of the residents.			
	Between May 4 and May 5, 2010, activities were observed, which included a community outing and an exercise class.			
	On May 4, 2010, between 12:30 p.m. and 4:45 p.m., six residents were interviewed and they stated they received activities that met their interests.			
	On May 4, 2010, at 2:02 p.m., the activities director stated activities were customized to meet the residents needs, which included Wii bowling, exercise, word games, arts and crafts.			
	Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation.			
Allegation #4:	The facility did not consistently assist residents with compression stockings.			
Findings #4:	Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08.b for documenting when caregivers or nurses assisted an identified resident with compressockings. The facility was also issued a deficiency at IDAPA 16.03.22.350.05 for facility nurse not following up to ensure compression stockings were used as direct The facility was required to submit evidence of resolution within 30 days.			
Allegation #5:	The staff do not protect residents rights to privacy by walking into residents' rooms without knocking.			
Findings #5:	Between May 4 and May 5, 2010, the facility caregivers were observed to knock on residents' doors prior to entering their rooms.			

On May 4, 2010, between 12:30 p.m. and 4:45 p.m., eight residents were interviewed and they stated the staff respected their privacy and knocked before entering their

rooms.

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Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation.

Allegation #6:

The facility did not offer diabetic diets to residents who required them.

Findings #6:

The December 2009 to May 2010, "as served menus" documented the residents who required diabetic diets were served food in accordance with the diet.

On May 4, 2010, between 12:30 p.m. and 4:45 p.m., six residents were interviewed and they stated they received the appropriate diets. One resident, who was diabetic, stated she was served the appropriate diet.

On May 4, 2010, at 2:20 p.m., a white board was observed in the kitchen, which contained resident names and the therapeutic diets they required.

On May 4, 2010, at 2:22 p.m., the kitchen manager stated the residents were served therapeutic diets. He said diabetic desserts were offered; however, some residents would choose to have regular desserts.

Unsubstantiated. However the facility was issued a deficiency at IDAPA 16.03.22.711.04 for not documenting residents refusals of their therapeutic diets or informing the residents physicians' of those refusals. The facility was required to submit evidence of resolution within 30 days.

Allegation #7:

Staff do not protect residents' rights to be treated with dignity and respect.

Findings #7:

The facility's complaint log was reviewed. There were no documented complaints related to caregivers not treating the residents respectfully.

Between May 4 and May 5, 2010, the caregivers were observed to treat residents with dignity and respect when assisting them with cares.

On May 4, 2010, between 12:30 p.m. and 4:45 p.m., five residents were interviewed and stated caregivers treated them with dignity and respect. One resident stated the caregivers were respectful and she had not seen them be disrespectful to other residents.

Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation.

Allegation #8:

An identified resident's medication was not given according to physician's order.

Findings #8:

The identified resident's record was reviewed. The physician's order did not document that any medication needed to be given with food. One of the resident's medications was to be given at 5:00 a.m. and the December 2009 through May 2010 medication assistance records indicated the medication was given at the appropriate time.

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On May 4, 2010, between 12:30 p.m. and 4:45 p.m., seven residents were interviewed and stated they had no issues with getting their medications.

On May 5, 2010, at 9:37 a.m., the facility nurse stated the identified resident was receiving her medication at the appropriate time.

Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation.

Allegation #9:

An identified resident was not being toileted according to their Negotiated Service Agreement (NSA).

Findings #9:

Five resident records were reviewed. None of the residents' NSAs documented they required a two-hour toileting schedule. The identified resident's NSA, dated March 30, 2010, documented the resident required assistance with toileting; however, there was no documentation stating she required a two-hour toileting schedule.

On May 4, 2010, between 12:30 p.m. and 4:45 p.m., six residents stated the caregivers assisted them with their cares as needed.

Between May 4 and May 5, 2010, on four separate occasions the identified resident was observed to be well-groomed and no odors were present in her room.

Unsubstantiated. Although the allegation may have occurred, it could not be verified during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

POLLY WATT-GEIER, LSW

Health Facility Surveyor

Residential Assisted Living Facility Program

PWG/sm

cc:

Jamie Simpson, MBA, QMRP, Supervisor, Residential Assisted Living Facility Program



## BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888

## ASSISTED LIVING Non-Core Issues Punch List

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Facility	Name		Physical Address	Phone Number		
Summer And Administrator		od	5955 Castle Dr.	(608) 331-	- 1300	
Administrator			City	ZIP Code	-	
Survey Team Leader			Survey Type	83703		
Survey	Team Leader	<u>.</u>	Survey Type	Survey Date		
	Pilly Watt	- Geier	Complaint Inschapn	5/5/10		
	CORE ISSU		, )			
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Response Required Date		Signature of Facility Representative			Date Signed	
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