IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

November 13, 2006

FILE COPY

Ken Madsen, Administrator
Fairwinds - Sandcreek
3310 Valencia Dr
Idaho Falls, ID 83404

License #: RC-661

Dear Mr. Madsen:

On October 5, 2006, a State Licensure survey was conducted at Fairwinds - Sandcreek. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Rebecca Winter, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Rebecca Winter-Heier, MSW Rev

REBECCA WINTER, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RW/slc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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October 16, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 1299

Ken Madsen, Administrator
Fairwinds - Sandcreek
3310 Valencia Dr
Idaho Falls, ID 83404

FILE COPY

Dear Mr. Madsen:

Based on the state licensure survey conducted by our staff at Fairwinds - Sandcreek on **October 5, 2006,** we have determined that the facility failed to protect residents from inadequate care. Based on observations, interview, and record review it was determined the facility failed to provide assistance and monitoring of medications for 2 of 10 sampled residents (#8 and #10).

This core issue deficiency substantially limits the capacity of Fairwinds - Sandcreek to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **November 20, 2006.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **October 26, 2006,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 26, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 26, 2006,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 5, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Fairwinds - Sandcreek.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Melanie Belnap, Program Manager, Regional Medicaid Services, Region VII - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R661	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/05/2006
NAME OF PROVIDER OR SUPPLIER: FAIRWINDS - SANDCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE: 3310 VALENCIA DR IDAHO FALLS, ID 83404		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard survey conducted at your residential care/assisted living facility on 10/3/06. The surveyors conducting your survey were: Rebecca Winter, RN. Team Coordinator Health Facility Surveyor Patrick Hendrickson, RN. Health Facility Surveyor Survey Definitions: MAR = Medication Administration Record mg = milligrams NSA = Negotiated Service Agreement	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observations, interview, and record review it was determined the facility failed to provide assistance and monitoring of medications for 2 of 10 sampled residents (#8 and # 10). The findings include: 1. Review of Resident #8's record on 10/3/06, revealed the resident was admitted on 11/1/02 with diagnoses which included type 2 diabetes, hypertension and cerebral vascular accident. Further review of the resident's record revealed	R 008	The administrator will assure that policies and procedures are implemented to assure that all residents are free from inadequate care	11-1-06 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE General Mgr — (X6) DATE 10-23-06

Bureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R661	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/05/2006
IAME OF PROVIDER OR SUPPLIER FAIRWINDS - SANDCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3310 VALENCIA DR IDAHO FALLS, ID 83404		

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R 008	Continued From page 1 an NSA dated 7/29/06 that documented the resident managed her own medication and the licensed professional nurse would review the medication program monthly for compliance, appropriateness and ability to continue to self-medicate. The resident's record contained a "Quarterly Self Medication Assessment" dated 8/1/06, that was completed by the facility's licensed professional nurse. The assessment documented the resident was able to self administer her own medications. Observation of Resident #8's medications on 10/3/06 at 1:30 p.m. in the resident's room revealed pharmacy filled bottles labeled as follows: Crestor 10 mg 1/2 tab each day. The prescription was filled on 5/27/06 for a quantity of 30 tablets. Glipizide 5 mg each day. The prescription was filled on 6/26/06 for a quantity of 30 tablets. On 10/3/06 at 1:40 p.m., the resident stated she had stopped taking her Detrol LA, and had ran out of her synthroid two days ago. Further, she stated she had no Amyril available to her so she was taking Glipizide in its place. On 10/3/06 at 3:09 p.m., the resident's physician's office faxed a current list of medications to the facility. The orders were dated 11/10/05 and documented the resident was to take the following; Crestor 5 mg each day Amyril 4 mg each day Synthroid 0.05 mg each day Detrol LA 4 mg each day	R 008		

Bureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R661	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/05/2006
AME OF PROVIDER OR SUPPLIER FAIRWINDS - SANDCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3310 VALENCIA DR IDAHO FALLS, ID 83404		

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R 008	Continued From page 2 On 10/3/06 at 3:30 a.m., the pharmacist confirmed the following; Crestor 10 mg was dispensed on 5/27/06 for a quantity of 30 tablets and the prescription should have been refilled by 7/27/06. Glipizide 5 mg was dispensed on 6/26/06 for a quantity of 30 tablets and the prescription should have been refilled by 7/26/06, 8/26/06 and 9/26/06. Amyril 8 mg was dispensed on 6/26/06 for a quantity of 60 tablets and the prescription should have been refilled by 8/26/06. Synthroid 0.05 mg was dispensed on 7/28/06 for a quantity of 30 tablets and the resident should have been refilled by 8/28/06 and 9/28/06. On 10/3/06 at 4:00 p.m., the facility nurse stated she was unaware the resident had not been taking her medications as prescribed by the physician. She said she did not know why the resident's synthroid and Amyril was not available to the resident. Additionally, she was unable to provide documentation the Amyril had been changed from 4 mg to 8 mg or that Glipizide was ordered in place of the Amyril for the resident at the time of the survey. 2. Review of Resident #10's record on 10/4/06, revealed the resident was admitted on 4/18/06 with diagnosis which included chronic back pain. Further review of the resident's record revealed an NSA dated 4/16/06 that documented staff would assist with all medications and the licensed professional nurse would review medications	R 008		

Bureau of Facility Standards

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R661	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/05/2006
AME OF PROVIDER OR SUPPLIER FAIRWINDS - SANDCREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 3310 VALENCIA DR IDAHO FALLS, ID 83404		

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R 008	Continued From page 3 quarterly for efficacy, necessity and side effects. Review of the resident's record revealed physician orders dated 6/25/05 which documented the resident was to take: Clonazepam 0.5 mg 1/2 to 1 tablet by mouth twice a day as needed. Review of the resident's MAR revealed the resident was assisted with clonazepam 1 mg as a scheduled dose every evening from 6/6/06 through 10/3/06. Further, the MAR's also listed the medication as "clonazepam 1 mg every night". On 10/4/06 at 10:00 a.m., the facility nurse stated she was unaware the resident had been assisted with clonazepam as a scheduled dose every evening from 6/6/06 through 10/3/06. Further, she confirmed she had written the MAR's to directed staff to give clonazepam 1 mg every night rather then 1/2 to 1 tablet by mouth twice a day as needed, as ordered by the physician. The facility failed to provide assistance and monitoring of medications to resident #8 and #10 which resulted in Resident #2 not receiving her Crestor, Amyril, synthroid, Detrol LA and glipizide as prescribed by her physician. Further Resident #10 was assisted with clonazepam 1 mg every night rather then 1/2 to 1 tablet by mouth twice a day as needed as ordered by the physician. These failures resulted in inadequate care.	R 008		

It's More Than Retirement. It's Five-Star Fun.

Plan of Correction for Deficiency for Resident #8

1. What corrective action(s) will be accomplished for those specific residents found to have been affected by the deficient practice?
   a. The licensed nurse will complete an assessment every 90 days to determine that medication is being taken according to Physicians orders. (See attached form #1-Quarterly RN Assessment). The assessment will also provide information to determine if that resident is able and safe to continue to self medicate for the next 90 days.
   b. The licensed nurse will also complete a quarterly assessment specific to self medicators' to determine if the resident is capable of self medicating and able to continue to do so. (See attached form #2-Quarterly Self Medication Assessment.)
2. How will you identify other residents that may be affected by the same deficient practice and what corrective action(s) will be taken.
   a. All residents will be assessed quarterly (or at any significant change in medicators') is being taken in accordance with the physicians orders, and if they are capable of safely continuing to self medicate. If it is determined that the resident is either mentally or physically incapable of continuing to self medicate, a recommendation will be made to the family and/or resident that other measures must be instituted to ensure that this resident is being appropriately medicated according to physicians orders.
   b. All residents who self medicate will be assessed quarterly using the form Quarterly Self Medication Assessment. If by that assessment it is determined the resident is not capable of continuing to safely self medicate, a recommendation, as stated in item (a) will be made and acted upon.
3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?
   a. Refer to item (a) and item (b) in both numbers 1 and 2 above.
4. How will the corrective actions be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?
   a. A licensed nurse will do the above stated assessments and will also complete an assessment when any significant change in resident condition is determined. Monitoring will be done routinely as stated in the assessments and ongoing.
5. What date will the corrective actions be completed by:
   Completion date: November 1, 2006

In addition to the corrections stated above, a letter (attached #3) will be sent to all residents who currently self medicate to make them aware of the regulations and their part in assisting us in Assisted Living to come into and remain in compliance.

3310 Valencia Drive • Idaho Falls • ID 83404
P 208.542.6200 • F 208.552.6139 • www.leisurecare.com

Plan of Correction for Deficiency for Resident #10

1. What corrective actions(s) will be accomplished for those specific residents found to have been affected by the deficient:
   a. Resident's medication order will be stated in the MARS specifically as is on the Physicians written order.
2. How will you identify other residents that may be affected by the same deficient practice and what corrective action will be taken.
   a. The licensed nurse will monitor all MARS at the beginning of every month to assure the MAR as written corresponds with the written physicians order. Any discrepancy will be investigated by the licensed nurse and corrected appropriately.
3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice will not recur?
   a. The licensed nurse will make any changes to medication orders on the MAR, send a copy of the order to the pharmacy and then send a copy of the change in order to the pharmacy that generates the MARS for the beginning of each month.
4. How will the corrective actions be monitored and how often will monitoring occur to ensure that the deficient practice will not recur?
   a. The licensed nurse will monitor the MARS at the beginning of each month with the original MD order. The licensed nurse will make any changes on the MAR as changes occur and will communicate changes to the pharmacy generating the MAR. Periodic monitoring will take place thru the month to ensure MARS are correctly being followed and medication being appropriately being documented.

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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

Facility Name	Physical Address	Phone Number
Fairwinds - Sand Creek	3310 Valencia Ave	542-6200
Administrator	**City**	**ZIP Code**
Ken Madsen	Idaho Falls	83404
Survey Team Leader	**Survey Type**	**Survey Date**
Rebecca Winter	Standard	10/5/06

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	305	The RN did not assess and document for each resident as described, to include resident response to medications and therapies, current medication orders, resident health status, recommendations, progress of previous recommendations and resident education needs for 10 of 10 residents.	11/7/06 pw	
2	310.02	Unused medications accumulated in the facility longer than 30 days, Residents # 5 and 8.	11/8/06 pw	
3	320	Resident #4's NSA was not signed within 14 days of Admission.	11/7/06 pw	
4	320.03	The Administrator or designee did not sign NSA updates for Resident #1, 3, 5, 6 and 10. Additionally, the NSA's for Residents #1 and 6 that were developed on Admission were not signed.	11/7/06 pw	

Response Required Date	Signature of Facility Representative	Date Signed
11/5/06	Ken Madsen	

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ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Fairwinds-Sandcreek	3310 Valencia Ave	542-6200
Administrator	**City**	**ZIP Code**
Ken Madsen	Idaho Falls	83404
Survey Team Leader	**Survey Type**	**Survey Date**
Rebecca Winter	Standard	10/5/06

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
5	350.02	The administrator or designee did not complete an investigation and written report of findings for each accident or incident.	11/7/06	PW
6	405.01.b	Rooms 202, 206 and 227 had extension cords and/or multiple adaptors.	11/7/06	PW
7	405.03	Rooms 210 and 211 did not have "oxygen in use" signs.	11/7/06	PW
8	450	There was no consumer advisory for raw or undercooked food.	11/7/06	PW
9.	650.01	There was no uniform assessment completed for Resident #8, a private pay resident.	11/7/06	PW
10.	711.09	10 of 10 Resident records did not contain a current list of medications prescribed for the resident which was signed and dated by the physician or authorized provider.	Resolved on site at Pharmacy	

Response Required Date	Signature of Facility Representative	Date Signed
11-5-06	Ken Madsen	

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ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Fairwinds - Sand creek	3310 Valencia Ave	542-6200
Administrator	**City**	**ZIP Code**
Ken Madsen	Idaho Falls	83404
Survey Team Leader	**Survey Type**	**Survey Date**
Rebecca Winter	Standard	10/5/06

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
11	730.01.e	Staff records did not contain signed evidence of 16 hours of orientation. 4 of 4.	resolved on site	
12	730.01.f.	One of 4 staff records did not contain a current CPR card and/or first aid training.	11/13/06 PWG	

Response Required Date	Signature of Facility Representative	Date Signed
11/5/06	Ken Madsen	