



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
JAMIE SIMPSON – PROGRAM SUPERVISOR
RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-334-6626
FAX: 208-364-1888

February 11, 2013

Amy Robinson, Administrator
Emeritus At Summer Wind
5955 Castle Drive
Boise, ID 83703

License #: RC-480

Dear Ms. Robinson:

On January 4, 2013, a Complaint Investigation survey was conducted at Emeritus At Summer Wind. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- 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 evidence of resolution.

Should you have questions, please contact Rae Jean McPhillips, RN, BSN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

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

Reset Form

Print Form



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MEDICAID LICENSING & CERTIFICATION - RALF
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Boise, ID 83720-0036
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ASSISTED LIVING
Non-Core Issues
Punch List

Table with 3 columns: Facility Name, Administrator, Team Leader, Physical Address, City, Survey Type, Phone Number, Zip Code, Survey Date.

NON-CORE ISSUES

Table with 5 columns: Item #, RULE #, DESCRIPTION, DATE RESOLVED, L&C USE. Contains one main entry with handwritten notes and dates.

Table with 3 columns: Response Required Date, Signature of Facility Representative, Date Signed.



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January 18, 2013

Amy Robinson, Administrator
5955 Castle Drive
Boise, ID 83703

Dear Ms. Robinson:

An unannounced, on-site complaint investigation survey was conducted at Emeritus At Summer Wind from January 2, 2013, to January 4, 2013. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005661

Allegation #1: The facility ran out of residents' medications.

Findings #1: From 1/3 until 1/4/13, twelve residents' medication records were reviewed. The records reviewed were both open and closed records and included scheduled and PRN (as needed) medications. All twelve records documented the scheduled and PRN medications were available at the facility and given as prescribed.

On 1/3/13 at 1:30 PM, the facility administrator/RN stated the medication aides monitored the medications and were to reorder a week prior to the last dose. She stated that if for some reason a medication was not available, she would go to the pharmacy and pick it up. She stated, she was unaware of any resident not receiving medications due to it not being available at the facility.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #2: Medication aides gave the wrong medication to an identified resident.

Findings #2: The identified resident could not be interviewed as she no longer resided at the facility.

The resident's record and the facility's incident reports were reviewed on 1/4/12. There was no documentation in either that the resident received the wrong medication.

On 1/4/12 at 9:30 AM, the facility administrator/RN stated the identified resident had not received the wrong medications.

On 1/4/13 between 10:00 and 10:30 AM, two medication aides, who worked at the facility when the identified resident resided there, were interviewed. Both stated they were unaware of a time when the resident received the wrong medications.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: The facility did not have a licensed administrator in July 2012.

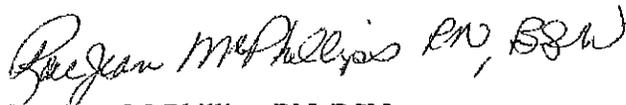
Findings #3: Letters sent to the Department of Licensing and Certification from the facility were reviewed on 1/2/13. A letter, dated 8/23/12, documented that as of July 18, 2012, Tamara McCann was no longer the administrator of the facility. The letter further documented, that Amy Robinson, who was the Registered Nurse, became the interim administrator when Ms. McCann left. The letter included a copy of Ms. Robinson's "Residential Care Facility Administrator" license, which documented the original date of issue was 10/13/2011.

On 1/3/13 at 1:30 PM, the administrator/RN stated that she became the acting interim administrator when the previous administrator moved out of the area.

Unsubstantiated.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,



Rae Jean McPhillips, RN, BSN
Health Facility Surveyor
Residential Assisted Living Facility Program

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



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January 18, 2013

Amy Robinson, Administrator
Emeritus At Summer Wind
5955 Castle Drive
Boise, ID 83703

Dear Ms. Robinson:

An unannounced, on-site complaint investigation survey was conducted at Emeritus At Summer Wind from January 2, 2013 to January 4, 2013. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00005850

Allegation #1: Residents' rooms were dirty.

Findings #1: From 1/2/13 through 1/4/13 and between 8:45 AM and 4:30 PM, observations of the facility common areas and residents' rooms were conducted. The facility's common areas were observed to be clean and odor free. Residents' rooms were also observed during the survey. Three residents' rooms were observed to be in need of cleaning.

On 1/2/13 at 8:45 AM, a shared residents' room was observed to have a dirty bathroom and the shared living area carpet needed to be vacuumed. No offensive odors were detected in the room. At 10:15 AM, on 1/2/13, the bathroom and carpet were observed to be clean.

On 1/2/13 at 9:15 AM, another room was observed to have a bathroom that needed cleaning and at 9:25 AM, a third room was observed to have a dirty carpet in the shared living area. Additionally, the third room had a slight urine odor.

On 1/2/13 at 9:50 AM, the housekeeper stated she worked at the facility Monday through Friday from 7:30 AM until 3:30 PM. She stated when she was off, caregivers provided the needed housekeeping. She stated that one resident's room was vacuumed almost daily because the resident had a habit of "tearing up paper

and scattering" it on the carpet. She said residents' rooms were deep cleaned at least weekly and more often if needed. She said that if caregivers observed that a room needed extra cleaning they would let her know or they would clean it themselves.

On 1/2/13 at 10:40 AM, two caregivers were observed going in and out of residents' rooms emptying trash cans. Both caregivers stated that each shift were responsible to check the room for any housekeeping needs and ensure residents' trash can were emptied. They confirmed the rooms identified, during the facility tour on 1/2/13, required more frequent cleaning than other rooms.

On 1/3/13 at 2:45 PM, the maintenance staff stated it was his responsibility to make sure carpets and furniture were shampooed on a regular schedule. He stated that in addition to "full" carpet shampooing, they also did frequent "spot" shampooing. He confirmed the room observed during tour with a dirty carpet and odor was a room that required frequent "full" shampooing. He provided the carpet cleaning schedule, dated from June 2012 through December 2012, that documented the carpet was shampooed at least twice a month.

Between 1/2/13 and 1/4/13, eight caregivers, an LPN and the administrator were interviewed. One caregiver, who worked the night shift, stated they were expected to complete cleaning tasks when time permitted. She stated that most nights the cleaning could be done, but if they were too busy taking care of residents, day shift or the housekeeper would clean the next day.

Between 1/2/13 and 1/4/13, six residents, three family members, and four outside service providers were interviewed. All stated they had no concerns regarding the cleanliness of the facility or the residents' rooms.

Substantiated. However, the facility was not cited as they had identified and implemented appropriate measures to maintain the building and residents' rooms in a clean manner.

Allegation #2: Residents wore the same clothing for several days.

Findings #2: Residents were observed on 1/2/13, 1/3/13 and 1/4/13. During these days none of the residents observed were dressed in the same clothing.

Between 1/2/13 and 1/4/13, three family members and four outside service providers were interviewed. Family members stated their loved ones' clothing was changed on a daily basis and more frequently, if needed. One family member, who visited the facility daily, stated she had not seen residents wearing

the same clothing for more than one day. The outside service providers stated the residents they visited were dressed in clothing that was changed at least daily.

On 1/2/13 between 8:45 AM and 2:30 PM, four caregivers were interviewed. They stated some residents would wear their clothing for a few days in a row if allowed. They said they would try to assist residents into clean clothing at least daily, but at times the residents were resistant to changing. They stated they would reapproach the resident several times during the day to try and assist them into clean clothing. They stated they were usually successful in assisting the resident to change but there had been times that a resident did wear the same clothing for two days. They stated that some residents had favorite "sweaters" that would be worn for several days until they were washed. They stated residents' clothing was washed at least weekly. They stated they were not aware of a time when a resident wore the same clothing for several days.

On 1/3/12 at 11:25 AM, the administrator confirmed that some residents were resistant when caregivers attempted to assist them with dressing. She said that caregivers were instructed to reapproach the resident at a later time and try again. Additionally, she stated caregivers assisted residents to change their clothing on an as-needed basis when residents' clothing was soiled.

On 1/3/13 the facility's documentation of complaints was reviewed. There was no documentation by residents, families or outside agencies regarding residents wearing the same clothing for several days.

Unsubstantiated. This does not mean the incident did not take place; it only means that the allegation could not be proven.

Allegation #3: The Facility did not provide sufficient staff to assist residents with transfers.

Findings #3: From 1/2/13 to 1/3/13, eight current residents' Negotiated Service Agreements (NSA) were reviewed. Observations of caregivers assisting residents were conducted from 1/2/13 until 1/4/13. Additionally, eight caregivers were interviewed regarding assisting residents with transfers.

On 1/2/13, the caregivers stated that although some residents' NSAs documented they only needed one caregiver to assist with transfers, they would request help from another caregiver prior to assisting. They stated it was safer for residents when two caregivers helped, because some days the residents were less able to participate in transfers.

On 1/3/13 at 12:48 PM, a caregiver was observed to call for help prior to assisting a resident whose NSA documented she was a one person transfer. He stated he could probably assist the resident by himself, but always asked for help to ensure her safety. He said there was always another caregiver available to assist with cares or transfers.

On 1/3/13 the facility's documentation of incidents and accidents, from June 2012 through December 2012, were reviewed. There was one documented incident in August 2012 of when a resident fell while being assisted with a transfer by one caregiver. There was no other documentation of falls during transfers. The resident's NSA was reviewed on 1/3/13. The NSA documented the resident required the assistance of one person during a transfer.

On 1/3/13 at 1:15 PM, two caregivers confirmed the resident's NSA documented she needed the assistance of one person during a transfer. However, both caregivers stated that when the resident was assisted with transfers two caregivers were always present because of the fall in August 2012.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation. However, the facility was cited at IDAPA 16.03.22.320.01 for residents' NSA not documenting residents' need for additional assistance during transfers.

Allegation #4: The facility did not provide enough assistance with daily living to residents.

Findings #4: From 1/2/13 to 1/3/13, eight current residents' Negotiated Service Agreements (NSAs) were reviewed. Observations of caregivers providing assistance to residents were conducted from 1/2/13 until 1/4/13. Additionally, residents' families, outside service providers and eight caregivers were interviewed regarding assistance with activities of daily living, such as eating, housekeeping and toileting.

The interviewed caregivers were able to describe the services the residents needed. However, they stated the residents' NSAs did not document all the needs of the residents. They stated some residents needed more frequent housekeeping and assistance with personal hygiene than indicated on the NSA.

On 1/3/13 at 12:15 PM, four caregivers, the administrator and the facility nurse were observed to be available in the dining room to assist residents with eating, if needed. One caregiver was observed to be seated with a resident assisting her with eating. He stated that some days the resident was able to eat by herself, but on other days she required help.

Amy Robinson, Administrator
January 18, 2013
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From 1/2/13 through 1/4/13, caregivers were observed to assist residents to their rooms for toileting. Additionally, one resident was observed to be assisted back to her room for clothing change due to spilled fluids on her blouse.

Between 1/2/13 and 1/4/13, three family members and four outside service providers were interviewed. Family members stated their loved ones were well cared for and they had no concerns regarding the cares. One family member, who visited the facility daily, stated that she had observed caregivers providing assistance with eating and toileting to residents. She stated that she had no concerns about the care her loved one received. Four of five outside service providers stated the residents they visited were receiving appropriate care and they had no concerns.

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation. However, the facility was cited at IDAPA 16.03.22.320.01 for residents' NSA not clearly reflecting residents' needs.

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, on **01/04/2013**. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

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,



Rae Jean McPhillips, RN, BSN
Health Facility Surveyor
Residential Assisted Living Facility Program

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