



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

June 26, 2012

Tamara McCann, Administrator  
Emeritus At Summer Wind  
5955 Castle Drive  
Boise, ID 83703

License #: RC-480

Dear Ms. McCann:

On May 3, 2012, a licensure/follow-up survey and complaint investigation 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):

- 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 Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

*Polly Watt-Geier, MSW*

Polly Watt-Geier, MSW  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

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



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

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LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
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May 14, 2012

CERTIFIED MAIL #: 7007302000140507626

Tamara McCann, Administrator  
Emeritus At Summer Wind  
5955 Castle Drive  
Boise, ID 83703

Dear Ms. McCann:

Based on the state licensure/follow-up and complaint investigation conducted by our staff at Emeritus At Summer Wind between April 30, 2012 and May 3, 2012, we have determined that the facility failed to appropriately assist and monitor residents' medications.

This core issue deficiency substantially limits the capacity of Emeritus At Summer Wind 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 **June 17, 2012**. **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 **May 27, 2012**, 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 Supervisor of the Residential Care Program 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. See the IDR policy and directions on our website at [www.assistedliving.dhw.idaho.gov](http://www.assistedliving.dhw.idaho.gov). If your request for informal dispute resolution is not received within the appropriate time-frame, 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 evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **June 2, 2012**.

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 in Idaho, the Department will have no alternative but to initiate an enforcement action against the license held by Emeritus At Summer Wind.

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

Sincerely,



JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Assisted Living Facility Program  
Medicaid Licensing & Certification

JS/pwg

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R480</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>EMERITUS AT SUMMER WIND</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5955 CASTLE DRIVE BOISE, ID 83703</b>		
(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) COMPLETE DATE
R 000	<p>Initial Comments</p> <p>The following deficiency was cited during the licensure/follow-up survey and complaint investigation conducted between 04/30/2012 and 5/3/2012 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Polly Watt-Geier, MSW Team Leader Health Facility Surveyor</p> <p>Rachel Corey, RN, BSN Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Survey Definitions:</p> <p>AM = morning Appt = appointment BG = blood glucose level cap = capsule D/C = discontinue HS = before bedtime LPN = Licensed Practical Nurse MAR = Medication Assistance Record med = medication mcg = microgram mg = milligrams PM = afternoon PO = By Mouth QID = four times a day RN = Registered Nurse tab = tablet</p>	R 000	<p align="center"><b>State Survey Plan of Correction</b></p> <p><i>The following is Summer Winds Plan of Correction to the Department of Social and Health Services Statement of Deficiencies dated May 03, 2012 and received at the community via certified mail on May 17, 2012 This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions outlined in the Statement of Deficiencies. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or findings. We have not presented all contrary factual or legal arguments, nor have we identified all mitigation factors.</i></p>	
R 008	16.03.22.520 Protect Residents from Inadequate Care.	R 008		

Bureau of Facility Standards

TITLE

(X6) DATE ..

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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R 008	<p>Continued From page 1</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility did not provide appropriate assistance and monitoring of medications for 4 of 12 residents (#4, #5, #6 and #10) whose records were reviewed. The findings include:</p> <p>I. Insulin</p> <p>1. Resident #6 was admitted to the facility on 10/11/02, with diagnoses which included diabetes, cognitive impairment and limited vision in right eye.</p> <p>A physician's order, dated 3/1/11, documented if the resident's BG was less than 120, lower Humalog Insulin to 30 units.</p> <p>Another physician's order, dated 4/20/11, documented the resident was supposed to receive 37 units of Humalog before meals and at bed time</p> <p>Resident #6's February 2012 MAR also documented the resident was to receive the following sliding scale insulin:</p> <p>BG 0 - 160 = 0 units BG 161 - 200 = 2 units BG 201 - 250 = 4 units BG 251 - 300 = 6 units BG 301 - 350 = 8 units BG "351 OR" = 10 units</p>	R 008	<p>I. <u>Rule # 16.03.22.520 Protect Residents from inadequate care.</u></p> <p><b>I. Corrective Action: Resident #6, #5 &amp; #4.</b></p> <p>1. Insulin</p> <p>A request was sent to physician for clarification on Resident #6 insulin related to his Humalog order on 5-1-12 and was received back on 5-3-12. (See attachment #1)</p> <p>A request was also sent to Resident #6's physician to clarify our insulin sliding scale order and to clarify the actual date of the discontinuation of the resident's sliding scale. (See attachment #2)</p> <p>BG parameters have been ordered and clarified with Resident #6's physician. These parameters have been transcribed onto the MAR. An in-service was held with all Med-Techs to support they understand the parameters ordered and when to contact the licensed nurse. Resident #6's new insulin orders along with new BG parameters were reviewed during this in-service. Hypoglycemia and Hyperglycemia were also covered during this in-service. (See attachment # 3)</p> <p><i>Continued on page 3</i></p>	

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R 008	<p>Continued From page 2</p> <p>The following errors were documented on the February 2012 MAR:</p> <p>* On the following dates, the resident was not assisted with the appropriate amount of sliding scale insulin.</p> <p>2/3 - AM BG was 155: the resident was given 2 units of sliding scale insulin; however, the resident should not have received any insulin.</p> <p>2/7 - HS BG was 303: there was no additional sliding scale insulin documented as being given; however, the resident should have received 8 units.</p> <p>2/8 - HS BG was 125: the resident was given 2 units of sliding scale; however, the resident should not have received any insulin.</p> <p>2/17 - PM BG was 199: there was no additional sliding scale insulin documented as being given; however, the resident should have received 2 units.</p> <p>2/20 - Noon BG was 302: the resident received 10 units of sliding scale insulin; however, the resident should have only received 8 units.</p> <p>2/21 - HS BG was 225: there was no additional sliding scale insulin documented as being given; however, the resident should have received 4 units.</p> <p>2/27 - AM BG was 161: there was no additional sliding scale insulin documented as being given; however, the resident should have received 2 units.</p> <p>2/29 - PM BG was 226: there was no additional</p>	R 008	<p>Med Techs completed an additional 2 hour training with the facility licensed nurse (see attachments # 4 &amp; #5) which included the importance of accuracy during a medication pass, the 6 Rights of medication administration, and correct documentation.</p> <p>Current orders for Resident #6 no longer require the resident to determine his insulin dose based on blood glucose levels. The facility nurse has completed a self medication assessment related to self injection ability for Resident #6.</p> <p>Medication issues have been investigated and summaries have been completed for the medication issues. Resident #6's physician and responsible party have been notified.</p>	

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R 008	Continued From page 3  sliding scale insulin documented as being given; however, the resident should have received 4 units.  * On the following dates, the resident's BGs were under 120; however, the resident was assisted with 37 units of insulin, rather than the prescribed 30 units:  2/2 - HS BG was 78 2/7 - PM BG was 116 2/18 - AM BG was 55  * On the following dates, 30 units and 37 units of insulin doses were signed as given. It could not be determined if the resident received 30, 37 or 67 units of insulin:  2/6 - HS 2/9 - HS  * The resident's HS BG on 2/17 was not documented, however the medication aide signed that both the 30 and 37 units of Humalog were given. It could not be determined how much insulin the resident should have received or if the resident received 30, 37 or 67 units of insulin.  * There were no documented BG levels for the following days; therefore, it could not be determined if the resident received an appropriate amount of insulin:  2/1 - AM 2/4 - HS 2/14 - HS 2/18 - HS 2/25 - PM 2/25 - HS	R 008		

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R 008	<p>Continued From page 4</p> <p>* On the following dates, it could not be determined if the resident received insulin, as neither the 30 or 37 units were signed as given:</p> <p>2/4 - PM BG 2/5 - PM BG 2/10 - PM BG 2/11 - PM BG 2/12 - PM BG 2/15 - HS 2/16 - HS</p> <p>There were a total of 27 documented errors with Resident #6's insulin in February.</p> <p>Resident #6's March 2012 MAR documented the following sliding scale:</p> <p>BG 0 - 160 = 0 units BG 161 - 200 = 2 units BG 201 - 250 = 4 units BG 251 - 300 = 6 units BG 301 - 350 = 8 units BG "351 OR" = 10 units</p> <p>The following errors were documented on the March 2012 MAR, between 3/1 through 3/15:</p> <p>* On the following dates, the resident was not assisted with the appropriate amount of sliding scale insulin:</p> <p>3/3 - PM BG was 141: the MAR documented the resident was assisted with 2 units of the sliding scale insulin, but he should not have received any additional sliding scale insulin.</p> <p>3/4 - HS BG was 180: there was no additional sliding scale insulin documented as being given; however, the resident should have received 2</p>	R 008		

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R 008	<p>Continued From page 5</p> <p>units</p> <p>3/6 - HS BG was 220: there was no additional sliding scale insulin documented as being given; however, the resident should have received 4 units</p> <p>3/7 - Noon BG was 259: the MAR documented the resident received 4 units of sliding scale insulin; however, the resident should have received 6 units.</p> <p>3/8 - AM BG was 262: the MAR documented the resident received 4 units of sliding scale insulin; however, the resident should have received 6 units.</p> <p>* On the following dates, the resident's BGs were under 120; however, the resident was assisted with 37 units of insulin, rather than the prescribed 30 units:</p> <p>3/5 - PM BG was 103 3/5 - HS BG was 113 3/12 - PM BG was 79</p> <p>* On 3/2 the HS BG was not documented; therefore, it could not be determined if the resident had received the appropriate amount of insulin.</p> <p>* On 3/9 the PM BG, both the 30 and 37 units of insulin were signed as given. It could not be determined if the resident received 30, 37 or 67 units of insulin.</p> <p>* On the following dates, it could not be determined if the resident received insulin, as both the 30 and 37 units portion of the MARS were not signed.</p>	R 008		
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R 008	<p>Continued From page 6</p> <p>3/10 - PM 3/13 - PM</p> <p>There were 12 documented insulin errors between 3/1 through 3/15.</p> <p>A physician's order, dated 3/13/12, documented the resident was supposed to receive 40 units of Novolog before meals and at bed time.</p> <p>A fax to the physician from the facility, dated 3/14/12, documented the resident "has been on Humalog Insulin. New Order [sic] is for Novolog Insulin. His insurance does not cover the Novolog. Do you want to D/C sliding scale with new orders or keep." The physician responded on 3/15/12, "Humalog ok, keep sliding scale."</p> <p>A fax to the physician from a home health agency, dated 3/15/12, documented a request for insulin orders with fixed dosing and no sliding scale. The physician responded on 3/16/12, "Your med list is wrong." Novolog was written with a line through it and was replaced by the word "Humalog" is 40 (underlined) units QID, not 37. Sorry. Needs sliding scale together with fixed dose."</p> <p>The physician sent clarification to the facility on 3/16, advising them the resident should be taking Humalog 40 units QID and also should continue taking the sliding scale insulin. Additionally, the 3/1/11 order for 30 units to be given if BG was less than 120, was still in effect and being given.</p> <p>The following errors were documented on the March 2012 MAR, between 3/17 through 3/31:</p> <p>* The March MAR documented, the facility</p>	R 008		

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R 008	<p>Continued From page 7</p> <p>discontinued the sliding scale insulin on 3/18/12. There was no evidence in the resident's record the physician discontinued the sliding scale, nor could the facility provide clarification as to the reason the sliding scale was discontinued. The resident should have received the sliding scale insulin as ordered on the following days and times:</p> <p>3/17 - PM BG was 203 = 4 additional units            3/18 - HS BG was 162 = 2 additional units            3/19 - AM BG was 262 = 6 additional units            3/19 - Noon BG was 307 = 8 additional units            3/19 - PM BG was 308 = 8 additional units            3/19 - HS BG was 275 = 6 additional units            3/20 - AM BG was 285 = 6 additional units            3/20 - Noon BG was 262 = 6 additional units            3/20 - PM BG was 185 = 2 additional units            3/21 - AM BG was 194 = 2 additional units            3/21 - PM BG was 224 = 4 additional units            3/21 - HS BG was 194 = 2 additional units            3/24 - Noon BG was 211 = 4 additional units            3/26 - Noon BG was 191 = 2 additional units            3/28 - AM BG was 168 = 2 additional units            3/28 - PM BG was 245 = 4 additional units            3/28 - HS BG was 262 = 6 additional units            3/29 - AM BG was 191 = 2 additional units            3/29 - PM BG was 201 = 4 additional units            3/29 - HS BG was 181 = 2 additional units            3/30 - AM BG was 252 = 6 additional units</p> <p>* The facility assisted the resident with 37 units, rather than 40 units from 3/17 through 3/28. The resident required 40 units on the following dates and times, but was assisted with 37 units:</p> <p>3/17 - AM BG            3/18 - AM BG, Noon BG            3/19 - AM BG, Noon BG, PM BG, HS BG            3/20 - AM BG, Noon BG, PM BG, HS BG</p>	R 008		

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R 008	<p>Continued From page 8</p> <p>3/21 - AM BG, Noon BG, PM BG, HS BG 3/22 - AM BG 3/23 - AM BG 3/24 - AM BG, Noon BG 3/25 - AM BG, PM BG 3/26 - Noon BG, HS BG 3/27 - AM BG, Noon BG 3/28 - AM BG</p> <p>* The resident was assisted with 30 units on 3/18 when the PM BG was 124; however, the resident should have received 40 units, although the facility was only assiting with 37 units at that time.</p> <p>* Between 3/17 through 3/28, the resident was assisted with 37 units of insulin, although they should have been assisted with 40 units of insulin. After 3/28, the facility began assisting the resident with 40 units of insulin as ordered. On the following dates, both the 30 and 37 units were signed or the 30 and 40 units were signed as given; therefore, it could not be determined if the resident received the appropriate amount of insulin:</p> <p>3/22 - HS BG 3/26 - PM BG 3/29 - Noon BG 3/29 - HS BG</p> <p>* On the following dates, it could not be determined if the resident received the appropriate amount of insulin as there were no signatures on the insulin doses or, one or both of the unit doses were circled and none were signed as given:</p> <p>3/17 - Noon BG 3/18 - HS BG 3/22 - PM BG</p>	R 008		

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R 008	<p>Continued From page 9</p> <p>3/25 - HS BG 3/27 - PM BG 3/27 - HS BG 3/28 - PM BG 3/28 - HS BG</p> <p>* On the following dates, the resident received the wrong dosage of insulin:</p> <p>3/30 - HS BG was 91, the resident received 40 units, not 30 units. 3/31 - Noon BG was 113, the resident received 40 units, not 30 units.</p> <p>There were a total of 74 documented errors with Resident #6's insulin in March. The facility assisted the resident 26 times with 37 units of insulin; instead of 40 units of insulin as clarified on 3/16/12. Additionally, the facility discontinued the resident's sliding scale insulin without an order or clarification from the physician, this resulted in 21 times when the resident did not receive sliding scale insulin as ordered.</p> <p>Resident #6's April 2012 MAR did not contain a sliding scale.</p> <p>A physician's order dated 4/12/12, documented the sliding scale was discontinued.</p> <p>The following errors were documented on the April 2012 MAR:</p> <p>* The resident did not receive sliding scale insulin on 14 different occasions as ordered between 4/1 and 4/11.</p> <p>* On 4/12, the resident's PM BG was 120: the resident received the incorrect dose of 30 units, rather than the prescribed 40 units.</p>	R 008		

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R 008	<p>Continued From page 10</p> <p>* On the following dates, the 40 unit doses were circled, it could not be determined if the resident received insulin:</p> <p>4/9 - PM BG was 125 4/15 - PM BG was 85 4/16 - PM BG was 80 4/16 - HS BG was 112 4/18 - PM BG was 100 4/24 - Noon BG was 108</p> <p>* On 4/29, the resident's HS BG level was not documented; therefore, it could not be determined the resident received the appropriate amount of insulin.</p> <p>* On the following dates, it could not be determined if the resident received insulin, as both the 30 and 40 units were not signed as given:</p> <p>4/7 - HS BG 4/8 - HS BG 4/25 - HS BG</p> <p>* On 4/16, the resident's Noon BG documented that both the 30 unit and 40 unit insulin doses were signed as given. It could not be determined if the resident received 30, 40 or 70 units of insulin:</p> <p>There were a total of 26 documented errors with Resident #6's insulin in April. Additionally, the resident went 24 days without sliding scale insulin before the facility received a discontinuation order from the resident's physician on 4/12/12.</p> <p>On 4/30/12 at 12:31 PM, the medication aide was observed checking the resident's BG. The blood</p>	R 008		

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R 008	<p>Continued From page 11</p> <p>glucometer registered the resident's BG was 118. The medication aide then left the resident's room and went back to the medication cart. There were two different bags observed in the medication cart, which were labeled "[Resident's name, 40 units] and [Resident's name, 30 units]. The medication aide picked out a pre-filled syringe out of the 30 unit bag and took it into the resident's room for him to self-inject.</p> <p>On 4/30/12 at 12:36 PM, the medication aide was asked if the resident could interpret or understand when he would require 30 or 40 units of insulin. The aide responded that she was not sure if the resident understood his dosage and didn't know if the resident was trained to determine the appropriate dose.</p> <p>Resident #6 had been evaluated to safely self-administer insulin; however, the medication aides were observed to choose the dosage of insulin the resident received. Additionally, between February and April 2012, the facility's medication aides made 127 errors when assisting Resident #6 with his insulin.</p> <p>2. Resident #5 was admitted to the facility on 9/15/11 with a diagnosis of insulin dependent diabetes.</p> <p>Resident #5's record documented that he was started on sliding scale insulin, in addition to his routine dosage, on 2/8/12.</p> <p>The February and March 2012 MARs documented the resident was to receive the following sliding insulin dosage prior to meals:</p> <p>For BGs of:</p>	R 008	<p>1. Insulin – Resident #5</p> <p>Med Techs completed an additional 2 hour training with the facility licensed nurse (see attachments # 4 &amp; #5) which included the importance of accuracy during a medication pass, the 6 Rights of medication administration, and correct documentation.</p> <p>BG parameters have been ordered and clarified with Resident #5's physician. These parameters have been transcribed onto the MAR. An in-service was held with the Med-Techs to support that they understand the parameters ordered and when to contact the facility nurse. Resident #5's new insulin orders along with new BG parameters were reviewed during this in-service. Hypoglycemia and Hyperglycemia were also covered during this in-service. (See attachment # 6)</p> <p>An in-service was held on the importance of documenting legibly while working as a Med Tech. (see attachment # 4 &amp; #5)</p> <p>Current orders for Resident #5 no longer require the resident to determine his insulin dose based on blood glucose levels. The facility nurse has completed a self medication assessment related to self injection ability along with the ability to dial an insulin pen for Resident #5.</p> <p>Medication issues have been investigated and summaries have been completed for the medication issues. Resident #5's physician and responsible party have been notified.</p>	

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R 008	<p>Continued From page 12</p> <p>151 to 200 = 1 unit 201 to 250 = 2 units 251 to 300 = 3 units 301 to 350 = 4 units 351 to 400 = 5 units 401 to 450 = 6 units</p> <p>The February and March MARs documented the following insulin dosage errors:</p> <p>*On 2/18/12, the resident's BG, prior to breakfast, was 369. The resident was assisted with 4 units of insulin instead of the 5 units as prescribed.</p> <p>*On 2/21/12, his BG, prior to lunch, was 216. He did not receive any sliding scale insulin, but he should have received 2 units.</p> <p>*On 3/2/12, his BG, prior to lunch, was 425. He was assisted with 1 unit of insulin instead of the 6 units as prescribed.</p> <p>*On 3/6 and 3/8/12, the resident's BGs, prior to dinner, were 208 and 305. The medication aide did not document on the MAR the amounts of insulin, if any, the resident was assisted with.</p> <p>*On 3/9/12, his BG, prior to dinner, was 375. He was assisted with 4 units of insulin instead of the 5 units as prescribed.</p> <p>*On 3/16/12, his BG, prior to lunch, was 228. He was assisted with 3 units of insulin instead of the 2 units as prescribed.</p> <p>*On 3/22/12, his BG, prior to dinner, was 217. He was assisted with 1 unit of insulin instead of the 2 units as prescribed.</p> <p>*On 3/23/12, his BG, prior to lunch, was 288. The</p>	R 008		

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R 008	<p>Continued From page 13</p> <p>MARs documented the resident was not assisted with sliding scale insulin, but he should have received 3 units.</p> <p>*On 3/24/12, his BGs, prior to breakfast and lunch, were 154 and 230. The MARs documented the resident was not assisted with sliding scale insulin, but he should have received 1 unit prior to breakfast and 2 units prior to lunch.</p> <p>*On 3/29/12, his BG, prior to dinner, was 156. The MARs documented the resident was not assisted with sliding scale insulin; he should have received 1 unit.</p> <p>From 2/8/12 until 3/31/12, the resident received too much insulin once and not enough insulin 9 times. Additionally, the medication aide failed twice to document on the MAR the amount of insulin she assisted the resident with, if any. This resulted in 12 insulin errors in less than two months.</p> <p>The April 2012 MAR documented the resident was to receive the following sliding insulin dosage prior to meals:</p> <p>For BGs of:</p> <p>151 to 200 = 1 unit 201 to 250 = 2 units 251 to 300 = 3 units 301 to 350 = 4 units 351 to 400 = 5 units</p> <p>The MARs did not document what, if any, sliding scale insulin the resident was to be assisted with if his BGs exceed 400. Additionally there were no instructions as to what the unlicensed medication aides were to do if the BGs exceeded 400.</p>	R 008		

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R 008	Continued From page 14  The April 2012 MAR documented the following errors:  *On 4/6/12, the resident's BG, prior to lunch, was 185. The MARs documented the resident was not assisted with sliding scale insulin; he should have received 1 unit of insulin.  *On 4/7/12, his BG, prior to dinner, was 364. He was assisted with 4 units of insulin, instead of the 5 units as prescribed.  *On 4/12/12, his BG, prior to dinner, was 476 and he was assisted with 4 units of insulin. There were no orders for the amount of sliding scale insulin the resident was to receive when his BG exceeded 400. The medication aide did not consult with the resident's physician or the facility nurse prior to assisting the resident with the 4 units of insulin.  *On 4/13/12, the resident's BGs, prior to breakfast, lunch and dinner, were 211, 411 and 426. He was assisted with 1 unit, 5 units, and 4 units of insulin. Prior to breakfast he was assisted with 1 unit, when he should have received 2 units of insulin. Additionally, the medication aide did not consult with the resident's physician or the facility nurse prior to assisting the resident with the sliding scale insulin when his BGs exceed 400.  *On 4/14/12, the resident's BGs, prior breakfast and lunch, were 167 and 330. The MARs documented the resident was not assisted with sliding scale insulin prior to breakfast; he should have received 1 unit. He was assisted with 3 units prior to lunch, when he should have received 4 units. Additionally, the documented BG prior to dinner was illegible, as was the amount of insulin	R 008		
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R 008	<p>Continued From page 15</p> <p>he was assisted with. Due to the illegibility of the documentation, it could not be determined if the resident received the correct insulin dosage.</p> <p>*On 4/16/12, the documented BG, prior to dinner, was illegible. The resident was assisted with 2 units of insulin. Due to the illegibility of the blood glucose level it could not be determined if the resident received the correct insulin dosage.</p> <p>*On 4/20/12, his BGs, prior to lunch and dinner, were 372 and 416. Prior to lunch he was assisted with 2 units of insulin; he should have received 5 units. The amount of insulin he was assisted with prior to dinner was illegible. Additionally, there was no documentation the medication aide consulted with the resident's physician or the facility nurse prior to assisting the resident with the sliding scale insulin when his blood glucose levels exceed 400.</p> <p>Resident #5's sliding scale insulin was discontinued on 4/21/12.</p> <p>From 4/1 until 4/20/12, the resident was not assisted with the correct amount of insulin 5 times. There were 3 instances where the documentation on the MARs was illegible, making it impossible to determine if the resident was assisted with the correct dosage of insulin. Additionally, there were 4 instances when the unlicensed medication aide made the determination, without consulting a physician or nurse, to assist the resident with sliding scale insulin when his BGs exceeded 400. This resulted in 12 insulin errors in 20 days.</p> <p>On 5/2/12 at 11:58 AM, the resident stated his physician started him on the sliding insulin scale sometime in February 2012. He said it was</p>	R 008	<p>II Oral Medications – Resident #4</p> <p>A. Seroquel</p> <p>We received a clarification order for the resident's ordered Seroquel from Resident #4's physician dated 5/2/12. (See attachment 7)</p> <p>Upon investigation, we found that the resident did receive the correct dosage of Seroquel as ordered by his physician.</p> <p>An in-service was held with the Med Techs regarding bubble packaged medications. It was reviewed during this in-service that they are not to make changes by writing on the bubble packaged medications as only a licensed nurse is allowed to do so under their scope of practice. The Med Techs have been educated to contact the licensed nurse if an order is unclear when completing a medication pass. (See attachments # 3 &amp; #4)</p> <p>II Oral Medications – Resident #4</p> <p>B. Colace</p> <p>An order clarification was sent to Resident #4's physician regarding his Colace order on 5/17/12. This order has been transcribed onto the MAR, bubbled packaged correctly, and is being administered as ordered.</p>	

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R 008	<p>Continued From page 16</p> <p>confusing to him, but the medication aides usually handed him the insulin pen already dialed and told him to go ahead and inject it.</p> <p>On 5/2/12 at 3:38 PM, the facility nurse and administrator confirmed the medication aides made errors when they assisted Resident #5 with his sliding scale insulin.</p> <p>From 2/8/12 until 4/20/12, the facility's medication aides made 24 errors when assisting Resident #5 with his insulin. Additionally, the unlicensed medication aides determined the dosage of insulin needed when Resident #5's BGs exceeded 400, even when there were no orders for sliding scale insulin.</p> <p><b>II. Oral Medications</b></p> <p>Resident #4 was admitted to the facility on 9/21/10, with diagnoses including hypertension, and dementia with behavioral disturbance.</p> <p><b>A. Seroquel (a psychotropic medication)</b></p> <p>The record contained a physician's order, dated 4/4/12, documenting quetiapine (Seroquel) was to be increased to 200 mg at night time.</p> <p>Resident #4's record contained a physician's order, dated 4/16/12, documenting, "Seroquel 100 mg tablet take 1 tab by mouth at bedtime."</p> <p>Resident #4's April 2012 MAR documented from 4/1/12 to 4/3/12, Seroquel 100 mg was given at bedtime; then on 4/4/12, Seroquel, 200 mg was given at bedtime through 4/30/12.</p> <p>The 4/4/12 order and the 4/16/12 order were not congruent. The 4/4/12 order of 200 mg of</p>	R 008	<p>Medication issues have been investigated and summaries have been completed for the medication issues. Resident #4's physician and responsible party have been notified.</p> <p><b>III Inhaler</b></p> <p>Resident #10 has been discharged from the community.</p> <p><b>II. How to Identify Other Residents:</b></p> <p><b>1. Insulin</b></p> <p>Current Insulin dependent diabetics have been audited thoroughly by the licensed nurse and Administrator. Current physician orders are in place and have been verified against the MAR for accuracy. Insulin dependent resident's files have been audited to support that current BG parameters have been ordered and transcribed onto the MAR. The licensed nurse has completed current self med assessments with the insulin dependent diabetics related to the ability to self injection their insulin as ordered and/or dial an insulin pen independently.</p> <p>Med Techs completed an additional 2 hour training with the facility nurse which included the importance of accuracy during a medication pass, the 6 Rights of medication administration, and correct documentation.</p>	
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R 008	<p>Continued From page 17</p> <p>Seroquel was implemented through the end of the month, despite an order on 4/16/12 documenting 100 mg should be given. There was no documentation in the record that the facility attempted to clarify the orders.</p> <p>On 5/2/12 at 10:25 AM, the medication bubble-pack was observed. The label was hand-written and contained two different orders. One order stated, "Take 2 tabs (1/2) = 100 mg". (It appeared that the 100 mg was originally 200 mg, but someone had written over the 2, making it read 100 mg). The second order on the label stated, "Seroquel 200 mg tablet. Take 1/2 tablet by mouth at bedtime." It was unclear whether staff were to assist with 2 (1/2) tablets, or one (1/2) tablet.</p> <p>On 5/2/12 at 10:28 AM, the medication aide stated she did not work the evening shift and was unsure whether staff were assisting with 2 (1/2) tablets or one (1/2) tablet. She confirmed the bubble-pack was unclear.</p> <p>On 5/2/12 at 10:30 AM, the facility RN was unsure what dosage of Seroquel Resident #4 should be on. "I will get on the phone and get on it."</p> <p>On 5/2/12 at 11:05 AM, the LPN stated Resident #4 had two different physicians who sent orders in about the same time, which was why the Seroquel orders were incongruent. She stated, she had not clarified what dosage of Seroquel Resident #4 was supposed to be on. She confirmed the bubble-pack label was confusing.</p> <p>The facility did not clarify what dosage of Seroquel resident #4 was supposed to be on, when two different doctors ordered different</p>	R 008	<p>Current insulin dependent diabetic residents have been audited by the licensed nurse and Administrator to support that the Med Techs are not making determination of an insulin dose based off the blood glucose result.</p> <p>The MAR has been audited by the licensed nurse and Administrator for illegible documentation.</p> <p>II Oral Medications &amp; III Inhaler</p> <p>Current bubble packaged medications have been audited to support that the documentation is clear and that the dose of the medication matches the current physician orders.</p> <p>An in-service was held on 5/11/12 – 5/18/12 regarding the importance of calling the facility nurse with any questions or concerns staff might have related to ordered medications.</p> <p>Current orders have been reviewed against the MAR and medications in the cart which are being given.</p>	

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R 008	<p>Continued From page 18</p> <p>amounts. Further, the bubble-pack was not labeled appropriately, which made it unclear as to how many tablets staff were to assist the resident with, or how much the resident actually received.</p> <p>B. Colace (a stool softener)</p> <p>Resident #4's record contained a physician's order, dated 4/16/12, documenting he was to receive 100 mg of Colace daily.</p> <p>Resident #4's April 2012 MAR documented, "Colace, 100 mg capsule, take 1 cap by mouth every day."</p> <p>On 5/2/12 at 10:24 AM, the bubble-pack was observed and it documented that 250 mg tablets were in the bubble-pack. At this time, the medication aide stated she was not aware that the bubble-pack did not match the MAR and the order.</p> <p>On 5/2/12 at 10:30 AM, the facility RN stated she was not aware the Colace bubble-pack was incongruent with the physician's orders and the MAR.</p> <p>Resident #4 was assisted with 2.5 times more Colace than ordered.</p> <p>III. Inhaler</p> <p>Resident #10 was admitted to the facility on 12/4/09, with a diagnosis of Chronic Obstructive Pulmonary disease and was discharged from the facility on 3/3/12</p> <p>The record contained a physician's order dated, 11/22/11, documenting, "Advair 50/250, 1 puff twice daily." Advair contains Fluticason</p>	R 008	<p><b>III. Systemic Change:</b></p> <p>I. Insulin</p> <p>If a licensed nurse receives an order from a physician regarding a medication which is unclear or is not congruent with other providers, clarification will be obtained. If a physician other than the PCP orders a medication, the facility nurse will communicate with the PCP and notify them of any changes to the resident's medication regimen.</p> <p>Insulin dependent diabetics will have ordered BG parameters from their physician which will be transcribed onto the MAR and communicated to the Med Techs.</p> <p>Med Techs will complete a documented in-service training which will include the importance of accuracy during a medication pass, the 6 Rights of medication administration, and correct documentation before working as a community Med Tech.</p> <p>If a resident has an insulin sliding scale ordered by their physician, the resident will be assessed by the licensed nurse for the ability to determine his/her own insulin dose based off their BG level.</p> <p>If a resident is insulin dependent as ordered, the licensed nurse will complete</p>	

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R 008	<p>Continued From page 19</p> <p>Propionate and Salmeterol.</p> <p>The record contained a hospital report, dated 12/27/11, documenting "Active Outpatient Medications." This report did not include Advair as an active medication. The report documented, Budesonide 80/Formoterol 4.5 mcg, was to be inhaled twice daily to prevent shortness of breath. The report was initialed by the facility LPN on 12/27/11.</p> <p>Resident #10's December 2011 through March 2012 MARS, did not document he received the Budesonide/Formoterol inhaler. The MARS documented he received Advair 50/250 twice daily.</p> <p>Resident #10's record contained a care note from the LPN, dated 12/27/11, documenting "Appt today. 0 new orders noted."</p> <p>On 4/2/12 at 10:15 AM, the medication aide stated she only remembered assisting the resident with Advair.</p> <p>On 4/2/12 at 10:32 AM, the facility RN stated Resident #10 was "before my time." She did not know what inhalers were ordered.</p> <p>Resident #10 was not assisted with the Budesonide/Formoterol inhaler, as ordered on 12/27/11. Further, it was unclear as to whether Advair was to be continued after 12/27/11, as it was not ordered at that time. There was no documentation in the record that the facility attempted to clarify what inhalers resident #10 was supposed to be on.</p> <p>The facility did not ensure Resident #5 and Resident #6 received the correct doses of insulin</p>	R 008	<p>a self medication assessment related to their ability to self inject an insulin syringe and/or an insulin pen.</p> <p>A meeting will be held consistently with the Administrator, Nurse &amp; Medication Tech to review the medication administration records for accurate transcribed orders, documentation from the Med Techs, and correct administration for current and new insulin dependent diabetics.</p> <p>Licensed nurse will audit the medication cart frequently to support that the packaged medications are documented correctly, match the transcribed orders on the MAR, and are being administered as ordered.</p> <p>Before a medication recap for a resident is sent to the physician for signature, the medication recap will be compared to the current MAR and to the current orders. This will also be reviewed by the facility nurse for accuracy.</p> <p><b>IV. Monitoring:</b></p> <p>The licensed nurse and Administrator will complete consistent audits of resident's charts to review current physician orders. Orders from different providers other than the PCP will be audited to support that the communication has been sent to the PCP related to the resident's medication regimen. These orders will be compared to the MAR and to the medications in the med cart.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13R480	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  05/03/2012
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NAME OF PROVIDER OR SUPPLIER  EMERITUS AT SUMMER WIND	STREET ADDRESS, CITY, STATE, ZIP CODE 5955 CASTLE DRIVE BOISE, ID 83703
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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) COMPLETE DATE
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R 008	Continued From page 20  when they did not monitor or track the amount of insulin the residents received. Further, the unlicensed medication aides dialed residents' insulin pens and determined the dosage of insulin they received. Additionally, the facility did not ensure that Resident #4 and Resident #10 received medications as prescribed by their physicians. These failures demonstrated medication system problems that had the potential to affect 100% of the residents. This resulted in inadequate care.	R 008	<p>The licensed nurse and Administrator will complete consist audits of insulin dependent diabetics. This audit will include, reviewing the MAR for current BG parameters to support that these are in place as ordered. The BG levels will also be reviewed to support follow up is not needed with their physician. The chart will be audited to support that there is a self med assessment in place related to the resident's ability to self inject ordered insulin. Any Med Techs that are found to have illegible documentation will be in-serviced as needed.</p> <p>A meeting will be held consistently with the Administrator, Nurse &amp; Medication Tech to review the medication administration records for accurate transcribed orders, documentation from the Med Techs, and correct administration for insulin dependent diabetics.</p> <p><b>V. Date of Completion:</b></p> <p>This POC will be completed on or before: June 17<sup>th</sup> 2012</p> <p>Tamara McCann <i>Tamara McCann</i> Administrator Summer Wind Assisted Living <i>5/24/12</i></p>	
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**ASSISTED LIVING**  
**Non-Core Issues**  
**Punch List**

Facility Name Emeritus at Summerwind	Physical Address 5955 Castle Drive	Phone Number 331-1300
Administrator Tamara McCann	City Boise	Zip Code 83703
Team Leader Polly Watt-Geier	Survey Type Licensure, Follow-up and Complaint	Survey Date 05/03/12

**NON-CORE ISSUES**

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	220.03.c	The admission agreements did not disclose how the points/minutes were determined on the assessments (i.e. how many total points are in each category (assistance with toileting, communication, etc) or how points are determined in each category).	5/31/12	6/26/12 PWSG
2	220.17	The admission agreement did not describe what may occur when a resident transitions to Medicaid.	5/14/12	6/14/12 PWSG
3	225.01	The facility did not evaluate Residents #5's behaviors of verbal altercations with other residents/staff prior to adjusting medications. Resident #10's refusal of cares were not evaluated. ***REPEAT x 2***	5/31/12	6/26/12 PWSG
4	225.02	The facility did not develop Interventions for each behavior for Residents #5 and #10.	5/31/12	6/14/12 PWSG
5	260.06	The facility did not maintain the interior and exterior of the facility in a clean, safe and orderly manner. i.e. Resident # <del>8</del> , #5 and random residents rooms had a strong urine order.	5/31/12	6/14/12 PWSG
6	304.1.01	The facility nurse did not conduct 90 day nursing assessments for Resident # <del>8</del> . ***REPEAT***	5/31/12	6/14/12 PWSG
7	305.01	The facility nurse did not assess and evaluate Resident #2's response to medications or therapies provided by an outside provider.	5/31/12	6/14/12 PWSG
8	305.02	Resident # <del>8</del> 's Tylenol and Resident #6's insulin was not congruent with the MARS and medication label. ***REPEAT x 2***	5/31/12	6/14/12 PWSG
9	305.03	Resident #1, # <del>8</del> and #9's were not assessed when caregivers reported skin integrity issues. Resident # <del>8</del> was not assessed when he was readmitted from another facility.	5/31/12	6/14/12 PWSG
10	305.04	The facility nurse did not make recommendation regarding preventative measures to prevent further skin breakdown for Resident # <del>8</del> (i.e. reposition, frequent toileting or changing of attends, nutritional needs). ***REPEAT***	5/25/12	6/14/12 PWSG

Response Required Date  
06/02/12

Signature of Facility Representative  
*Tamara McCann*

Date Signed  
5/3/12



ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name Emeritus at Summerwind	Physical Address 5955 Castle Drive	Phone Number 331-1300
Administrator Tamara McCann	City Boise	Zip Code 83703
Team Leader Polly Watt-Geier	Survey Type Licensure, Follow-up and Complaint	Survey Date 05/03/12

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
11	305.06	Resident #10 and Resident #7 were not assessed to safely self-administer medications.	5/31/12	6/14/12 PWS
12	305.07	There were no parameters to guide staff when Resident #5's BGs were abnormal.	5/31/12	6/14/12 PWS
13	310.01	Resident #6's pre-filled syringes of insulin, Resident #8's Tylenol and Resident #4's Seroquel were not labeled in accordance with pharmacy requirements.	5/31/12	6/14/12 PWS
14	310.01.c	The temperature log was not maintained on a daily basis for refrigerator medications.	5/31/12	6/14/12 PWS
15	310.01.f	The medication aide did not observe residents taking medications.	5/31/12	6/14/12 PWS
16	310.04.e	The facility did not provide behavior updates to Resident #4's physician who was conducting psychotropic medication reviews.	5/31/12	6/14/12 PWS
17	320.01	NSAs did not clearly reflect the residents' needs. (Resident #1 - assistance with toileting and ambulation; Resident #2 - preventative measures for skin conditions and all ADLs; Resident #3 - assistance with eating and toileting; Resident #4 - dietary needs and mobility; Resident #5 - Diabetic management, mobility, personal hygiene; Resident #8 - assistance with toileting, mobility, reposition). Additionally, Resident #8's NSA was not implemented regarding her toileting needs.	5/31/12	6/14/12 PWS
18	320.03	NSAs were not signed and dated by residents, their legal representatives or administrator.	5/31/12	6/14/12 PWS
19	320.02	Care notes were not kept for 3 years.	5/31/12	6/14/12 PWS
20	350.02	The administrator did not document investigations of all complaints.	5/4/12	6/14/12 PWS
21	350.04	The administrator did not provide a written response to all complainants.	5/4/12	6/20/12 PWS
Response Required Date 06/02/12	Signature of Facility Representative <i>Tamara McCann</i>		Date Signed 5/3/12	





# IDAHO DEPARTMENT OF HEALTH & WELFARE Food Establishment Inspection Report

Food Protection Program, Division of Health  
450 W. State Street, Boise, Idaho 83720-0036  
208-334-5938

Establishment Name <u>Emeritus AT Summer Wind</u>		Operator <u>Tammara McCann</u>	
Address <u>5455 Castle Drive</u>			
County <u>ADA</u>	Estab #	EIIS/SUR.#	Travel time:
Inspection Type: <u>Standard</u>	Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up:
Date: _____		Date: _____	
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.			

# of Risk Factor Violations	<u>0</u>	# of Retail Practice Violations	<u>0</u>
# of Repeat Violations	<u>0</u>	# of Repeat Violations	<u>0</u>
Score	<u>0</u>	Score	<u>0</u>
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection.	

### RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
<u>Y</u> N	1. Certification by Accredited Program; or Approved Course; or correct responses; or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Employee Health (2-201)</b>		
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Good Hygienic Practices</b>		
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Control of Hands as a Vehicle of Contamination</b>		
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Approved Source</b>		
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>(N/A)</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Protection from Contamination</b>		
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>Y</u> N <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>(N/O)</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Consumer Advisory</b>		
<u>Y</u> N <u>(N/A)</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Highly Susceptible Populations</b>		
<u>Y</u> N <u>(N/O)</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Chemical</b>		
<u>Y</u> N <u>(N/A)</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Conformance with Approved Procedures</b>		
<u>Y</u> N <u>(N/A)</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance  
N/O = not observed  
COS = Corrected on-site  
N = no, not in compliance  
N/A = not applicable  
R = Repeat violation  
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Pork Chops</u>	<u>182°</u>	<u>Mayo</u>	<u>39.1</u>				
<u>Disc Mushrooms</u>	<u>163°</u>	<u>Biscuits</u>	<u>199.</u>				

### GOOD RETAIL PRACTICES ( = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/in-use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp. control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed; cross-connection, back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

### OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Tammara McCann</u>	(Print) <u>Tammara McCann</u>	Title <u>ED</u>	Date <u>5/2/12</u>
Inspector (Signature) <u>Mark Hauer</u>	(Print) <u>Mark Hauer</u>	Date <u>5/2/2012</u>	Follow-up: (Circle One) <u>Yes</u> <u>No</u>



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

LESLIE M. CLEMENT—DEPUTY DIRECTOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

May 14, 2012

Tamara McCann, Administrator  
Summer Wind, A Retirement & AI Facility  
3131 Elliott Avenue - Suite 500  
Seattle, WA 98121

Dear Ms. McCann:

An unannounced, on-site complaint investigation survey was conducted at Emeritus At Summer Wind from April 30, 2012, to May 3, 2012. During that time, observations, interviews or record reviews were conducted with the following results:

**Complaint # ID00005273**

**Allegation #1:** The facility did not toilet an identified resident as agreed upon in the NSA.

**Findings #1:** On 4/30/12 through 5/3/12, a survey was conducted. During this time, the identified resident no longer resided at the facility. Therefore, the identified resident could not be observed receiving assistance with toileting. His closed record documented caregivers approached the identified resident to provide assistance with toileting, for which he frequently refused. During the survey, only one caregiver was available for interview, who cared for the identified resident. She stated the identified resident was assisted with toileting, but staff had to reproach him several times a day, due to him refusing help.

Unsubstantiated. However, a current resident was not observed receiving assistance with toileting as agreed upon in the NSA. Therefore the facility was cited at 16.03.22.320.01 for not implementing the NSA. Additionally, the facility was cited at 16.03.22.225.01 and 16.03.22.225.01 for not developing a behavior management plan to guide caregivers on providing cares to the identified resident when he refused assistance. The facility was required to submit evidence of resolution within 30 days.

**Allegation #2:** The administrator was not investigating complaints or providing a written response to those complaints.

- Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.02 and 16.03.22.350.04 for not investigation all complaints and providing a written response to all complainants. The facility was required to submit evidence of resolution within 30 days.
- Allegation #3: The medication aides were not watching residents take their medications.
- Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.f for not observing residents take their medications. The facility was required to submit evidence of resolution within 30 days.
- Allegation #4: An identified resident did not receive inhaler treatments as ordered by the physician.
- Findings #4: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for not providing the appropriate assistance and monitoring of medications. The facility was required to submit a plan of correction.
- Allegation #5: Residents' rooms smelled of urine.
- Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for not ensuring the facility took precautions to prevent offensive odors. The facility was required to submit evidence of resolution within 30 days.
- Allegation #6: The facility limited a resident's mobility by placing him in a room too small to allow for all his equipment.
- Findings #6: On 4/30/12 through 5/3/12, a survey was conducted. At the time of the survey, the identified resident no longer lived at the facility; thus his room could not be observed. The identified resident's record did not contain any care notes or incident reports documenting he had difficulty maneuvering his equipment within his room. Incident reports did not document any current residents had incidents resulting from them being unable to utilize their adaptive equipment within their rooms. One current resident stated she had difficulty utilizing her wheelchair in her shared room. However, the facility was in the process of moving her to a larger room.
- On 5/10/12 at 10:30 AM, a caregiver stated she did not recall the identified resident having difficulty maneuvering his equipment within his room.
- Unsubstantiated.
- Allegation #7: The admission agreements did not clearly reflect how charges were calculated.

Tamara McCann, Administrator  
May 14, 2012  
Page 3 of 3

Findings #7: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.220.03.c for not ensuring admission agreements clearly reflected how charges were calculated. The facility was required to submit evidence of resolution within 30 days.

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, MSW  
Health Facility Surveyor  
Residential Assisted Living Facility Program

PWG

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