



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

July 26, 2011

Victor Odiakosa, Administrator
Wynwood At Twin Falls
1367 Locust Street North
Twin Falls, ID 83301

Dear Mr. Odiakosa:

An unannounced, on-site complaint investigation survey was conducted at Wynwood At Twin Falls on July 21, 2011. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00005111

Allegation #1: The facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of more than 30 days.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.215.03 for failure to retain a licensed administrator for more than 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,

Maureen McCann, RN
Health Facility Surveyor
Residential Assisted Living Facility Program



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July 26, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1880

Victor Odiakosa, Administrator
Wynwood At Twin Falls
1367 Locust Street North
Twin Falls, ID 83301

Dear Mr. Odiakosa:

Based on the Complaint Investigation conducted by our staff at Wynwood At Twin Falls on **July 21, 2011**, we have determined that the facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of more than 30 days.

This core issue deficiency substantially limits the capacity of Wynwood At Twin Falls 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 **September 4, 2011**. **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 **August 8, 2011**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

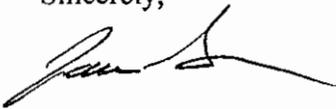
Victor Odiakosa, Administrator
July 26, 2011

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 (**August 8, 2011**). 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 Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **August 8, 2011**, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

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 Wynwood At Twin Falls.

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
Program Supervisor
Residential Assisted Living Facility Program
Medicaid Licensing & Certification

JS/mmc

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R569	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2011
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NAME OF PROVIDER OR SUPPLIER WYNWOOD AT TWIN FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1367 LOCUST STREET NORTH TWIN FALLS, ID 83301
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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 000	<p>Initial Comments</p> <p>The following deficiency was cited during the complaint investigation conducted on 7/21/2011 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Maureen McCann, RN Team Leader Health Facility Surveyor</p> <p>Rachel Corey, RN Health Facility Surveyor</p> <p>Matthew Hauser, QMRP Health Facility Surveyor</p>	R 000	<p style="text-align: center;">RECEIVED AUG 03 2011 FACILITY STANDARDS</p>	
R 004	<p>16.03.22.215.03 Licensed Administrator Requirement - 30 Days</p> <p>The facility may not operate for more than thirty (30) days without a licensed administrator.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of the facility for a period of more than 30 days. The findings include:</p> <p>IDAPA 16.03.22.215.03 documents, "The facility may not operate more then thirty days without a licensed administrator."</p> <p>A complaint investigation was conducted at the facility on 7/21/11.</p> <p>On 7/21/11 at 4:35 PM, the facility administrator stated the previous administrator's last day of</p>	R 004		

Bureau of Facility Standards	TITLE	(X8) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
STATE FORM	6899 QIOG11	If continuation sheet 1 of 2

Handwritten signature and date: V. A. 8/21/11

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R569	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2011
NAME OF PROVIDER OR SUPPLIER WYNWOOD AT TWIN FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1367 LOCUST STREET NORTH TWIN FALLS, ID 83301		
(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 004	Continued From page 1 work was 4/7/11. He further stated he obtained his provisional license effective 6/9/11. The facility operated 62 days without a licensed administrator.	R 004	I have completed every necessary requirements to obtain my Idaho Assisted Living Admin. License; I have also paid the appropriate Licensing Fee to the Bureau of Occupational Licenses. I will schedule to take the exams with Hdmasters on the 5th of August. I will be taking my exams by 12th of August. I will notify the Bureau of Facility Stds after my exams and would send in a copy of my license as soon as I receive it no later than the 25th of August.	

RECEIVED
AUG 03 2011
FACILITY STANDARDS

V. S. O.
8/1/2011



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

LESLIE M. CLEMENT – DEPUTY DIRECTOR
RANDY MAY – DEPUTY ADMINISTRATOR
LICENSING AND CERTIFICATION
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 22, 2011

Victor Odiakosa, Administrator
Wynwood At Twin Falls
1367 Locust Street North
Twin Falls, ID 83301

License #: Rc-569

Dear Mr. Odiakosa:

On July 21, 2011, a Complaint Investigation survey was conducted at Wynwood At Twin Falls. 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.

This office is accepting your submitted plan of correction.

Should you have questions, please contact Maureen A. McCann, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Maureen A. McCann, RN
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program