



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 27, 2014

Michael Day, Administrator  
Independent Living Services Summerwind  
P.O. Box 6395  
Boise, ID 83711

RE: Independent Living Services Summerwind, Provider #13G013

Dear Mr. Day:

This is to advise you of the findings of the Medicaid/Licensure survey of Independent Living Services Summerwind, which was conducted on February 26, 2014.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MONICA NIELSEN  
Health Facility Surveyor  
Non-Long Term Care

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MN/pmt  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/26/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING SERVICES SUMMERWIND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10349 SUMMERWIND DRIVE BOISE, ID 83704</b>
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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) COMPLETION DATE
W 000	<p><b>INITIAL COMMENTS</b></p> <p>Independent Living Services Summerwind is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities. The annual recertification survey was conducted from 2/24/14 to 2/26/14.</p> <p>The survey was conducted by: Monica Nielsen, QIDP, Team Leader Trish O'Hara, RN</p>	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/26/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INDEPENDENT LIVING SERVICES SUMMERWI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10349 SUMMERWIND DRIVE BOISE, ID 83704</b>
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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
M 000	<p>16.03.11 Initial Comments</p> <p>Independent Living Services Summerwind is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)." The annual licensure survey was conducted from 2/24/14 to 2/26/14.</p> <p>The survey was conducted by: Monica Nielsen, QIDP, Team Leader Trish O'Hara, RN</p>	M 000		

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_