



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: 208-364-1962
FAX: 208-364-1888

April 17, 2014

Benjamin Knowles, Administrator
Wynwood at Twin Falls
1367 Locust Street North
Twin Falls, Idaho 83301

License #: RC-569

Mr. Knowles:

On March 6, 2014, a state licensure survey and complaint investigation were 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.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

Your submitted plan of correction and evidence of resolution are being accepted by this office. Please ensure the corrections you identified are implemented for all residents and situations, and implement a monitoring system to make certain the deficient practices do not recur.

Thank you for your work to correct these deficiencies. Should you have questions, please contact Karen Anderson, RN, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 364-1962.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program

JS/sc



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March 17, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8333

Benjamin Knowles
Wynwood at Twin Falls
1367 Locust Street North
Twin Falls, Idaho 83301

Dear Mr. Knowles:

Based on the state licensure survey and complaint investigation conducted by Department staff at Wynwood at Twin Falls between March 3, 2014 and March 6, 2014, it has been determined that the facility failed to protect residents from inadequate care.

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 protected. 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 **April 20, 2014**. **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)?
- ◆ By what date will the corrective action(s) be completed?

Return the **signed** and **dated** Plan of Correction to us by **March 30, 2014**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Benjamin Knowles

March 17, 2014

Page 2 of 2

In accordance with IDAPA 16.03.22.003.02, 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. 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. Your evidence of resolution (e.g., receipts, pictures, policy updates, etc.) for each of the non-core issue deficiencies is to be submitted to this office by **April 5, 2014**.

If, at the follow-up survey, the core deficiency still exists or a new core deficiency is identified, the Department will have no alternative but to initiate an enforcement action against the license held by Wynwood at Twin Falls.

Enforcement actions may include:

- imposition of civil monetary penalties;
- issuance of a provisional license;
- limitation on admission to the facility;
- requirement that the facility hire a consultant who submits periodic reports to Licensing and Certification.

Our staff is available to answer questions and to assist you in identifying appropriate corrections to avoid further enforcement actions. Should you have any questions, or if we may be of assistance, please contact us at (208) 364-1962 and ask for the Residential Assisted Living Facility program. Thank you for your continued participation in the Idaho Residential Care Assisted Living Facility program.

Sincerely,

Jamie Simpson, MS W for

JAMIE SIMPSON, MBA, QMRP

Program Supervisor

Residential Assisted Living Facility Program

KA/sc

Residential Care/Assisted Living

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 03/06/2014
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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
R 000	<p>Initial Comments</p> <p>The following deficiencies were cited during the licensure, follow-up and complaint survey conducted between March 3, 2014 and March 6, 2014 at your residential care/assisted living facility. The surveyors conducting the survey were:</p> <p>Karen Anderson, RN Health Facility Surveyor Team Leader</p> <p>Gloria Keathley, LSW Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Rae Jean McPhillips, RN, BSN Health Facility Surveyor</p> <p>Abbreviations and Definitions:</p> <p>@ - at blk/bwn - black or brown BG - blood glucose BIPAP - Bi-level positive airway pressure cm - centimeter COPD - chronic obstructive pulmonary disease CPAP - continuous positive airway pressure d/t - due to LPN - Licensed Practical Nurse MAR - medication assistance record MRSA - methicillin-resistant staphylococcus aureus NSA - negotiated service agreement O2 - oxygen R - right</p>	R 000		

Bureau of Facility Standards

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

TITLE

(X6) DATE

Ben Howle

Executive Director

3-26-14

Residential Care/Assisted Living

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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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R 000	Continued From page 1 RN - Registered Nurse x - by	R 000		
R 008	<p>16.03.22.520 Protect Residents from Inadequate Care.</p> <p>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.</p> <p><i>This Rule is not met as evidenced by:</i> Based on observation, interview and record review it was determined the facility retained 3 of 11 sampled residents (Residents #7, #9 and #11) who required care beyond what the facility was licensed to provide. Resident #9 had wounds that did not improve bi-weekly and had MRSA. Resident #7 and #11 required the support of a mechanical breathing system. Additionally, the facility did not monitor the assistance of insulin for 2 of 2 sampled residents (#2 and #6). The findings include:</p> <p>1. RETENTION</p> <p>A. Wounds/MRSA</p> <p>IDAPA 16.03.22.152.05.b - No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include:</p> <p>x - A resident with any type of pressure ulcer or open wound that is not improving bi-weekly; and xi - A resident who has MRSA (methicillin-resistant staphylococcus aureus) in an active state (infective state).</p>	R 008		

Residential Care/Assisted Living

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WYNWOOD AT TWIN FALLS

1367 LOCUST STREET NORTH

TWIN FALLS, ID 83304

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R 008	<p>Continued From page 2</p> <p>1. Resident #9's record documented she was admitted to the facility on 3/29/12 with a diagnosis of cancer. According to the record the resident was admitted to hospice services on 6/1/12 and was on hospice at the time of survey.</p> <p>a. Wound on right lower back/MRSA:</p> <p>On 10/18/12, the facility RN documented in the care notes, that Resident #9 had an open area on her right lower back. She documented the area around the wound was red and warm to the touch with a 0.25 cm dark brown area.</p> <p>A quarterly nursing assessment completed by the RN, dated 10/22/12, documented, "In the last week, a reddened area measuring 3 cm x 2.5 cm x 1 cm opened up on R side of back." The nurse documented the wound had a 25% necrotic (dead) area with a small amount of yellow drainage.</p> <p>On 11/7/12, the RN documented in care notes, that the hospice nurse, "...felt that there was infection @ site." The note documented the resident was started on an antibiotic for the infection.</p> <p>On 11/10/12, the facility LPN documented in care notes, the wound had a foul odor and the wound did not show signs of improvement.</p> <p>On 11/19/12, the RN documented in care notes, "Informed by Hospice RN that resident's wound is MRSA." The note documented the physician discontinued the original antibiotic and ordered a new antibiotic.</p> <p>On 11/21/12, the LPN documented in care notes, that Resident #9's physician came to the facility</p>	R 008	<p>Resident # 9 had no active MRSA at time of the Survey.</p> <p>No other residents have non-healing stage 2 or greater wounds or diagnosis of MRSA.</p> <p>Any resident with a non-healing stage 2 wound will have a request for a physician order for culture. Any culture coming back as positive for MRSA will result in a discharge notice given.</p> <p>Residents with wounds will be assessed and any non-healing stage 2 will be issued a move-out notice. If appropriate treatment cannot be provided while a 30 day notice is underway than discharge will occur.</p>	4-16-14

Residential Care/Assisted Living

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WYNWOOD AT TWIN FALLS

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TWIN FALLS, ID 83301**

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R 008	<p>Continued From page 3</p> <p>and debrided the resident's wound.</p> <p>On 12/7/12, the RN documented on the "Open Area Flow Sheet" the wound bed was "80% Blk/Brwn." with a moderate amount of brown drainage that had an odor.</p> <p>On 12/26/12, the RN documented in care notes, the resident was started on antibiotics for a wound infection.</p> <p>On 1/2/13, the LPN documented in care notes, a physical therapist came to the facility and debrided the wound.</p> <p>A quarterly nursing assessment, completed by the RN and dated 2/4/13, documented, "Resident is declining d/t a non-healing wound..." and "Multiple change of types of wound dressings and debriding (removal of dead tissue) have not yielded positive results." The RN documented the wound was 30% covered by necrotic tissue and 30% covered by slough. Additionally, she documented there was a small amount of yellow/tan drainage that had an odor.</p> <p>On 2/12/13, the LPN documented in care notes the resident was started on another antibiotic for a wound infection. The facility RN documented on the "Open Area Flow Sheet," dated 2/12/13, the wound bed was "60% Blk/Brwn" with moderate tan drainage.</p> <p>On 4/15/13, the LPN documented in care notes, the resident was started on another antibiotic for a wound infection.</p> <p>A quarterly nursing assessment, completed by the RN and dated 4/23/13, documented, "Continued slow decline d/t a non-healing wound</p>	R 008	<p>Discussed bi-monthly at Collaborative Care Review where resident clinical needs are discussed. Those scheduled to attend meeting will be Administrator, RN, LPN, Dining Room Manager, Activities Director, Resident Care Coordinator, Business Office Coordinator, Maintenance Technician, Sales/Marketing.</p> <p>Administer is responsible to ensure compliance by attending Collaborative Care Review and by taking appropriate follow-up action.</p>	4-16-14

Residential Care/Assisted Living

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R 008	<p><i>Continued From page 4</i></p> <p>and onset of a new one..."</p> <p>A hospice nurse documented, on 10/18/13, there was a large amount of purulent drainage with slight odor from the wound.</p> <p>A hospice nurse documented, on 11/25/13, the wound had a moderate amount of purulent drainage with slight odor.</p> <p>A hospice nurse documented, on 1/17/14, the wound had a scant amount of drainage.</p> <p>A quarterly nursing assessment completed by the RN, dated 1/18/14, documented the wound was unchanged.</p> <p>On 2/27/14, the RN documented on the "Open Area Flow Sheet" the wound base was "Clean/Pink" and had no drainage.</p> <p>The wound on Resident #9's right hip, which started on 10/18/12, did not improve bi-weekly and had not resolved at the time of survey on 3/6/14, over 16 months later. Additionally, the resident was retained after she developed a MRSA infection in her wound.</p> <p>2. Wound on Left Hip:</p> <p>The RN documented on the "Open Area Flow Sheet" that Resident #9 had developed a wound on her left hip with the "date of initial appearance" as 2/15/13.</p> <p>A hospice nurse documented, on 10/18/13, there was a large amount of purulent drainage with slight odor from the wound.</p> <p>A hospice nurse documented, on 11/25/13, the</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/06/2014
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R 008	<p>Continued From page 5</p> <p>wound had a large amount of purulent drainage with an odor.</p> <p>A hospice nurse documented, on 12/27/13, the wound had a small amount of purulent drainage.</p> <p>A quarterly nursing assessment, completed by the RN and dated 1/18/14, documented the wound did not show signs of improvement.</p> <p>A hospice nurse documented, on 1/17/14, the wound to the left hip had a small amount of drainage with a "slight" odor.</p> <p>A hospice nurse documented, on 2/3/14, Resident #9's wound on her left hip had a scant amount of drainage with a "slight" odor.</p> <p>On 2/27/14, the RN documented on the "Open Area Flow Sheet" the wound bed could not be visualized.</p> <p>The wound on Resident #9's left hip, which started on 2/5/13, did not improve bi-weekly and had not resolved at the time of survey on 3/6/14, approximately 12 months later.</p> <p>3. Wound on right heel:</p> <p>A quarterly nursing assessment, completed by the RN and dated 4/23/13, documented Resident #9's right heel "black decubitus" and the "smaller" left heel "black" decubitus were closed.</p> <p>An "Open Area Flow Sheet" documented Resident #9 developed a wound on her right heel with the "date of initial appearance" as 6/10/13.</p> <p>A quarterly nursing assessment, completed by the RN and dated 7/25/13, documented the right</p>	R 008		

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R 008	<p>Continued From page 6</p> <p>"heel trauma wound re-opened."</p> <p>A hospice nurse documented, on 10/18/13, the wound had a "hard scab."</p> <p>The "Open Area Flow Sheet, documented the wound was "healed" on 11/8/13.</p> <p>A hospice nurse documented, on 11/25/13, the wound continued to have a "hard dry scab."</p> <p>A hospice nurse documented, on 2/3/14, the wound continued to have a "hard dry scab."</p> <p>There was no additional information, after 2/3/14, in Resident #9's record regarding the condition of the wound on her right heel.</p> <p>On 3/5/14 at 12:49 PM, the former hospice nurse, stated she had provided wound care to Resident #9 until mid-February.</p> <p>The wound on Resident #9's right heel, which started on 6/10/13, did not improve bi-weekly for approximately 10 months.</p> <p>On 3/4/14 at 2:15 PM, the resident stated the wound on her right hip started a long time ago after she "hit it" on her wheelchair. She stated the wound on her left hip started after her husband tried to help her transfer. She said the hospice nurse came in at least twice a week to do dressing changes.</p> <p>On 3/5/14 at 10:32 AM, the facility LPN stated the wound on the right hip started in October of 2012 and never "totally healed," but "has gotten better."</p> <p>On 3/5/14 at 10:58 AM, the current hospice nurse stated both wounds on the hips were improving.</p>	R 008		

Residential Care/Assisted Living

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R 008	<p>Continued From page 7</p> <p>He stated the wound on right hip was larger than the wound on the left hip. He stated neither wound had drainage at this time.</p> <p>On 3/5/14 at 12:49 PM, the former hospice nurse stated the resident did develop a MRSA infection at one time. She stated the physician did not test all further suspected wound infections for MRSA.</p> <p>The facility retained Resident #9 when her wounds did not improve bi-weekly and she developed MRSA in a wound.</p> <p>B. Mechanically supported breathing system</p> <p>IDAPA 16.03.22.152.05.b - No resident will be admitted or retained who requires ongoing skilled nursing or care not within the legally licensed authority of the facility. Such residents include:</p> <p>v - A resident who is on a mechanically supported breathing system, except for residents who use CPAP, (continuous positive airway pressure).</p> <p>1. Resident #7's record documented she was an 85 year-old female who was admitted to the facility on 9/25/11 with a diagnosis of sleep apnea.</p> <p>The resident's record contained an undated "Physician Plan of Care" which documented Resident #7 had a diagnosis of obstructive sleep apnea and required a BiPAP machine.</p> <p>"Medical Reports," dated 9/3/13 and 12/23/13, documented Resident #7 was to continue with her BiPAP machine.</p> <p>A "Personal Service Plan," dated 12/31/13, documented Resident #7 used oxygen. The plan</p>	R 008	<p>Obtained sleep study for residents # 7 and # 11. Obtained documentation from Physicians stating that a CPAP would not address the concern of sleep Apnea. BiPAP was recommended by both doctors. 30 day notice will be given if variance from state is not granted.</p> <p>CPAP machines will be checked to ensure that it is a CPAP and not a BiPAP machine.</p> <p>Part of the nurse pre move-in evaluation will be to ask if a CPAP or BiPAP is used. The nurse will check to ensure it is a CPAP. Residents with a BiPAP will not be permitted to move-in unless a variance is obtained from the Bureau of Facility Standards prior to move-in.</p> <p>Administrator will ensure compliance through review of all pre move-in paperwork and review and sign off on quarterly and change of condition assessments.</p>	4-16-14

Residential Care/Assisted Living

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R 008	<p>Continued From page 8</p> <p>did not state that a BiPAP machine was used.</p> <p>A facility nursing assessment, dated 1/2/14, did not document that Resident #7 used a BiPAP machine.</p> <p>On 3/4/14 at 9:40 AM, Resident #7 stated she used a BiPAP machine at night with oxygen. She stated she cleaned the machine and placed it on herself at night.</p> <p>2. Resident #11's record documented she was a 77 year-old female who was admitted to the facility on 6/15/12, with diagnoses including hypoxia, obstructive sleep apnea and COPD.</p> <p>Resident #11's "Personal Service Plan"/NSA, dated 12/31/13, documented she "has a Bi-PAP [sic] that staff need to put water in and move the tubing from the bi-pap [sic] to the concentrator and also to the portable tank when [Resident #11's name] gets up and then again when she prepares for the day."</p> <p>On 3/4/14 at 9:30 AM, an undated note was observed taped to the facility medication cart. The note documented the morning staff were to empty, rinse and air dry the BiPAP machine, and the evening staff were to fill the BiPAP with distilled water.</p> <p>On 3/5/14 at 11:15 AM, Resident #11's BiPAP machine was observed on a table in her room. At that time, Resident #11 stated she used the BiPAP every evening.</p> <p>On 3/4/14 at 11:30 AM, the administrator stated he was not aware of the rule that prohibited the use of BiPAP machines in assisted living facilities.</p>	R 008		

Residential Care/Assisted Living

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TWIN FALLS, ID 83301**

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R 008	<p>Continued From page 9</p> <p>The facility admitted and retained Residents #7 and #11, who required the use of a BIPAP machine.</p> <p>II. ASSISTANCE & MONITORING OF MEDICATIONS</p> <p>The facility's admission agreement contained an assessment titled "Assessment Summary Report" which documented the facility would provide the following services for medications: "Order and coordinate medications...Provide attention and/or assistance with taking medication" and document medications on the "Medication Administration Record."</p> <p>1. Resident #6's record documented she was an 81 year-old female who was admitted to the facility on 3/22/13, with diagnoses including Type II diabetes and rheumatoid arthritis.</p> <p>a. Insulin/Set Dose</p> <p>On 3/3/14 at 12:15 PM, Resident #6 was observed in her room sitting in her recliner. The resident stated she had rheumatoid arthritis and other health issues so caregivers assisted her with ADLs, and the medication aides brought her medications to her room.</p> <p>A physician's order, dated 11/1/13, documented Resident #6 was to receive Humalog insulin, 2 units before meals and Lantus insulin, 10 units at bedtime.</p> <p>The 11/5/13 to 12/4/13 MAR documented the following:</p> <p>*45 times there was no documentation the</p>	R 008	<p>Obtained new Doctors order for Resident # 2 and # 6, removing them from a sliding scale. Nurse and LPN MAR audits to ensure that residents are getting their BG's and insulin and documentation is appropriate.</p> <p>Current residents were screened for those who are diabetic receiving BG's and insulin. MAR audits will be instituted on these residents</p> <p>Ongoing MAR audits will be done to ensure residents receiving BG's and insulin are receiving these with correct doses and related documentation.</p> <p>Administrator will ensure compliance by attending Collaborative Care Review meetings with discussion and review of MAR audits of diabetic residents with BG's and insulin.</p>	4-16-14

Residential Care/Assisted Living

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 03/06/2014
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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**

(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 008	<p>Continued From page 10</p> <p>resident received 2 units of Humalog insulin.</p> <p>*6 times there was no documentation the resident received 10 units of Lantus insulin.</p> <p>The 12/5/13 to 1/4/14 MAR documented the following:</p> <p>*59 times there was no documentation the resident received 2 units of Humalog Insulin.</p> <p>*10 times there was no documentation the resident received 10 units of Lantus insulin.</p> <p>The 1/5/14 to 2/4/14 MAR documented the following:</p> <p>*56 times there was no documentation the resident received 2 units of Humalog insulin.</p> <p>The 2/5/14 to 3/4/14 MAR documented the following:</p> <p>*26 times there was no documentation the resident received 2 units of Humalog Insulin.</p> <p>*3 times there was no documentation the resident received 10 units of Lantus insulin.</p> <p>On 3/5/14 at 9:33 AM, the LPN stated, she had wondered why there had been so many syringes with 2 units of insulin left over each month. The LPN further stated, she thought the left over insulin could have been from the multiple times the resident had been out of the facility with her family.</p> <p>From 11/5/13 until 3/4/14, the facility failed to ensure caregivers checked Resident #6's BG levels, failed to ensure she received insulin as needed, and failed to ensure the correct insulin</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R669	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/06/2014
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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

(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 008	<p>Continued From page 11</p> <p>dose was given on 205 occasions.</p> <p>b. Insulin/Sliding Scale</p> <p>On 3/4/14 at 3:30 PM, Resident #6 was observed in her room, sitting in her recliner. When asked by surveyors how much insulin she required, Resident #6 stated, "I have no idea how much insulin I take." The resident stated, the medication aides brought pre-filled syringes with a dose of insulin based on her blood glucose readings.</p> <p>A Personal Service Plan, dated 2/7/14, documented Resident #6 had a sliding scale dose of insulin ordered before each meal based on her blood glucose. The service plan documented the resident required assistance and supervision to monitor her blood glucose and to provide oversight.</p> <p>According to physician's orders, dated 11/1/13, Resident #6 was to also receive the following sliding scale insulin, before meals and at bedtime, based on the following BG parameters:</p> <p>71 - 150 = 0 unit 151 - 200 = 3 unit 201 - 250 = 6 units 251 - 300 = 9 units 301 - 350 = 12 units 351 - 400 = 15 units over 400 = 18 units and call the physician</p> <p>The 11/5/13 to 12/4/13 MAR documented the following:</p> <p>*41 times there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin</p>	R 008		

Residential Care/Assisted Living

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 03/06/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WYNWOOD AT TWIN FALLS

1367 LOCUST STREET NORTH

TWIN FALLS, ID 83301

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R 008	<p>Continued From page 12</p> <p>was required.</p> <p>*5 times the resident should have received insulin, but none was documented as given.</p> <p>The 12/5/13 to 1/4/14 MAR, documented the following:</p> <p>*44 times there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin was required.</p> <p>*1 time the resident should have received insulin, but none was documented as given.</p> <p>The 1/5/14 to 2/4/14 MAR documented the following:</p> <p>*33 times there was no documentation Resident #6's BG levels were checked, therefore it could not be determined if sliding scale insulin was required.</p> <p>The 2/5/14 to 3/4/14 MAR documented the following:</p> <p>*8 times there was no documentation the resident's BG levels were checked, therefore it could not be determined if sliding scale insulin was required.</p> <p>*2 times the resident should have received insulin, but insulin was not documented as given.</p> <p>*4 times the resident received insulin when her BG was below 150.</p> <p>From 11/5/13 until 3/4/14, the facility failed to ensure caregivers checked Resident #6's BG</p>	R 008		

Residential Care/Assisted Living

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 03/06/2014
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NAME OF PROVIDER OR SUPPLIER

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1367 LOCUST STREET NORTH
TWIN FALLS, ID 83301

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R 008	<p>Continued From page 13</p> <p>levels, failed to ensure she received insulin as needed, and failed to ensure the correct insulin dose was given.</p> <p>2. Resident #2's record documented she was a 96 year-old female who was admitted to the facility on 9/14/07 with diagnoses that included Type II diabetes.</p> <p>When asked by surveyors, on 3/4/14 at 11:45 AM, about how much insulin she required, the resident stated she did not know. She stated the caregivers tested her blood glucose levels, brought in a syringe with insulin and injected her.</p> <p>A physician's order, dated 10/24/13, documented Resident #2 was to receive a sliding scale insulin dosage before each meal and at bedtime based on the following BG parameters:</p> <p>0 - 150 = 0 units 151 - 200 = 4 units 201 - 250 = 8 units 251 - 300 = 12 units 301 - 350 = 16 units 351 - 400 = 20 units over 400 = 24 units and call MD</p> <p>The 10/5/13 to 11/4/13 MARs documented the following:</p> <p>*10 times, from 10/24 through 11/4/13, there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin was required.</p> <p>*4 times, from 10/24 through 11/4/13, the resident should have received insulin, but none was documented as given.</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R669	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/06/2014
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NAME OF PROVIDER OR SUPPLIER
WYNWOOD AT TWIN FALLS

STREET ADDRESS, CITY, STATE, ZIP CODE
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TWIN FALLS, ID 83301**

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R 008	<p>Continued From page 14</p> <p>The 11/5/13 to 12/4/13 the MAR documented the following:</p> <p>*28 times there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin was required.</p> <p>*12 times the resident should have received insulin, but none was documented as given.</p> <p>*On 11/25/13, insulin was documented as given, but the BG level was not documented.</p> <p>The 12/5/13 to 1/4/14 MAR documented the following:</p> <p>*5 times there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin was required.</p> <p>*3 times the resident should have received insulin, but none was documented as given.</p> <p>*On 12/22/13, insulin was given but the BG level was not documented.</p> <p>The 1/5/14 to 2/4/14 MAR documented the following:</p> <p>*8 times there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin was required.</p> <p>*3 times the resident should have received insulin, but none was documented as given.</p> <p>The 2/5/14 to 3/4/14 MAR documented the</p>	R 008		

Residential Care/Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R559	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/06/2014
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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
R 008	<p>Continued From page 15</p> <p>following:</p> <p>*3 times there was no documentation the resident's BG levels were checked. Therefore, it could not be determined if sliding scale insulin was required.</p> <p>*2 times the resident should have received insulin, but none was documented as given.</p> <p>*On 2/26/14, the resident's BG level was 165, which required 4 units of insulin, but 16 units were documented as given.</p> <p>On 3/5/14 at 9:33 AM, the LPN stated medication aides were to call her or the RN before assisting residents with their sliding scale insulin. The LPN stated, she had not reviewed any of the MARs to ensure the aides were documenting and assisting with insulin appropriately.</p> <p>On 3/5/14 at 10:05 AM, the facility RN stated she had only worked at the facility for a month. She stated during her time as the facility nurse, she had not reviewed the residents' MARs to ensure medication aides had been documenting and assisting with the appropriate doses of insulin.</p> <p>From 10/24/13 until 3/4/14, the facility failed to ensure caregivers checked Resident #2's BG levels as required, failed to ensure she received insulin as needed, and failed to ensure the correct insulin dose was given.</p> <p>The facility admitted and retained Residents #7 and #11, who required the use of a BiPAP machine. The facility also retained Resident #9, who had active MRSA and wounds that were not improving bi-weekly. The facility failed to provide monitoring and assistance of insulin use for</p>	R 008		

Residential Care/Assisted Living

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 03/06/2014
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NAME OF PROVIDER OR SUPPLIER
WYNWOOD AT TWIN FALLS

STREET ADDRESS, CITY, STATE, ZIP CODE
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R 008	Continued From page 16 Residents #2 and #6 insulin. These failures resulted in inadequate care.	R 008		



Facility WYNWOOD AT TWIN FALLS	License # RC-569	Physical Address 1367 LOCUST STREET NORTH	Phone Number (208) 735-0700
Administrator Ben Knowles	City TWIN FALLS	ZIP Code 83301	Survey Date March 6, 2014
Survey Team Leader Karen Anderson	Survey Type Licensure and Complaint Investigation		RESPONSE DUE: April 5, 2014
Administrator Signature <i>Ben Knowles</i>	Date Signed 3-6-14		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOB Accepted	Initials
1	16.03.22	Side rails were observed on Residents' beds.	4/14/14	KA
2	220.02	The facility's admission agreement was not updated to include all items described in the 2010 rule change.	4/14/14	KA
3	220.09	The facility's admission agreement did not identify conditions under which emergency transfers would occur.	4/14/14	KA
4	225.01a-g	The facility did not identify or evaluate Resident #8's and three random residents' behavioral symptoms. Previously cited 12/29/09	4/14/14	KA
5	225.02.a-c	The facility did not develop interventions for each behavioral symptom for Resident #8 and three random residents. Previously cited 12/29/09.	4/14/14	KA
6	250.13.i-	Several windows in residents' rooms did not have screens.	4/14/14	KA
7	250.14	The facility did not provide a secure environment for Resident #1 who had cognitive impairment and whose record documented she had left the building twice. Additionally, staff did not respond when the door alarm was activated in the south hallway.	4/14/14	KA
8	250.15	A call light was not available in a random resident's living area. Error K Anderson	4/14/14	KA
9	300.01	The facility RN did not delegate nursing functions to 7 of 7 staff. Previously cited 12/29/09.	4/14/14	KA
10	305.02	The facility did not ensure all medications were available such as; sharing of medications and medications documented as not available. Previously cited 12/29/09.	4/14/14	KA
11	305.03	The RN did not document residents' changes of condition. Such as Resident #2, #9 and #11's wounds and Resident #8 had weight loss and a new diet order.	4/14/14	KA
12	305.04	The RN did not document recommendations for wound care follow up and weight loss.	4/14/14	KA
13	305.06.a	The RN did not document Residents ability to self administer their medications.	4/14/14	KA
14	310.01.a	Medications were observed not secured in residents' rooms and in the nurses office.	4/14/14	KA
15	310.01.d	Unlicensed staff were injecting insulin and adjusting oxygen.	4/14/14	KA
16	310.01.f	Unlicensed staff did not observe residents taking their medications.	4/14/14	KA
17	310.04.e	Behavioral updates were not provided to the physician for psychotropic medication reviews. Previously cited 12/29/09.	4/14/14	KA



Facility WYNWOOD AT TWIN FALLS	License # RC-569	Physical Address 1367 LOCUST STREET NORTH	Phone Number (208) 735-0700
Administrator Ben Knowles	City TWIN FALLS	ZIP Code 83301	Survey Date March 6, 2014
Survey Team Leader Karen Anderson	Survey Type Licensure and Complaint Investigation	RESPONSE DUE: April 5, 2014	
Administrator Signature 	Date Signed 3-6-14		

NON-CORE ISSUES

Item #	IDAPA Rule #	Description	Department Use Only	
			EOR Accepted	Initials
18	320.01	NSAs did not clearly describe services residents required. Resident #5's NSA was not implemented regarding showers.	4/14/14	KA
19	335.02	Staff were required to work when they were ill.	4/14/14	KA
20	350.02	The administrator did not document an investigation of all incidents and accidents.	4/14/14	KA
21	350.04	The administrator did not document a response to complaints within 30 days.	4/14/14	KA
22	451.02	Snacks were not offered between meals and before bed to residents who did not leave their room.	4/14/14	KA
23	600.06.a	The administrator did not schedule sufficient staff. For example residents were awakened between 4 AM and 5:30 AM, dressed and prepared before day shift arrived.	4/14/14	KA
24	630.04	There was no documented evidence 10 of 10 staff members had traumatic brain injury training.	4/14/14	KA
25	711.01 a-c	The facility did not track residents behaviors.	4/14/14	KA
26	711.04	The facility did not document when Resident #5 refused showers on multiple days.	4/14/14	KA
27	711.08.e	There was no documentation when staff notified the nurses.	4/14/14	KA
28	711.08.f	Outside agency care notes were not available in residents records.	4/14/14	KA
29	730.01.f	There was no evidence of first aid and CPR training in employee records.	4/14/14	KA
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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: 208-364-1962
FAX: 208-364-1888

March 17, 2014

Benjamin Knowles, Administrator
Wynwood at Twin Falls
1367 Locust Street North
Twin Falls, Idaho 83301

Mr. Knowles:

An unannounced, on-site state licensure survey and complaint investigation was conducted at Wynwood at Twin Falls between March 3, 2014 and March 6, 2014. During that time, observations, interviews, and record reviews were conducted with the following results:

Complaint # ID00006388

Allegation #1: Unlicensed staff were filling syringes.

Findings: Nine staff were interviewed between 3/3/14 and 3/6/14. All staff stated they did not fill syringes. They stated the syringes came pre-filled. One staff member stated they had heard a rumor that staff on day shift filled syringes, but they had never seen it done. Further, the staff stated this was a licensed nursing task.

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

Allegation #2: Unlicensed staff were adjusting residents' oxygen.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.d for unlicensed staff adjusting residents' oxygen. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility nurse instructed medication aides to borrow other resident's medications.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not ensuring all medications were available in the facility. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Medication aides left pills in residents' rooms and did not watch the resident take their medication.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.f for unlicensed staff

Benjamin Knowles, Administrator

March 17, 2014

Page 2 of 3

not watching residents take their medication. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: Staff were not trained on using a hooyer lift.

Findings: Seven staff records were reviewed. Staff records contained documentation of hooyer lift training.

A "Training Attendance Form" dated 1/23/13, documented staff received hooyer lift training from a home health agency.

Between 3/3/14 and 3/6/13, Nine staff were interviewed. All staff interviewed stated they had received hooyer lift training. They further stated they used the hooyer lift on one resident, but that resident no longer required to be lifted by a hooyer lift.

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

Allegation #6: Caregivers were not trained on using gait belts.

Findings: Seven staff records were reviewed. Staff records contained documentation of gait belt training.

Between 3/3/14 and 3/6/13, staff were observed either wearing a gait belt or assisting a resident with transferring with a gait belt.

Between 3/3/14 and 3/6/13, Nine staff were interviewed. All staff interviewed stated they had received gait belt training.

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

Allegation #7: Staff were required to work when they were ill.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.02 for staff being required to work when they were ill. The facility was required to submit evidence of resolution within 30 days.

Allegation #8: Residents were retained with MRSA.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for retaining a resident that had MRSA. The facility was required to submit a plan of correction.

Allegation #9: New employees did not receive orientation training.

Findings: Ten staff records were reviewed. Staff records contained documentation of orientation training for their discipline.

Between 3/3/14 and 3/6/13, nine staff were interviewed. All staff interviewed stated they had received orientation training.

Benjamin Knowles, Administrator

March 17, 2014

Page 3 of 3

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

Allegation #10: The facility did not schedule sufficient staffing on night shift.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a for not scheduling sufficient staff. The facility was required to submit evidence of resolution within 30 days.

Allegation #11: Residents were made to get out of bed when they were in extreme pain.

Findings: Between 3/3/14 and 3/6/13, nine caregivers were interviewed about getting residents up when they were in pain. All nine caregivers stated they did not remember a time residents were required to get up out of bed when they were in severe pain.

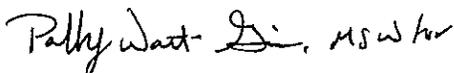
On 3/4/14 at 10:12 AM, the RN and LPN stated any resident who was in pain or not feeling well, would not be expected to get up out of bed. They stated when residents were not feeling well, the caregivers would report the information to them and they would make sure the residents received additional assistance. Such as; having a food tray delivered to their room or increase the frequency of checking on the residents to ensure their pain was being managed.

Twenty residents were interviewed between 3/3/14 and 3/6/14, and stated they were not made to get up or get out of bed when they were in pain or not feeling well.

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

If you have questions or concerns regarding our visit, please call us at (208) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sc

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RESIDENTIAL ASSISTED LIVING FACILITY PROGRAM
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: 208-364-1962
FAX: 208-364-1888

March 17, 2014

Benjamin Knowles, Administrator
Wynwood at Twin Falls
1367 Locust Street North
Twin Falls, Idaho 83301

Dear Mr. Knowles:

An unannounced, on-site complaint investigation was conducted at Wynwood at Twin Falls between March 3, 2014 and March 6, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006305

Allegation#1: Residents did not receive showers per their Negotiated Service Agreement (NSA).

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.320.01 for NSAs not being implemented for showers. 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) 364-1962. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

KAREN ANDERSON, RN
Health Facility Surveyor
Residential Assisted Living Facility Program

KA/sc

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



IDAHO DEPARTMENT OF HEALTH & WELFARE **Food Establishment Inspection Report**

Residential Assisted Living Facility Program, Medicaid L & C
3232 W. Elder Street, Boise, Idaho 83705
208-334-6626

Critical Violations Noncritical Violations

Establishment Name <u>WYNNWOOD AT TWIN FALLS</u>		Operator <u>BENJAMIN KNOWLES</u>	
Address <u>1307 Locust Street</u>			
County <u>TWIN FALLS</u>	Estab #	EHS/SUR#	Inspection time: Travel time:
Inspection Type: <u>STANDARD</u>	Risk Category: <u>High</u>	Follow-Up Report Date: <u>N/A</u>	OR On-Site Follow-Up Date: <u>N/A</u>
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"/>
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>
<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"/>
<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"/>
<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>X</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"/>
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>
<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"/>
<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 = no, not in compliance
N/O = not observed N/A = not applicable
COS = Corrected on-site R = Repeat violation
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Hamburger</u>	<u>202</u>	<u>Chicken</u>	<u>193</u>	<u>Mayo</u>	<u>40°</u>		
<u>Gravy</u>	<u>199</u>	<u>TARTAR Sauce</u>	<u>41</u>				

GOOD RETAIL PRACTICES (input X = 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>Brandy Dye</u> (Print) <u>Brandy Dye</u> Title <u>Dsm</u> Date <u>3/5/2014</u>	Follow-up: (Circle One) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Inspector (Signature) <u>[Signature]</u> (Print) <u>MATT HAUSER</u> Date <u>3/5/2014</u>	