



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

June 12, 2014

Randal Barnes, Administrator
Wynwood at Riverplace
739 East Parkcenter Boulevard
Boise, Idaho 83706

Provider ID: RC-401

Mr. Barnes:

On May 1, 2014, a state licensure/follow-up survey and complaint investigation were conducted at Wynwood at Riverplace. 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,

Karen Anderson, RN

KAREN ANDERSON, RN
Team Leader
Health Facility Surveyor

KA/sc

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



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P.O. Box 83720
Boise, Idaho 83720-0009
EMAIL: ralf@dhw.idaho.gov
PHONE: 208-364-1962
FAX: 208-364-1888

May 9, 2014

CERTIFIED MAIL #: 7007 3020 0001 4050 8401

Administrator
Wynwood at Riverplace
739 East Parkcenter Boulevard
Boise, Idaho 83706

Dear Administrator:

On May 1, 2014, a licensure survey, follow-up survey and complaint investigation survey were conducted at Wynwood at Riverplace. The facility was cited with a core issue deficiency for inadequate care including retaining residents whose needs exceeded that which the facility was licensed to provide, failing to provide assistance and monitoring of medications, and retaining a resident who was not compatible with the other residents and whose behaviors the facility was not able to effectively manage.

This core issue deficiency substantially limits the capacity of Wynwood at Riverplace to provide for residents' basic health and safety needs. The deficiency is described on the enclosed Statement of Deficiencies.

PLAN OF CORRECTION:

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?

An acceptable, **signed** and **dated** Plan of Correction must be submitted to the Division of Licensing and Certification within **ten (10) calendar days of your receipt of the Statement of Deficiencies**. You are encouraged to immediately develop and submit this plan so any adjustments or corrections to the plan

can be completed prior to the deadline.

EVIDENCE OF RESOLUTION:

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 following administrative rule for Residential Care or Assisted Living Facilities in Idaho (IDAPA 16.03.22) describes the requirements for submitting evidence that the non-core issue deficiencies have been resolved:

910. Non-core Issues Deficiency.

01. Evidence of Resolution. *Acceptable evidence of resolution as described in Subsection 130.09 of these rules, must be submitted by the facility to the Licensing and Survey Agency. If acceptable evidence of resolution is not submitted within sixty (60) days from when the facility was found to be out of compliance, the Department may impose enforcement actions as described in Subsection 910.02.a through 910.02.c of these rules.*

The 31 non-core issue deficiencies must be corrected and evidence (including but not limited to receipts, pictures, completed forms, records of training) must be submitted to this office by **6/1/2014**.

CIVIL MONETARY PENALTIES

Of the 31 non-core issue deficiencies identified on the punch list, 5 were repeat punches. All of the repeat deficiencies, 305.02, 305.06, 320.01, 350.02 and 350.04 were cited on both of the two (2) previous surveys, 1/22/2013 and 3/21/2013.

The following administrative rules for Residential Care or Assisted Living Facilities in Idaho give the Department the authority to impose a monetary penalty for these violations:

IDAPA 925. ENFORCEMENT REMEDY OF CIVIL MONETARY PENALTIES.

01. Civil Monetary Penalties. *Civil monetary penalties are based upon one (1) or more deficiencies of noncompliance. Nothing will prevent the Department from imposing this remedy for deficiencies which existed prior to survey or complaint investigation through which they are identified. Actual harm to a resident or residents does not need to be shown. A single act, omission or incident will not give rise to imposition of multiple penalties, even though such act, omission or incident may violate more than one (1) rule.*

02. Assessment Amount for Civil Monetary Penalty. *When civil monetary penalties are imposed, such penalties are assessed for each day the facility is or was out of compliance. The amounts below are multiplied by the total number of occupied licensed beds according to the records of the Department at the time noncompliance is established.*

b. Repeat deficiency is ten dollars (\$10). (Initial deficiency is eight dollars (\$8)).

For the dates of 3/21/2013 through 5/1/2014:

Penalty	Number of Deficiencies	Times number of Occupied Beds	Times Number of days of non-compliance	Amount of Penalty
\$10.00	5	75	405	\$ 1,518,750

Maximum penalties allowed in any ninety-day period per IDAPA 16.03.22.925.02.c:

# of Occupied Beds in Facility	Initial Deficiency	Repeat Deficiency
3-4 Beds	\$1,440	\$2,880
5-50 Beds	\$3,200	\$6,400
51-100 Beds	\$5,400	\$10,800
101-150 Beds	\$8,800	\$17,600
151 or More Beds	\$14,600	\$29,200

Your facility had 75 occupied beds at the time of the survey. Therefore, your maximum penalty is: \$10,800.

Send payment of \$10,800 by check or money order, made payable to:

Licensing and Certification

Mail your payment to:

**Licensing and Certification - RALF
PO Box 83720
Boise, ID 83720-0009**

Payment must be received in full within 30 calendar days from the date this notice is received. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount may be withheld from Medicaid payments to the facility.

ADMINISTRATIVE REVIEW

You may contest the civil monetary penalty by filing a written request for administrative review pursuant to IDAPA 16.05.03.300, which states: **the request must be signed by the licensed administrator of the facility, identify the challenged decision, and state specifically the grounds for your contention that this decision is erroneous.** The request must be received **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

**Tamara Prisock, Administrator
Division of Licensing and Certification - DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036**

Upon receipt of a written request that meets the requirements specified in IDAPA 16.05.03.300, an administrative review conference will be scheduled and conducted. The purpose of the conference is to clarify and attempt to resolve the issues. A written review decision will be sent to you within thirty (30) days of the date of the conclusion of the administrative review conference.

If the facility fails to file a request for administrative review within the time period, this decision shall become final.

INFORMAL DISPUTE RESOLUTION

Pursuant to IDAPA 16.03.22.003.02, you have available the opportunity to question the core issue deficiency 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 Assisted Living Facility Program for an IDR meeting. The request for the meeting must be in writing and must be made within ten (10) business days of receipt of the Statement of Deficiencies. The facility's request must include sufficient information for Licensing and Certification to determine the basis for the provider's appeal, including reference to the specific deficiency to be reconsidered and the basis for the reconsideration request. If your request for informal dispute resolution is received more than ten (10) days after you receive the Statement of Deficiencies, 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.

FOLLOW-UP SURVEY

An on-site, follow-up survey will be scheduled after the administrator submits a letter stating that all deficiencies have been corrected and systems are in place to assure the deficient practices remain corrected. If at the follow-up survey, the core issue deficiency still exists, a new core issue deficiency is identified, or non-core deficiencies have not been corrected, the Department will take enforcement action against the license held by Wynwood at Riverplace. Those enforcement actions will include one or more of the following:

- Require the facility to hire a consultant
- Limit on Admissions
- Additional Civil Monetary Penalties
- Provisional Facility License

Division of Licensing and Certification staff is available to assist you in determining appropriate corrections and avoiding further enforcement actions. Please contact our office at (208) 364-1962 if we may be of assistance, or if you have any questions.

Sincerely,



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

JS/sc

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2014
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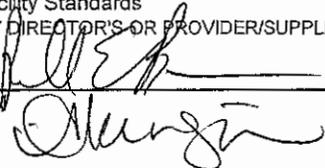
NAME OF PROVIDER OR SUPPLIER WYNWOOD AT RIVERPLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 739 EAST PARKCENTER BOULEVARD BOISE, ID 83706
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 deficiencies were cited during the licensure, follow-up and complaint investigations conducted between April 28, 2014 and May 1 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>Rachel Corey, RN BSN Health Facility Surveyor</p> <p>Maureen McCann, RN Health Facility Surveyor</p> <p>Matt Hauser, QMRP Health Facility Surveyor</p> <p>Abbreviations and Definitions:</p> <p>@ = at ADLs = activities of daily living ALF = Assisted Living Facility AVE = avenue BLVD = boulevard Cont. = continued Dtr = daughter F or Fri = Friday hr = hour Lethargy = fatigued LPN = Licensed Practical Nurse M = Monday Meds = medications med-tech = medication technician MAR - medication assistance record</p>	R 000	<p>The following is the Plan of Correction for Wynwood at RiverPlace regarding the Statement of Deficiencies dated 05/01/2014. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	
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RECEIVED
3
MAY 27 2014
DIV OF LIC & CERT

Bureau of Facility Standards

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

TITLE: Designee

(X6) DATE: 5-23-14

STATE FORM 6899 3WP111 If continuation sheet 1 of 20

Bureau of Facility Standards

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R 000	Continued From page 1 mcg = microgram mg = milligram NSA - negotiated service agreement POC = Plan of Care Pt = patient q = every Res = resident RM = room RN - Registered Nurse Sat = Saturday Sun = Sunday T = Tuesday TH = Thursday W or Wed = Wednesday 1:1 = one to one	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. 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 3 of 10 sampled residents (#1, #5 & #10,). Further, the facility retained 2 of 10 sampled residents (Residents #9 and #8) who required care beyond what the facility was licensed to provide. Resident #9 had supervision and behavior management needs for which the facility was unable to provide. Resident #8 required the support of a mechanical supported breathing system. The findings include: I. ASSISTANCE & MONITORING OF	R 008	R 008 <u>Resident</u> Resident #1: Additional Fentanyl patch was removed. The medication order on the MAR was rewritten for staff to indicate the site of the current patch and to document that the current patch was removed before adding the new patch. The location of the new patch placement is also documented on the MAR. These additional documentation steps were implemented prior to survey at the time these medication errors began. In addition to Brookdale training, med passers have received training through the ISBN Assistance with Medication Certification class which is required training for working in this position.	6-14-2014

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R 008	<p>Continued From page 2</p> <p>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 #1's record documented she was a 98 year-old female admitted to the facility on 7/19/07 with diagnoses including, congestive heart failure, hypertension and insomnia. At the time of the survey the resident was receiving hospice services.</p> <p>A. Fentanyl patches (according to the Nursing 2014 handbook: a narcotic used to manage chronic pain. Adverse reactions may include over sedation and fatal respiratory depression.)</p> <p>Resident #1's March 2014 and April 2014 MARs documented Resident #1 was to receive a Fentanyl patch, 25 mcg every 72 hours.</p> <p>On 4/28/14 at 3:10 PM, Resident #1's son stated the resident was "over medicated" on at least two occasions in April. He stated, his mother was found to have three Fentanyl patches on during one occasion and two Fentanyl patches on at another time.</p> <p>An incident report, dated 3/2/14, documented "2 Fentanyl patches were discovered on the resident when the 3rd one was being applied suggesting that the last patch placed there was not one removed." The incident report documented under "Follow-up Information," hospice and the</p>	R 008	<p>Med passers have been, and will continue to be, re-educated in accordance with nurse delegation practices related to trans-dermal patches and medication assistance in general. Based on our investigation, the individual responsible for multiple patch placement errors was determined to not be following community policy. Consequently, this med passer was removed from his med passer duties. This employee no longer works at this community.</p> <p>The community has re-organized its med passing assignments significantly reducing the number of residents each med passer is responsible for serving. This practice additionally allows the med passers to spend more time with the residents. This change was implemented to prevent further medication related incidents.</p> <p>Trazadone 50 mg tabs were received and given at HS on 4/23/2014 . Med passers have been trained by our Licensed Nurses and continue to be re-trained in accordance with the medication competency review guidelines. Med passers have been instructed that medications will be reordered no less than 5 days prior to the last dose of available medication.</p>	
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R 008	<p>Continued From page 3</p> <p>resident's son were notified. The incident further documented the resident experienced lethargy as a side-effect. The incident report did not include the facility's investigation of the incident or if interventions were put into place to prevent a re-occurrence.</p> <p>A nursing note, dated 3/19/14 (17 days after the incident report), documented a care conference was held with the resident's family and her hospice agency. "Fentanyl is a concern. We will place the patch on her lower back right above her buttocks. This will be placed on the MAR and followed by staff."</p> <p>A hospice nursing note, dated 3/19/14, documented "Pt's son also expressed concern over the Pt being overmedicated [sic] when several fintenayl [sic] were placed on the Pt at the same time...ALF to provide education to staff and make changes to ensure Pt's safety and correct amount of medication given."</p> <p>The March 2014 MAR was edited on 3/19/14 to read "Fentanyl 25 mcg/hr patch. Apply 1 patch topically every 72 hours. Document & rotate sites. Date and initial patch" The MAR did not include instructions to remove prior patches.</p> <p>A second incident report, dated 4/15/14, documented, "multiple Fentanyl patches on per son." The note further documented, "second time that incident has occurred...order requested for time change with Fentanyl patch. Nursing order for documentation of MAR placement and when patch is taken off. Med-tech pulled off cart." The incident report did not include if all staff were re-trained on proper Fentanyl patch placement or how the facility would monitor staff's practices to ensure the issue did not reoccur.</p>	R 008	<p>Staff will further document on the reverse side of the MAR the date and time medications are reordered and the name of the pharmacy technician with whom they placed the re-order.</p> <p>To further decrease the likelihood of "unavailable medications", the community is working with its contracted pharmacy to start a cycle fill system. This system will be in place by July 1, 2014. The Regional Nurse will assist the community and pharmacy with this implementation.</p> <p>Resident #5: Medication orders for Warfarin were clarified through the Home Health group managing this resident. The Warfarin was being used as a preventative measure in conjunction with a wound vac. The order for Warfarin was discontinued on 11/30/2013. Per investigation related to the Warfarin, the medication was available and was located with the remaining Resident's medication in the proper medication cart. The med tech was unable to locate it for unknown reasons. A Licensed Nurse re-educated the med passers on the possibility of confusing brand/trade names with generic names for medications which could have been the root-cause of the confusion. Licensed Nurses will ensure both names appear on the MARs during month-end MAR reviews.</p>	

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R 008	<p>Continued From page 4</p> <p>On 4/28/14 at 3:45 PM, the facility RN stated there were two occasions she was aware of when Resident #1 was found with more than one Fentanyl patch on. She stated, after the second incident, she changed the patch application time to 8:00 AM, as she felt the morning staff was more attentive. She further stated, she updated the MAR to include a reminder to take previous patches off and to document the site of application.</p> <p>On 4/29/14 at 8:45 AM, a caregiver stated "they don't take the Fentanyl patches off. I heard over the radio, 'Oh my gosh, I can't believe they are not taking these off.' I heard it a couple of times." She stated, she was unaware if staff were retrained after the incidents occurred.</p> <p>On 4/29/14 at 10:28 AM, a caregiver stated she had been a medication aide in the past, but "I won't pass medications, as I can't do it safely." She further stated, errors were occurring, because medication aides had "3 minutes per person." She stated, she was aware of Fentanyl patches not being removed from Resident #1 and "it has happened more frequently than it should that patches are left on."</p> <p>On 4/29/14 at 10:55 AM, a medication aide stated, "it is hard to get 44 meds passed; it is 3 minutes per person...medications are late and medication errors are occurring." He further stated, he was unaware of any Fentanyl patch issues with Resident #1 and had not received any additional training regarding proper application of medication patches.</p> <p>On 4/29/14 at 10:59 AM, a medication aide stated she was aware of three Fentanyl patches being</p>	R 008	<p>Per the instructions in the Nursing Delegation/Medication Competency Review, med passers have been trained to call the nurse if a medication is not found or appears to be unavailable. Licensed Nurses will re-review the Medication Competency Review materials with the Medication Technicians and document this having occurred. This training will be completed by June 15th, 2014.</p> <p>Med passers have received instruction on the process of filling out incident reports and the necessity for complete information to fully and accurately report resident incidents.</p> <p>The community has reorganized its med passing assignments significantly reducing the number of residents each associate is responsible for serving. This practice increases the amount of time each med passer is able to spend with their assigned residents. This change has been implemented to prevent further medication related incidents.</p> <p>Resident #10: The medication orders were clarified for this resident. The order printed on the MAR has been confirmed as correct and is being correctly administered. Licensed Nurses have blocked out the days this medication is NOT to be given to assist the Med Techs in understanding the dosing schedule. Documentation indicates that Levothyroxine 100 mcg is being given on all days except Sunday and Wednesday.</p>	
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R 008	<p>Continued From page 5</p> <p>left on Resident #1. She stated Resident #1 "was not the first resident." She further stated, she did not get any extra training on medication patches after the incidents occurred. She stated, she was unsure how the facility was preventing it from happening again.</p> <p>On 4/29/14 at 11:25 AM, a medication aide stated she was aware of the issue with staff forgetting to take extra patches off of Resident #1, but she had not received any extra training or instructions after the incident.</p> <p>On 4/29/14 at 2:07 PM, the hospice RN stated, there had been three instances where Resident #1 was found to have more than one Fentanyl patch on her. She stated, two instances were "recorded times." She stated, the first instance was 3-4 months ago and the two "recorded times" occurred at the end of March and again a couple of weeks ago.</p> <p>On 4/29/14 at 3:30 PM, a facility caregiver stated, "they were not paying attention when patches were placed. They were not removing the old patches and putting new ones on." She further stated she found "multiple patches" on Resident #1 on three occasions. She stated, the first time she reported it to the facility nurse, she was told "they would keep an eye on it." She further stated, the second time she reported it to the facility nurse, she was told the nurse would "talk to the shift." She stated, the third time she reported it, she was told the application time would be moved from the evening to the morning shift.</p> <p>On 4/29/14 at 3:45 PM, a hospice aide stated she "witnessed a couple of times extra patches" were on Resident #1. "She further stated, "I don't know what the facility ever did about it."</p>	R 008	<p>The resident continues to receive assistance with his/her medications.</p> <p>Nurses will conduct frequent MAR audits to ensure medication orders and medications are correctly transcribed, documented, and administered. Physicians will be notified with noted discrepancies, incident reports, as needed, will be completed, and staff will be re-educated on medication safety and assistance, as warranted.</p> <p>Resident #6: Resident was reassessed for appropriateness of self-administration of medications. The orders for Bumex were clarified and are in the resident's chart and on the MAR.</p> <p>Nurses will conduct frequent MAR audits to ensure medication orders and medications are correctly transcribed, documented and administered.</p> <p>In summary: Medication Technicians have participated in numerous in-services and trainings since the survey. In addition, they will be attending the ISBN Assistance with Medication Course to be taught by our Regional RN, Sheila S. Beesley-Smith, who is also an approved trainer. These AWM training sessions will begin on June 13, 2014.</p> <p>Resident #8: Resident to be discharged on or before June 19th. All potential residents with mechanical ventilation devices will be assessed. Only those with CPAPs will be admitted or retained.</p>	
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R 008	<p>Continued From page 6</p> <p>On 4/30/14 at 8:30 AM, a newly hired caregiver, stated she had not been instructed on application and removal of Fentanyl patches when hired at the facility, but had assisted with medications her second night of working. She further stated she had worked as a hospice aide at one time and had cared for residents at the facility and "Fentanyl patches were not always removed."</p> <p>The facility did not investigate, implement interventions to prevent the reoccurrence or monitor the application of Resident #1's Fentanyl patches, after two patches were found on 3/2/14. As a result, the practice continued to occur. This represented a system failure, which had the potential to over-medicate Resident #1.</p> <p>B. Trazodone</p> <p>Resident #1's April 2014 MAR, documented she was to receive Trazodone 50 mg daily at bedtime for insomnia. A physician's order contained in her record, documented the Trazodone was initiated on 1/24/14.</p> <p>The April 2014 MAR documented (17 doses) of the medication was not given from 4/6/14 through 4/22/14. The back of the MAR documented the medication was not available. The MAR documented hospice was notified on 4/15/14.</p> <p>On 4/29/14 at 11:10 AM, the facility RN stated she was not sure why the Trazodone was not available. She stated, "Hospice takes care of all the medications." She further stated, she was not made aware that the medication was not available.</p> <p>On 4/29/14 at 11:25 AM, a medication aide stated</p>	R 008	<p>Resident #9: Resident was discharged on 4/6/2014 to a secure dementia care community.</p> <p>In the future, Elopement Risk Assessments will be conducted by licensed nurses with current and potential residents with cognitive impairments. In addition, an Elopement Risk Assessment will be completed for any Resident who suffers a significant decline in cognition.</p> <p>With the cognitively impaired residents, service plans will be reviewed quarterly, or as needed, to monitor for changes and to ensure continued appropriate placement. Updated behavior plans will be implemented, as needed.</p>	
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R 008	<p>Continued From page 7</p> <p>she was unaware the Trazodone had not been available for Resident #1 as it "wasn't reported to anyone."</p> <p>On 4/29/14 at 2:10 PM, the hospice RN stated there was a mix up with the pharmacy not filling the medication. However, she had not been notified by facility staff about the medication not being available, until after several doses were missed; as a result, there was a delay in getting the issue corrected.</p> <p>Resident #1 missed 17 doses of Trazodone.</p> <p>2. Resident #5's record documented, she was an 89 year-old female, admitted to the facility on 5/1/11, with diagnoses including dementia, atrial fibrillation and osteoarthritis. The record further documented on 8/15/13, the resident had fallen, fractured her right hip and was hospitalized. After surgery, Resident #5 returned to the facility, according to the record, on 8/18/13.</p> <p>A. Warfarin/Coumadin (according to the Nurse 2014 handbook: Is an anticoagulant that must be monitor to achieve a therapeutic dosage. Adverse effects, may include fatal bleeding.)</p> <p>Physician's orders, dated 10/21/13, documented Resident #5 was to receive warfarin: *Wednesdays and Sundays = 2.5 mg. *Mondays, Tuesdays, Thursdays, and Fridays = 5 mg.</p> <p>The October 2013 MAR, documented warfarin 5 mg was given on 10/21/13, when it should have been held. The MAR further documented, the warfarin was held on 10/23/13, when 2.5 mg should have been given..</p>	R 008		
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R 008	<p>Continued From page 8</p> <p>There was no documentation in Resident #5's record regarding why the physician's orders were not followed or that the physician was notified of the errors.</p> <p>The October 2013 MAR, documented on 10/27/13, "warfarin (7.5 mg given instead of 5 mg per nurses request.)"</p> <p>A "Communication/Physician Order" form, dated 10/28/13 from the nurse to the physician, documented "give pt 7.5 mg of Coumadin today (10/27/13) and 5 mg all other days." Below this note, the physician documented, "No. Cancel the above. Give 5 mg nightly...as faxed in earlier today!"</p> <p>There was no documentation in the resident's record why the nurse had requested this order from the physician, one day after the resident received the 7.5 mg instead of the 5.0 mg of warfarin as originally ordered by the physician.</p> <p>Physician's orders, dated 11/7/13, documented Resident #5 was to receive warfarin 5 mg "nightly M-Sat. 7.5 mg q Sun."</p> <p>The November 2013 MAR, documented warfarin was not given to Resident #5 between November 8 and 14, (for 7 days). A note dated 11/8/13, documented "awaiting refill" on the back of Resident #5's MAR.</p> <p>A note from the nurse to the physician, dated 11/11/13, documented Resident #5 missed 3 doses of warfarin.</p> <p>Incident reports, dated 11/8, 11/9, 11/10 and 11/11/13, documented Resident #5 missed her daily dose of warfarin because the staff "could not</p>	R 008		

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R 008	<p>Continued From page 9</p> <p>find med."</p> <p>There was no documentation found in Resident #5's record regarding the reason for the missed doses on 11/12, 11/13 or 11/14. Also, there was no documentation the physician had been notified of the errors.</p> <p>A physician's order, dated 11/20/13, documented Resident #5 was to receive warfarin: *Wednesdays and Sundays = 7.5 mg. *Mondays, Tuesdays, Thursdays, Fridays and Saturdays = 5 mg.</p> <p>Resident #5's November 2013 MAR, documented 7.5 mg of warfarin was given to the resident on Thursday 11/21/13, when the resident should have received only 5 mg. There was no documentation found in the resident's record why the physician's orders were not followed or that the physician was notified of the error.</p> <p>On 4/29/14, the facility nurse confirmed Resident #5 missed 7 doses of warfarin between 11/8/13 and 11/14/13 and confirmed there had been other errors with her warfarin.</p> <p>Between 10/21/13 and 11/21/13, during a period of 31 days, 10 doses of warfarin were not given according to Resident #5's physician's orders. As a result, the resident may not have achieved the therapeutic dosage.</p> <p>B. Lisinopril</p> <p>An incident report, dated 12/19/13, documented Resident #5 had received the "wrong dose, incorrect medication." The incident report did not document the name or the dose of the medication. Further, the report did not describe</p>	R 008		
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R 008	<p>Continued From page 10</p> <p>the actual error, or include an investigation with interventions to prevent a recurrence.</p> <p>A fax from the nurse to Resident #5's physician, dated 12/20/13, documented the resident "was given an extra Lisinopril 10 mg on 12/19/13." The physician responded, "Noted - note this is not the first med error on [Resident #5's name]. Please reassess process."</p> <p>Resident #5 had 10 medication errors over a period of 31 days. The following month, the facility made another medication error when assisting Resident #5 with her medications.</p> <p>3. Resident #10's record documented she was an 84 year-old female who was admitted to the facility on 7/31/11, with diagnoses including dementia and hypothyroidism.</p> <p>On 4/28/14 at 12:05 PM, Resident #10 was observed in her room sitting in her recliner. The resident stated caregivers assisted her with medications.</p> <p>A physician's order, dated 5/19/13, documented Resident #10 was to receive "Levothyroxine 100 mcg", 5 days a week on Monday, Tuesday, Thursday, Friday and Saturday. The medication was not to be given on Wednesdays or Sundays.</p> <p>Levothyroxine (according to the Nurse 2014 handbook: A thyroid hormone replacement used to treat hypothyroidism.)</p> <p>The 11/5/13 to 12/4/13 MAR documented, Resident #10 did not receive levothyroxine 100 mcgs as ordered for 9 days. Medication aides documented on the MAR, the levothyroxine was not available. Additionally, Resident #10 received</p>	R 008		

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R 008	<p>Continued From page 11</p> <p>levothyroxine Wednesdays on 11/6/13 and 11/27/13, when it should not have been given.</p> <p>The 12/5/13 through 1/4/14 MAR documented, Resident #10 received 100 mcg of levothyroxine 8 times on Wednesdays and Sundays, when it should not have been given.</p> <p>The 2/5/14 to 3/4/14 MAR documented, Resident #10 received 100 mcg of levothyroxine 8 times on Wednesdays and Sundays, when it should not have been given.</p> <p>The 3/5/14 through 4/4/14 MAR documented Resident #10 received 100 mcg of levothyroxine 7 times on Wednesdays and Sundays, when it should not have been given.</p> <p>The 4/5/14 through 4/29/14 MAR documented the resident received 100 mcg of levothyroxine 7 times on Wednesdays and Sundays, when it should not have been given.</p> <p>On 4/29/14 at 10:33 AM, two LPNs stated they were not aware that Resident #10's levothyroxine was not being given as ordered.</p> <p>On 4/29/14 at 4:00 PM, the RN confirmed Resident #10's medication was not being assisted with as ordered by her physician.</p> <p>From 11/5/13 until 5/1/14, the facility failed to ensure Resident #10 received the correct dose of levothyroxine which resulted in 41 incorrect doses given. By not following physician's orders, the resident may not have achieved the appropriate effect of the medication.</p> <p>4. Resident #6's record documented she was a 90 year-old female, with diagnoses including atrial</p>	R 008		
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R 008	<p>Continued From page 12</p> <p>fibrillation, edema and stroke. Her record documented she was admitted to the facility on 1/5/13 and that she was assessed that she could safely administer her own medications on 3/7/14.</p> <p>Physician's orders for Resident #6, dated 4/11/14, documented, "Bumex, 2 mg every day in the morning and every day at supper, Bumex, 3 mg every day at lunch." Another physician's order, dated 4/16/14, documented, "Recommended Bumex dose was 2 mg, one tablet po [by mouth] BID [twice a day]." The physician's order further documented, "I recommend continuing this dose unless you receive guidance from another provider."</p> <p>II. Admission/Retention</p> <p>According to IDAPA 16.02.03.22.152.05.a "A resident will be admitted or retained only when the facility has the capability, capacity and services to provide appropriate care..."</p> <p>1. Resident #9's record documented she was an 80 year-old female, admitted to the facility on 9/23/11, with a diagnosis of dementia. The resident was discharged from the facility on 4/6/14.</p> <p>A. Supervision</p> <p>On 4/28/14, the facility was observed to have the capacity for 100 beds; the building was two stories and contained multiple hallways, common areas and exits. The exterior and interior of the facility were not secured. The facility was located beside a six lane boulevard, with steady traffic.</p> <p>Resident #9's NSA, dated 11/5/13, documented she "wanders and needs companions during the</p>	R 008		
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R 008	<p>Continued From page 13</p> <p>day time and ALF staff to monitor after 7 PM to prevent elopement...is encouraged to ambulate around community only."</p> <p>Resident #9's record contained "Resident Log" notes which documented the following:</p> <p>*12/6/11: "Front desk was notified that res was found walking down Parkcenter BLVD toward Apple by receptionist at [a facility's name]. They caught up with res and directed her back to the community...Res was wearing a light jacket in cooler weather. Res instructed to stay in the building and walk laps...Res verbalized that she should be able to go wherever she wants. Staff are to check on res every 2 hrs."</p> <p>*3/30/13: "LPN notified this nurse around 1430 [2:30 PM] she saw res walking onto Pennsylvania Ave. Receptionist and this nurse drove around looking for res. Dtr notified. Police notified to assist with locating resident. Res found and escorted back to community by police...Will cont. to observe and coordinate POC with dtr in relation to having a day companion to walk with and observe."</p> <p>*1/7/14: "...Daughter did stop companion until this spring when the weather becomes nicer. Staff will monitor for the elopement risk...Daughter is aware of the risks of elopement."</p> <p>*3/22/14: "At 7 AM this morning it was noted that [Resident #9's name] was not in the dining RM. Her RM & adjoining areas were checked with Res not being seen...Police notified, they arrived searched facility and were unable to locate resident. While search was happening police received call that res was @ nearby hotel lobby - unclothed but with a blanket wrapped around</p>	R 008		
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R 008	<p>Continued From page 14</p> <p>herself...Res denies pain or knowledge of what had happened...Res assigned 1:1 caregiver."</p> <p>On 4/28/14 at 10:55 AM, a caregiver stated, "She was not appropriate...went down Parkcenter in a bathrobe...she would wander a lot and wander into other residents' rooms...supervised her as much as possible, but staffing numbers did not change."</p> <p>On 4/29/14 at 2:50 PM, the facility RN stated, "Her daughter felt she would not be going outside because of the weather, so daughter took it upon herself to discontinue the companion. I did not think she was appropriate. The executive director was going to give a 30 day notice, but never did. I think it had to do with the census. She needed memory care."</p> <p>On 4/29/14 at 3:30 PM, a caregiver stated Resident #9 wandered a lot and would follow other residents around. She stated Resident #9 would become angry when staff redirected her.</p> <p>On 4/30/14 at 8:45 AM, a caregiver stated, "facility was not able to meet her needs due to her dementia...the final straw was when she left with no clothes on at 5 AM...She always just walked everywhere and one time she went out the front door and I had to go and get her. When redirecting her, she would get angry."</p> <p>On 4/30/14 at 9:15 AM, a caregiver stated, "...Different people were coming in to follow her around then it stopped...then one day we realized she was not in her room."</p> <p>The facility Retained Resident #9 when they could not meet her supervision needs. When her companion was discontinued, the facility did not</p>	R 008		

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R 008	<p>Continued From page 15</p> <p>put a plan in place to ensure adequate supervision. As a result the resident eloped a third time on 3/22/14.</p> <p>B. Behaviors</p> <p>According to IDAPA 16.03.22.152.05.d "A resident will not be admitted or retained who has physical, emotional, or social needs that are not compatible with other residents in the facility."</p> <p>Resident #9's NSA, dated 11/5/13, documented Resident #9 "cannot use the downstairs bathroom without assistance as she urinates on the floor next to the toilet...will not allow staff to assist her in the community bathroom, she becomes agitated and aggressive if she is asked to allow assistance or when she is redirected to her own bathroom...has had verbal altercations with other residents but is redirected..."</p> <p>Resident #9's record, contained "Resident Log" notes and "Resident Behavior Log" notes which documented the following:</p> <p>*5/1/13: "Private companion notified staff that resident verbally abused another resident by saying, I'm going to smash you in the face."</p> <p>*10/2/13: "Resident was found urinating on the floor in the woman's [sic] restroom."</p> <p>*11/8/13: "Resident was found urinating on the floor in the woman's [sic] restroom."</p> <p>*12/9/13: "Has been urinating in employee brake [sic] room between the small fridge and lockers on carpet."</p> <p>*12/18/13: "Resident was found urinating in the</p>	R 008		

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R 008	<p>Continued From page 16</p> <p>facility employee breakroom."</p> <p>12/27/13: "Resident was found urinating in the facility breakroom. A lock was placed on the door."</p> <p>12/30/13: "Staff noted that over the weekend [Resident #9's name] was urinating in the activity room garbage can. Staff tried to redirect to restroom [Resident #9's name] became very agitated."</p> <p>*1/1/14: "Resident caught peeing in the private dining room."</p> <p>*1/2/14: Resident #9 "was found urinating in the private dining room. Staff has reported that Resident is urinating in her room in various places..."</p> <p>*1/3/14: "Resident caught peeing in the activity room."</p> <p>*1/7/14: "Care conference with daughter regarding behaviors...Daughter was informed of the behaviors that have been noted, urinating in various areas not the bathroom, the aggressive threatening behavior and the wandering in and out of other residents' room [sic]..." The note did not document if the facility had evaluated the resident's behaviors to determine if the resident should remain at the facility.</p> <p>1/29/14: "Found Resident squatting and urinating on floor and trash can in activity room after dinner. I told Resident she cannot be peeing on anything except a toilet and directed Resident back to room."</p> <p>On 1/10/14, the executive director emailed the</p>	R 008		

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R 008	<p>Continued From page 17</p> <p>nurse, "...at the dinner hour [Resident #9's name] became combative with the other residents at the table. She did not like where one resident was sitting and began telling her to go back to her room and get away from the table. She told her she was sitting in the wrong seat and to move out."</p> <p>On 1/14/14, the maintenance director emailed the nurse, "...housekeepers just informed that they are now cleaning up urine off the floor in the upstairs laundry room and [Resident #9's name] was seen in the area just before they found the mess..."</p> <p>There was no evidence in Resident #9's record that her behaviors were evaluated to determine the cause of the behaviors and potential interventions to prevent the behavior.</p> <p>On 4/29/14 at 10:55 AM a caregiver stated Resident #9 would go into other residents' rooms and would urinate in various places making other residents upset. The caregiver further stated, staff supervised her "as much as possible," but the incidents still occurred.</p> <p>On 4/29/14 at 2:50 PM, the facility RN stated, "We could not get her to urinate in her room without her wanting to punch the caregivers."</p> <p>On 4/29/14 at 3:30 PM, a caregiver stated, "She would go to the bathroom everywhere. I would try to follow her around and I would try to talk to her so she would not go in the elevator or other inappropriate places; she would get mad. She would walk around a lot and would follow residents into their rooms and use their bathrooms. She would blow up and have a temper and throw things. There were several</p>	R 008		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2014
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NAME OF PROVIDER OR SUPPLIER WYNWOOD AT RIVERPLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 739 EAST PARKCENTER BOULEVARD BOISE, ID 83706
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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	<p>Continued From page 18</p> <p>complaints [from residents]."</p> <p>On 4/30/14 at 8:45 AM, a caregiver stated Resident #9, "...would go to the bathroom in the theatre room, in garbage cans, in the private dining room..when redirecting her she would get angry."</p> <p>On 4/30/14 at 9:15 AM, a caregiver stated, Resident #9 was "peeing and pooping all over facility..."</p> <p>Resident #9 wandered into residents' rooms, urinated in inappropriate places, and exhibited aggressive behaviors, which caused distress to other residents. The facility retained Resident #9 even though they were unable to manage her behaviors.</p> <p>2. Mechanically supported breathing system</p> <p>According to 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: 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 #8's record documented he was an 84 year-old male who was admitted to the facility on 2/7/13, with a diagnoses including sleep apnea and obstructive pulmonary disease.</p> <p>Resident #8's NSA, dated 11/27/13, documented he used a CPAP every evening while he slept. However, a "History and Physical," dated 1/31/14, documented, "Sleep apnea, on BiPAP."</p>	R 008		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2014
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NAME OF PROVIDER OR SUPPLIER WYNWOOD AT RIVERPLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 739 EAST PARKCENTER BOULEVARD BOISE, ID 83706
--	---

(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	<p>Continued From page 19</p> <p>On 4/29/14 at 2:20 PM, Resident #8's room was observed to have a BiPAP (bi-level positive airway pressure) breathing system. At that time, Resident #8 stated he used a BiPAP machine every evening.</p> <p>On 4/29/14 at 2:40 PM, the facility nurse stated she was not aware Resident #8 was actually using a BiPAP, instead of the CPAP. She further stated she was unaware of the rule that prohibited the use of BiPAP machines in assisted living facilities.</p> <p>The facility admitted and retained Resident #8 who required the use of a BiPAP machine.</p> <p>The facility did not provide appropriate assistance and monitoring of medications for residents #1, #5 & #10. Further, the facility retained Resident #9 who had supervision and behavior management needs the facility was unable to provide. Further, the facility retained Resident #8 who required the support of a mechanical supported breathing system. These failures resulted in inadequate care.</p>	R 008		
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Facility Name Wynwood at River Place 13R401	Physical Address 739 East Parkcenter Blvd	Phone Number 208-338-5600
Administrator <i>Karen Anderson</i> Survey Team Leader Karen Anderson	City Boise	ZIP Code 83706
	Survey Type Licensure/follow-up survey and complaint investigation	Survey Date May 1, 2014

NON-CORE ISSUES PAGE 1 OF 3

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	009.01	Two of 10 staff did not have criminal history clearance checks completed.	6/9/14	KA
2	215	The facility did not have a current licensed administration.	6/9/14	KA
3	250.13.1	Room 157 did not have a closet door.	6/9/14	KA
4	250.14	The facility did not provide a secure interior and exterior environment for residents with cognitive impairment.	6/9/14	KA
5	260.05.b	Bath towels, hand towels and wash clothes were observed to be thread-bare.	6/9/14	KA
6	260.05.c	The clean laundry cart was observed to have soiled laundry placed on top of the clean laundry.	6/9/14	KA
7	260.06	The facility was not maintained in a clean and orderly manner such as: several rooms had dirty carpet, blinds were broken, beds were not made, and several residents' rooms had strong urine odors.	6/9/14	KA
8	300.01	The facility RN did not delegate to all staff. The facility RN did not conduct 90 day assessments.	6/9/14	KA
9	305.02	Resident #3's and #6's did not have signed physician orders in their records. ****Previously cited 1/22/13 and 3/21/13.****	6/9/14	KA
10	305.03	The facility RN did not assess residents' changes of conditions such as: Resident #2's swollen feet, Resident #5's severe diarrhea, Resident #10's leg wound and Resident #1's multiple falls.	6/9/14	KA
11	305.04	The facility RN did not make recommendations to the administrator when residents experienced changes in their health condition and required changes in care needs. Such as: Resident #2's need to have TED hose.	6/9/14	KA
12	305.06	Resident #7 was not assessed to self-administer her medications. ****Previously cited 1/22/13 and 3/21/13.****	6/9/14	KA

Response Required Date May 31, 2014	Signature of Facility Representative	Date Signed
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Facility Name Wynwood at River Place	Physical Address 13R401 739 East Parkcenter Blvd	Phone Number 208-338-5600
Administrator <i>Karen Anderson</i>	City Boise	ZIP Code 83706
Survey Team Leader Karen Anderson	Survey Type Licensure/follow-up survey and complaint investigation	Survey Date May 1, 2014

NON-CORE ISSUES PAGE 2 OF 3

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
13	310.01.a	The medication room was observed unlocked and medications were left unattended.	6/9/14	KA
14	310.04.e	Six month psychotropic medications reviews were not sent to Resident #1 and #4's physicians.	6/9/14	KA
15	320.01	NSA were not implemented, for example Resident #3's food was not being cut up, and Resident #7 was not being toilet per her NSA. Further, NSAs did not clearly describe residents' care needs such as; Resident #1's increased need for toileting assistance and Resident #4 and #10's daily care needs. ****Previously cited 1/22/13 and 3/21/13.****	6/9/14	KA
16	320.03	NSAs were not signed and dated by Resident #5 and #7.	6/9/14	KA
17	335.02 ^{330.01 & 02}	The facility shredded current records.	6/9/14	KA
18	335.03	Paper towels and liquid hand soap were not observed in residents' rooms who required personal care assistance to ensure caregivers washed their hands appropriately.	6/9/14	KA
19	350.02	The administrator did not investigate all incidents and accidents such as: Resident #1's multiple falls. ****Previously cited 1/22/13 and 3/21/13.****	6/9/14	KA
20	350.04	The administrator did not provide a written response to all complainants. ****Previously cited 1/22/13 and 3/21/13. ****	6/9/14	KA
21	451.02	Snacks were not offered/provided to residents who were not able to obtain them independently.	6/9/14	KA
22	600.05	The administrated did not supervise outside service personnel to coordinate care.	6/9/14	KA
Response Required Date May 31, 2014		Signature of Facility Representative	Date Signed	



Facility Name Wynwood at River Place 13R401	Physical Address 739 East Parkcenter Blvd	Phone Number 208-338-5600
Administrator <i>Karen Anderson</i> Survey Team Leader Karen Anderson	City Boise	ZIP Code 83706
	Survey Type Licensure/follow-up survey and complaint investigation	Survey Date May 1, 2014

NON-CORE ISSUES PAGE 3 OF 3

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED	L&C USE
23	600.06.a	The facility did not ensure sufficient staff was scheduled to implement Residents' NSAs, answer call lights in a timely manner and serve meals in a timely manner.	6/9/14	KA
24	625.01	Eight of 10 staff did not have documented evidence of 16 hours of orientation.	6/9/14	KA
25	630.01	Eight of 10 staff did not have documented evidence of dementia training.	6/9/14	KA
26	630.02	Ten of 10 staff did not have documented evidence of mental illness training	6/9/14	KA
27	630.03	Ten of 10 staff did not have documented evidence of developmental disabilities.	6/9/14	KA
28	645	Five medication aides did not have evidence they completed a medication certification training class.	6/9/14	KA
29	711.08.f	Outside agency service notes were not in Resident #6 and #10's record.	6/9/14	KA
30	730.01.f	CPR/First aid training was not maintained in 10 of 10 employee records.	6/9/14	KA
31	711.11	There were holes on MARs for 10 of 10 sampled residents.	6/9/14	KA
Response Required Date May 31, 2014	Signature of Facility Representative		Date Signed	



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>Wynwood at Riverplace</u>		Operator <u>Rouchelle Severeid</u>	
Address <u>739 E Pinkcenter</u>		Boise <u>83706</u>	
County <u>ADA</u>	Estab # <u>20828</u>	EHS/SUR#	Inspection time: _____ Travel time: _____
Inspection Type: <u>High</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>3</u>	# of Retail Practice Violations <u>1</u>
# of Repeat Violations <u>0</u>	# of Repeat Violations <u>1</u>
Score <u>3</u>	Score <u>1</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
(Y) N	1. Certification by Accredited Program, or Approved Course, or correct responses, or compliance with Code	<input type="checkbox"/>	<input type="checkbox"/>
Employee Health (2-201)			
(Y) N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
(Y) N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
(Y) N	5. Clean hands, properly washed (2-301)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(Y) N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(Y) N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
(Y) N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/A	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
(Y) N N/A	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/A	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
(Y) N N/O N/A	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N N/O N/A	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Advisory			
(Y) N N/A	22. Consumer advisory for raw or undercooked food (3-603)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Highly Susceptible Populations			
(Y) N N/O N/A	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical			
(Y) N N/A	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
(Y) N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
Conformance with Approved Procedures			
(Y) N N/A	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>Ham</u>	<u>41.2 F</u>	<u>Turkey</u>	<u>41</u>				
<u>Chicken salad</u>	<u>40.9 F</u>	<u>Tuna salad</u>	<u>40.2</u>				

GOOD RETAIL PRACTICES (input checked = 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. Personnel cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Warewashing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" 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>Rouchelle Severeid</u>	Person in Charge (Print) <u>Rouchelle Severeid</u>	Title	Date <u>5/1/14</u>
Inspector (Signature) <u>Karen Anderson</u>	Inspector (Print) <u>KAREN Anderson</u>	Date <u>4-30-14</u>	Follow-up: (Circle One) Yes No



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

Page 2 of 2
Date 4/30/14

Establishment Name Wynwood@Riverplace	Operator Kathelle Severeid
Address 739 E Parkcenter	Boise 83706
County Estab # ADA	EHS/SUR.# 20828 License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#22: The facility served undercooked eggs and did not have a consumer advisory posted.

COS: The facility's dietary manager posted a consumer advisory for residents viewing.

#5: Kitchen staff were observed touching various surfaces and not washing their hands before re-gloving.

COS: Dietary manager was observing and reminded kitchen staff to wash their hands before gloving.

#6: Kitchen staff were observed touching the lid of a grey trash can & then cutting up ready to eat food.

COS: Dietary manager was observing meal prep and reminded kitchen staff to wash hands & change gloves between tasks.

Person in Charge Kathelle Severeid	Date 5/1/14	Inspector Karen Anderson	Date 4/30/14
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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

May 19, 2014

Administrator
Wynwood at Riverplace
739 East Parkcenter Boulevard
Boise, Idaho 83706

Administrator:

An unannounced, on-site complaint investigation survey was conducted at Wynwood at Riverplace between April 28, 2014 and May 1, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006313

Allegation #1: The facility did not assist residents with their medications as ordered by the residents' physicians.

Findings #1: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, for inadequate care when residents were not assisted with their medications as ordered by their physicians. The facility was required to submit a plan of correction.

Allegation #2: The facility staff was not adequately trained prior to assisting residents with their medications.

Findings #2: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.645, for scheduling unlicensed staff to assist residents with their medications prior to the staff receiving the required training. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility nurse did not follow-up after residents experienced a change in condition or had medication changes.

Findings #3: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.03, when the facility nurse did not follow-up after residents experienced a change in condition or had medication changes. The facility was required to submit evidence of resolution within 30 days.

Administrator
May 19, 2014
Page 2 of 2

Allegation #4: The facility retained residents when they did not have the capability, capacity or services to care for the residents.

Findings #4: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, inadequate care, for retaining residents the facility did not have the capability, capacity or services to provide care for. The facility was required to submit a plan of correction.

Allegation #5: The facility did not implement infectious control procedures.

Findings #5: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03, when dirty linen was observed being transported on top of clean linen and when paper towels were not available for caregivers to wash their hands after providing cares to residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: The facility staff did not answer residents' call lights in a timely manner.

Findings #6: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a, for not scheduling sufficient staff to answer residents' call lights in a timely manner. 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

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

KA/sc

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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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

May 19, 2014

Administrator
Wynwood at Riverplace
739 East Parkcenter Boulevard
Boise, Idaho 83706

Administrator:

An unannounced, on-site complaint investigation survey was conducted at Wynwood at Riverplace between April 28, 2014 and May 1, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006440

Allegation #1: The facility did not have a licensed administrator.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215 for not having a licensed administrator to oversee the day to day operations. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility did not implement proper infectious control procedures.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.335.03, for not having paper towels available for caregivers to wash their hands after providing cares to the residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility's bath and hand towels were torn and thread-bare.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.05.b, for using thread-bare hand clothes and towels to dry residents after their 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

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

KA/sc



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
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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

May 19, 2014

Administrator
Wynwood at Riverplace
739 East Parkcenter Boulevard
Boise, Idaho 83706

Administrator :

An unannounced, on-site complaint investigation survey was conducted at Wynwood at Riverplace between April 28, 2014 and May 1, 2014. During that time, observations, interviews or record reviews were conducted with the following results:

Complaint # ID00006459

Allegation #1: The facility did not assist residents with their medications as ordered by their physicians.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, for inadequate care when the facility did not assist resident's with their medications as ordered by their physicians. The facility was required to submit a plan of correction.

Allegation #2: The facility did not answer residents' call lights in a timely manner.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a, for not having sufficient staff scheduled to answer residents' call lights in a timely manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not schedule sufficient staff to meet all of the residents needs.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.a, for not having sufficient staff scheduled to meet all of the residents needs. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility was not kept in a clean and orderly manner.

Findings: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06, for not

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maintaining the facility in a clean and orderly manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility did not provide adequate supervision to residents.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520, for inadequate care for not providing supervision to a resident. The facility was required to submit a plan of correction.

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