



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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March 27, 2015

Rex Redden, Administrator  
Idaho Falls Group Home #2 Wanda  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

Provider #13G029

Dear Mr. Redden:

An unannounced on-site complaint investigation was conducted from March 16, 2015 to March 18, 2015 at Idaho Falls Group Home #2 Wanda. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006912**

**Allegation #1:** The facility's as-worked schedules do not accurately document when the facility is understaffed.

**Findings #1:** During the investigation observations and staff interviews were conducted and as-worked schedules and staff timecards were reviewed with the following results:

On 3/16/15 at 11:15 a.m., as-worked schedules were provided by the facility by Qualified Intellectual Disability Professional (QIDP). The QIDP stated the schedules reflect the number of staff each shift should have. The schedules reflect 5 staff positions on the morning and evening shifts and 2 staff on the night shift.

Observations were conducted at the facility on 3/16/15 from 5:10 to 5:45 p.m. and on 3/17/15 from 7:30 to 8:55 a.m. During the observations, adequate numbers of staff were observed to be on duty, appropriately interacting with individuals and providing active treatment.

On 3/17/15 interviews were conducted with 8 direct care who worked the morning and evening shifts. The direct care staff reported they typically worked with 5 staff on duty. The direct care staff stated when staff would call in sick, the facility would attempt to find a replacement staff. However, they did occasionally work with only 4 staff on duty.

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The facility's as-worked schedules from 12/2014 to 2/2015 were reviewed. The schedules documented the facility worked with only 4 staff on duty as follows:

December 2014: 4 staff were on duty for the p.m. shift on 12/19, 12/20, 12/23, and 12/24.

January 2015: 4 staff were on duty for the a.m. shift on 1/18.

February 2015: 4 staff were on duty for the a.m. shift on 2/14 and 2/15 and 4 staff were on duty for the p.m. shift on 2/8.

All other shifts were worked with 5 or more staff. Additionally, timecards of 10 randomly selected direct care staff were reviewed and compared to the as-worked schedules. No discrepancies were noted between the time cards and the as-worked schedules.

It could not be established that the facility as-worked schedules were inaccurate. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The facility incident and accident (I&A) reports do not accurately document incidents that take place in the facility.

**Findings #2:** During the investigation observations and staff interviews were conducted and individual records and I&As were reviewed with the following results:

Observations were conducted at the facility on 3/16/15 from 5:10 to 5:45 p.m. and on 3/17/15 from 7:30 to 8:55 a.m. During the observations, adequate numbers of staff were observed to be on duty, appropriately interacting with individuals and providing active treatment.

On 3/17/15 interviews were conducted with 8 direct care who worked the morning and evening shifts. The direct care staff stated they had either completed an I&A report or had observed another direct care staff complete I&A reports. All of the staff stated I&A reports were completed when incidents occurred and the reports were accurately documented.

Behavior reports and nursing notes from 12/1/14 to 3/15/15 were reviewed and compared to the facility's I&As for 4 randomly selected individuals. All 4 records included comprehensive reporting of all incidents.

It could not be determined that the facility failed to ensure comprehensive information was kept for individuals. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

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**Allegation #3:** Staff are trained to perform differently depending on who is in the facility.

**Findings #3:** During the investigation observations and staff interviews were conducted and staff training records were reviewed with the following results:

Observations were conducted at the facility on 3/16/15 from 5:10 to 5:45 p.m. and on 3/17/15 from 7:30 to 8:55 a.m. During the observations, adequate numbers of staff were observed to be on duty, appropriately interacting with individuals and providing active treatment.

On 3/17/15 interviews were conducted with 8 direct care who worked the morning and evening shifts. The direct care staff stated the facility provided training when hired and individual specific training related to the individuals with whom the staff worked. All staff stated the individuals' active treatment programs were implemented as written. The staff also stated if anyone said the active treatment program should be implemented different than written, they would ask for direction from the home supervisor or the Quality Assurance Manager.

It could not be determined that the facility trained staff to perform differently depending on who was at the facility. Therefore the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

  
JIM PROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

TF/pmt