



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

RECEIVED

APR - 9 2015

FACILITY STANDARDS

March 27, 2015

Rex Redden, Administrator  
Idaho Falls Group Home #3 Periska  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #3 Periska, Provider #13G045

Dear Mr. Redden:

This is to advise you of the findings of the complaint survey of Idaho Falls Group Home #3 Periska, which was conducted on March 18, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Rex Redden, Administrator  
March 27, 2015  
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 9, 2015**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by April 9, 2015. If a request for informal dispute resolution is received after April 9, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

  
JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

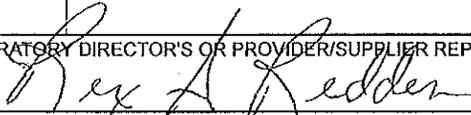
PRINTED: 03/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>13G045 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/18/2015 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>IDAHO FALLS GROUP HOME #3 PERISKA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>950 PERISKA WAY<br>IDAHO FALLS, ID 83405 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|       |   |       |   |   |
|-------|---|-------|---|---|
| W 000 | <p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the complaint survey conducted from 3/16/15 to 3/18/15.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead<br/>Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>I&amp;A - Incident and Accident</p>   | W 000 |   |   |
| W 111 | <p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained complete information for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in a lack of comprehensive information being available regarding an individual's experiences at the facility. The findings include:</p> <p>1. Individual #3's nursing notes, from 12/1/14 to 3/15/15 were reviewed. The notes documented multiple incidents and directed staff to complete an I&amp;A form. However, corresponding I&amp;A forms could not be found for all incidents. Examples included, but were not limited to, the following:</p> | W 111 | <p>W 111</p> <p>1. The QIDP will obtain the nursing call logs for the week from the LPN's. The QIDP will review all I&amp;A's and compare them to the nursing call logs. The QIDP will then initial both the I&amp;A and the nursing call logs to ensure they match.</p> <p>2. All individuals at all facilities have the potential to be affected by this practice. The QIDP will review all I&amp;A's and compared them to the nursing call logs for all facilities to ensure I&amp;A's were completed for each incident/accident.</p> <p>3. The QIDP will review all I&amp;A's and compare them to nursing call logs each week. The QIDP will then initial all I&amp;A's and nursing call logs to indicate that they have been reviewed and that the correlate. If I&amp;A's are found to be missing, the staff responsible for the I&amp;A will be asked to document one as a "late entry".</p> | <p>RECEIVED<br/>APR - 9 2015<br/>FACILITY STANDARDS</p> |

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|--|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE | (X6) DATE |
|--|-------|-----------|

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

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

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| NAME OF PROVIDER OR SUPPLIER<br><br>IDAHO FALLS GROUP HOME #3 PERISKA |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>950 PERISKA WAY<br>IDAHO FALLS, ID 83405  |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |   |
| W 111   | <p>Continued From page 1</p> <p>a. 2/4/15 at 1:35 p.m.: Individual #3's nursing notes documented he "is just waking up. can we give him his lunch meds. [sic] Yes and make sure you document that he is getting them late and fill out a [sic] I&amp;A."</p> <p>b. 2/5/15 at 6:23 a.m.: Individual #3's nursing notes documented the nurse "Called to check on [Individual #3]. He had not drank anything during the night. Give him the other Zofran and Ibuprofen and fill out a [sic] I&amp;A and continue to monitor."</p> <p>c. 2/5/15 at 9:27 a.m.: Individual #3's nursing notes documented staff called to report that Individual #3 "...did not want to get up. Continue to prompt him he [sic] is not feeling good. Fill out a [sic] I&amp;A."</p> <p>d. 2/5/15 at 9:41 a.m.: Individual #3's nursing notes documented staff called to report that Individual #3 would "...not eat give [sic] him the BRAT [bland food] diet and monitor and fill out an I&amp;A."</p> <p>When asked about the I&amp;As, during an interview on 3/17/15 at 1:10 p.m., the Quality Assurance Manager stated only 3 I&amp;As could be found for Individual #3 in February 2015. I&amp;As for all of Individual #3's other February 2015 incidents (including the incidents listed above) could not be found.</p> <p>The facility failed to ensure comprehensive information was kept for Individual #3.</p> | W 111  | <p>W 111 cont'd</p> <p>4. The QIDP will monitor all I&amp;A's and compared them to nursing call logs to ensure staff are filling them out as instructed by the LPN. Completion of I&amp;A's will be reviewed by the Home Supervisor at every monthly staff meeting. The QIDP will attend all staff meetings to ensure on-going training on I&amp;A's is being provided.</p> <p>5. Target date for completion will be May 25, 2015.</p> |                      |   |

Bureau of Facility Standards

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|--------------------|--|---------------|---|--------------------|
| M 000              | <p>16.03.11 Initial Comments</p> <p>The following deficiency was cited during the complaint survey conducted from 3/16/15 to 3/18/15.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead<br/>Karen Marshall, MS, RD, LD</p> | M 000         | <p style="text-align: center;"><b>RECEIVED</b><br/><b>APR - 9 2015</b><br/><b>FACILITY STANDARDS</b></p>        |                    |
| MM557              | <p>16.03.11.210.04(a) Reports of accidents, seizures, illnesses</p> <p>Reports of accidents, seizures, illnesses, treatments for the aforementioned, and immunizations; and (7-1-80)<br/>This Rule is not met as evidenced by:<br/>Refer to W111.</p>              | MM557         | <p>MM557<br/>Refer to W 111</p>   |                    |

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



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March 27, 2015

Rex Redden, Administrator  
Idaho Falls Group Home #3 Periska  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

Provider #13G045

Dear Mr. Redden:

An unannounced on-site complaint investigation was conducted from March 16, 2015 to March 18, 2015 at Idaho Falls Group Home #3 Periska. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006913**

**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 4:10 to 4:45 p.m. and on 3/17/15 from 10:25 to 11:35 a.m. During the observations, adequate numbers of staff were observed to be on duty, appropriately interacting with individuals and providing active treatment.

Rex Redden, Administrator  
March 27, 2015  
Page 2 of 4

On 3/17/15 interviews were conducted with 8 current direct care staff and 2 former direct care staff 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.

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 a.m. shift on 12/8 and 12/21.

January 2015: 4 staff were on duty for the a.m. shift on 1/10 and 4 staff were on duty for the p.m. shift on 1/17.

February 2015: 4 staff were on duty for the a.m. shift on 2/6, 2/12, and 2/15 and 4 staff were on duty for the p.m. shift on 2/22 and 2/28.

All other shifts were worked with 5 or more staff. Additionally, timecards of 6 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 determined 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 4:10 to 4:45 p.m. and on 3/17/15 from 10:25 to 11:35 a.m. and from 3:50 - 4:10 p.m. During the observations, staff were observed to appropriately interacting with individuals, providing active treatment and documenting activities.

Rex Redden, Administrator  
March 27, 2015  
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On 3/17/15 interviews were conducted with 8 direct care staff and 2 former direct care staff 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 3 randomly selected individuals. Two of the 3 records included comprehensive reporting of all incidents. However, one individual's records did not demonstrate I&As had been completed for all incidents. Examples included, but were not limited to the following:

- 2/4/15 at 1:35 p.m.: The individual's nursing notes documented he "is just waking up. can we give him his lunch meds. {sic} Yes and make sure you document that he is getting them late and fill out a {sic} I&A."

- 2/5/15 at 6:23 a.m.: The individual's nursing notes documented the nurse "Called to check on {individual's name}. He had not drank anything during the night. Give him the other Zofran and Ibuprofen and fill out a {sic} I&A and continue to monitor."

- 2/5/15 at 9:27 a.m.: The individual's nursing notes documented staff called to report that the individual "...did not want to get up. Continue to prompt him he {sic} is not feeling good. Fill out a {sic} I&A."

- 2/5/15 at 9:41 a.m.: The individual's nursing notes documented staff called to report that the individual would "...not eat give {sic} him the BRAT {bland food} diet and monitor and fill out an I&A."

When asked about the I&As, during an interview on 3/17/15 at 1:10 p.m., the Quality Assurance Manager stated only 3 I&As could be found for the individual in February 2015. I&As for the all of the individual's other incidents in February 2015 (including the incidents listed above) could not be found.

The facility failed to ensure comprehensive information was kept for the individual. Therefore, the allegation was substantiated and deficient practice was cited at W111 and M557.

**Conclusion #2:** Substantiated. Federal and State deficiencies related to the allegation are cited.

Rex Redden, Administrator  
March 27, 2015  
Page 4 of 4

**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 with the following results:

Observations were conducted at the facility on 3/16/15 from 4:10 to 4:45 p.m. and on 3/17/15 from 10:25 to 11:35 a.m. and from 3:50 - 4:10 p.m. During the observations, staff were observed appropriately interacting with individuals, providing active treatment and documenting activities.

On 3/17/15 interviews were conducted with 8 current direct care staff and 2 former direct care staff 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.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

  
JIM TROUFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt