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
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March 26, 2015

Rex Redden, Administrator
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #1 Bellin, Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the complaint survey of Idaho Falls Group Home #1 Bellin, which was conducted on March 19, 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

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 7, 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

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 7, 2015. If a request for informal dispute resolution is received after April 7, 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,

FOR
MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G024		C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN 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	INITIAL COMMENTS The following deficiencies were cited during the complaint survey conducted from 3/16/15 to 3/19/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Ashley Henscheid, QIDP Common abbreviations used in this report are: I&A - Incident/Accident LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional	W 000	RECEIVED APR - 9 2015 FACILITY STANDARDS	
W 111	483.410(c)(1) CLIENT RECORDS 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. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained complete information for 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed. This resulted in a lack of comprehensive information being available regarding the individuals' experiences at the facility. The findings include: 1. Individual #1 - #4's nursing notes from 12/1/14 to 3/15/15 were reviewed. The notes documented multiple incidents, many of which directed staff to complete an I&A form. However,	W 111	W 111 1. The QIDP will obtain the nursing call logs for the week from the LPN's. The QIDP will review all I&A's and compare them to the nursing call logs. The QIDP will then initial both the I&A and the nursing call logs to ensure they match. 2. All individuals at all facilities have the potential to be affected by this practice. The QIDP will review all I&A's and compared them to the nursing call logs for all facilities to ensure I&A's were completed for each incident/accident. 3. The QIDP will review all I&A's and compare them to nursing call logs each week. The QIDP will then initial all I&A's and nursing call logs to indicate that they have been reviewed and that the correlate. If I&A's are found to be missing, the staff responsible for the I&A will be asked to document one as a "late entry".	

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

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

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	13G024		C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN 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	Continued From page 1 corresponding I&A forms could not be found for all incidents. Examples included, but were not limited to, the following: a. 2/9/15 at 1:45 p.m.: Individual #1 had "spit up" after having a snack. The notes directed staff to monitor her and "...fill out an I&A!" b. 2/6/15 at 12:28 p.m.: Individual #3 was constipated and had a blockage. The note instructed the staff to "Fill out an I&A." A subsequent note, timed 4:35 p.m., documented Individual #3's peri area was raw and red. The note instructed staff to treat the area and "Fill out an I&A." c. 1/12/15 at 8:43 a.m.: Individual #2's tube feeding "...went over by 50 cc. Fill out an I&A." d. 1/10/15 at 11:38 a.m.: Individual #4 had a "...hangnail that is bleeding...Fill out an I&A and monitor." e. 1/10/15 at 6:40 p.m.: Individual #3 was having difficulty with her tube feeding. The note instructed staff to "...Fill out an I&A." f. 1/6/15 at 7:55 a.m.: Individual #4 had scratched the "...left side of his face...fill out an I&A and monitor." g. 12/30/14 at 3:16 p.m.: Individual #2 was "...upset and is not feeling well...Fill out an I&A." h. 12/30/14 at 3:21 p.m.: Individual #3 had a seizure with a 40 second recovery time, a fever and low oxygen saturation levels. The note instructed staff to "...fill out an I&A..."	W 111	W 111 cont'd 4. The QIDP will monitor all I&A's and compared them to nursing call logs to ensure staff are filling them out as instructed by the LPN. Completion of I&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&A's is being provided. 5. Target date for completion will be May 25, 2015.	

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IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

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W 111	Continued From page 2 i. 12/30/14 at 6:42 p.m.: Individual #1 had not had a bowel movement. The note instructed staff to "...Fill out an I&A." During an interview on 3/19/15 from 8:05 - 8:50 a.m., the LPN stated when staff called for any issue, she documented in her call log. The LPN stated any time she, the nursing assistant, or the on-call nurse visited the facility they would pick up the I&A forms and bring them to the office for review. The QIDP, who was present during the interview, stated the facility did not have a system to correlate the nursing on-call log with the I&A forms to ensure all forms were accounted for. The facility failed to ensure comprehensive information was kept for Individuals #1 - #4.	W 111		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: IDAHO FALLS GROUP HOME #1 BELLIN

STREET ADDRESS, CITY, STATE, ZIP CODE: 1664 SOUTH BELLIN, IDAHO FALLS, ID 83405

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint survey conducted from 3/16/15 to 3/19/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Ashley Henscheid, QIDP Common abbreviations used in this report are: QIDP - Qualified Intellectual Disabilities Professional	M 000		
MM557	16.03.11.210.04(a) Reports of accidents, seizures, illnesses Reports of accidents, seizures, illnesses, treatments for the aforementioned, and immunizations; and (7-1-80) This Rule is not met as evidenced by: Refer to W111.	MM557	MM557 Refer to W 111	
MM602	16.03.11.230.02(b) Work Schedules Daily work schedules, reflecting the daily adjustments of employees, shall be kept in writing, showing the personnel on duty at any given time for the previous three (3) month period. Personnel shall be identified by first and last names, including professional designation (R.N., L.P.N., Q.M.R.P., etc.), and position. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure as-worked schedules were reflective of daily adjustments for 4 of 4 staff (Staff A - D) whose timecards were	MM602	RECEIVED APR - 9 2015 FACILITY STANDARDS	

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

Bureau of Facility Standards

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STREET ADDRESS, CITY, STATE, ZIP CODE: 1664 SOUTH BELLIN, IDAHO FALLS, ID 83405

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MM602	Continued From page 1 compared to as-worked schedules. This impeded the facility's ability to monitor staffing patterns. The findings include: 1. The facility's as-worked schedules from 12/2014 through 2/2015 were compared to 4 randomly selected employee timecards. The as-worked schedules did not reflect the times the employees had actually worked. Examples included, but were not limited to, the following: a. Staff A: - 12/2/14: Timecard: 2 - 10 p.m. As-worked: 5 - 10 p.m. - 12/3/14: Timecard: 2 - 9 p.m. As-worked: 2 - 10 p.m. - 12/20/14: Timecard: 2 - 9:30 p.m. As-worked: 2 - 10 p.m. - 1/3/15: Timecard: 1 - 9 p.m. As-worked: 2 - 10 p.m. - 1/6/15: Timecard: 2 - 9 p.m. As-worked: 2 - 10 p.m. - 1/9/15: Timecard: 6 a.m. - 2 p.m. As-worked: 6 a.m. - 10 p.m. - 2/28/15: Timecard: 6 - 10 p.m. As-worked: Staff A was not present on the as-worked schedule. b. Staff B: - 12/18/14: Timecard: 6 - 10 a.m. As-worked: 6 - 9 a.m. - 1/8/15: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m. - 1/9/15: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m. - 1/17/15: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m. c. Staff C:	MM602	MM602 1. A new format for staff schedules has been implemented. The Home Supervisor will review the staff schedules on a weekly basis and compare the schedules to the time sheets to make sure it is an accurate reflection of who worked which shifts. 2. All individuals in all facilities have the potential to be affected by this practice. The new format for staff schedules has been implemented in all facilities. The Home Supervisor in all facilities will be responsible for reviewing the staff schedules weekly. The Home Supervisor will then compare the schedules to the time sheets to ensure they are an accurate reflection of which staff worked which shifts. 3. The Home Supervisor will review time sheets weekly and compare them to the new staff schedule. 4. The Quality Assurance Managers will review the time sheets at the end of the month and compare it with the staff schedule to ensure it is an accurate reflection of which staff worked which shifts. 5. Target date for completion will be May 5, 2015.	

Bureau of Facility Standards

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MM602	Continued From page 2 - 12/1/14: Timecard: 2 - 10 p.m. As-worked: Staff C was not present on the as-worked schedule. - 1/20/15: Timecard: 10 p.m. - 6 a.m. As-worked: Staff C was not present on the as-worked schedule. - 1/20/15: Timecard: 7:30 a.m. - 3:30 p.m. As-worked: Staff C was not present on the as-worked schedule. - 2/5/15: Timecard: 2 - 10 p.m. As-worked: Staff C was not present on the as-worked schedule. d. Staff D: - 12/5/14: Timecard: 10 p.m. - 6 a.m. As-worked: Staff D was not present on the as-worked schedule. - 12/6/14: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m. - 1/22/15: Timecard: 10 p.m. - 6 a.m. As-worked: Staff D was not present on the as-worked schedule. - 2/5/15: Timecard: 10 p.m. - 6 a.m. As-worked: Staff D was not present on the as-worked schedule. - 2/7/15: Timecard: 10 p.m. - 6 a.m. As-worked: Staff D was not present on the as-worked schedule. During an interview on 3/19/15 from 8:05 - 8:50 a.m., the Home Supervisor stated each facility in the company had a timecard book. When staff arrived at the facility for their shift, they would document in the timecard book for that facility. The Shift Lead or community person then transcribed information from the timecards onto the as-worked schedule. The QIDP, who was present during the interview, stated the as-worked schedules were inaccurate.	MM602		

Bureau of Facility Standards

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	13G024		C 03/19/2015

NAME OF PROVIDER OR SUPPLIER

IDAHO FALLS GROUP HOME #1 BELLIN

STREET ADDRESS, CITY, STATE, ZIP CODE

1664 SOUTH BELLIN
IDAHO FALLS, ID 83405

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MM602	Continued From page 3 The facility failed to ensure the as-worked schedules accurately reflected the staff who worked each shift.	MM602		

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March 26, 2015

Rex Redden, Administrator
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

Provider #13G024

Dear Mr. Redden:

An unannounced on-site complaint investigation was conducted from March 16, 2015 to March 19, 2015 at Idaho Falls Group Home #1 Bellin. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006911

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:

When asked, on 3/16/15 at 3:20 p.m., the Qualified Intellectual Disabilities Professional (QIDP) stated the facility required 6 staff on the morning shift, 6 staff on the evening shift, and 2 staff on the night shift. The QIDP stated periodically the facility would run with 5 staff on the morning or evening shift and the groups would be rearranged to meet individuals' needs. The QIDP stated the facility never ran with fewer than 5 staff on the morning or evening shift.

Observations were conducted at the facility on 3/16/15 from 6:00 to 6:30 p.m. and on 3/17/15 from 1:10 to 1:40 p.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 11 direct care staff who worked the morning and evening shifts. The direct care staff reported they typically worked with 6 staff on-duty, but sometimes dropped to 5 staff. The direct care staff stated when staff would call in sick, the facility would attempt to find a replacement staff. If a replacement staff was not available, the groups were rearranged to ensure all individuals' needs were met.

The facility's as-worked schedules from 12/2014 to 2/2015 were reviewed. The schedules did not demonstrate the facility had been understaffed. However, timecards of 4 randomly selected direct care staff were reviewed and compared to the as-worked schedules. The timecard information was not consistently reflected on the facility's as-worked schedules. Examples included, but were not limited to, the following:

First staff:

- 12/2/14: Timecard: 2 - 10 p.m. As-worked: 5 - 10 p.m.
- 12/3/14: Timecard: 2 - 9 p.m. As-worked: 2 - 10 p.m.
- 12/20/14: Timecard: 2 - 9:30 p.m. As-worked: 2 - 10 p.m.
- 1/3/15: Timecard: 1 - 9 p.m. As-worked: 2 - 10 p.m.
- 1/6/15: Timecard: 2 - 9 p.m. As-worked: 2 - 10 p.m.
- 1/9/15: Timecard: 6 a.m. - 2 p.m. As-worked: 6 a.m. - 10 p.m.
- 2/28/15: Timecard: 6 - 10 p.m. As-worked: The staff was not present on the as-worked schedule.

Second staff:

- 12/18/14: Timecard: 6 - 10 a.m. As-worked: 6 - 9 a.m.
- 1/8/15: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m.
- 1/9/15: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m.
- 1/17/15: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m.

Third staff:

- 12/1/14: Timecard: 2 - 10 p.m. As-worked: The staff was not present on the as-worked schedule.
- 1/20/15: Timecard: 10 p.m. - 6 a.m. As-worked: The staff was not present on the as-worked schedule.
- 1/20/15: Timecard: 7:30 a.m. - 3:30 p.m. As-worked: The staff was not present on the as-worked schedule.
- 2/5/15: Timecard: 2 - 10 p.m. As-worked: The staff was not present on the as-worked schedule.

Fourth staff :

- 12/5/14: Timecard: 10 p.m. - 6 a.m. As-worked: The staff was not present on the as-worked schedule.
- 12/6/14: Timecard: No time was recorded. As-worked: 10 p.m. - 6 a.m.
- 1/22/15: Timecard: 10 p.m. - 6 a.m. As-worked: The staff was not present on the as-worked schedule.
- 2/5/15: Timecard: 10 p.m. - 6 a.m. As-worked: The staff was not present on the as-worked schedule.
- 2/7/15: Timecard: 10 p.m. - 6 a.m. As-worked: The staff was not present on the as-worked schedule.

When asked about the discrepancies during an interview on 3/19/15 from 8:05 - 8:50 a.m., the Home Supervisor stated each facility in the company had a timecard book. When staff arrived at the facility for their shift, they would document in the timecard book for that facility. The Shift Lead or community person then transcribed information from the timecards onto the as-worked schedule. The Home Supervisor stated the timecards should be the accurate reflection of who was present in the facility for any given shift. The QIDP, who was present during the interview, stated the as-worked schedules were inaccurate.

It could not be established that the facility as-worked schedules did not accurately reflect when the facility was understaffed. Therefore, the allegation was unsubstantiated. However, it was determined the facility's as-worked schedules did not accurately reflect all staff who had worked each shift in accordance with the staffs' timecards. Therefore, deficient practice was cited at M602.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility Incident/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 6:00 to 6:30 p.m. and on 3/17/15 from 1:10 to 1:40 p.m. Staff were noted to appropriately interact with individuals and provide active treatment, with no significant incidents observed.

On 3/17/15 interviews were conducted with 11 direct care staff who worked the morning and evening shifts. The direct care staff stated anytime there was a medical concern, or an individual had an incident or engaged in a behavior that resulted in, or had the potential to result in, injury, they would call the nurse. The direct care staff stated they would then complete an I&A form, as well as additional documentation (e.g. behavior reporting forms, neurological reporting forms, seizure reports, etc.).

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. Four of 4 records documented incidents in the nursing notes for which corresponding I&As could not be found. Examples included, but were not limited to the following:

- 2/9/15 at 1:45 p.m.: An individual "spit up" after having a snack. The notes directed staff to monitor her and "...fill out an I&A!"

- 12/30/14 at 6:42 p.m.: The individual had not had a bowel movement. The note instructed staff to "...Fill out an I&A."

- 1/12/15 at 8:43 a.m.: A second individual's tube feeding "...went over by 50 cc. Fill out an I&A."

- 12/30/14 at 3:16 p.m.: The second individual was "...upset and is not feeling well...Fill out an I&A."

- 2/6/15 at 12:28 p.m.: A third individual was constipated and had a blockage. The note instructed the staff to "Fill out an I&A." A subsequent note, timed 4:35 p.m., documented the individual's peri area was raw and red. The note instructed staff to treat the area and "Fill out an I&A."

- 1/10/15 at 6:40 p.m.: The third individual was having difficulty with her tube feeding. The note instructed staff to "...Fill out an I&A."

- 1/10/15 at 11:38 a.m.: A fourth individual had a "...hangnail that is bleeding...Fill out an I&A and monitor."

- 1/6/15 at 7:55 a.m.: The fourth individual had scratched the "...left side of his face...fill out an I&A and monitor."

When asked about the I&As, during an interview on 3/19/15 from 8:05 - 8:50 a.m., the Licensed Practical Nurse (LPN) stated she documented in her call log any time staff called for any issue. The LPN stated any time she, the nursing assistant, or the on-call nurse visited the facility they would pick up the I&A forms and bring them to the office for review. The QIDP, who was present during the interview, stated the facility did not have a system to correlate the nursing on-call log with the I&A forms to ensure all forms were accounted for.

The facility failed to ensure comprehensive information was kept for the individuals. 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.

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:

The training records of all current staff were reviewed. The records included documentation of initial and on-going training for all staff.

Observations were conducted at the facility on 3/16/15 from 6:00 to 6:30 p.m. and on 3/17/15 from 1:10 to 1:40 p.m. During the observations, staff were observed to be appropriately interacting with individuals and providing active treatment.

On 3/17/15 interviews were conducted with 11 direct care staff who worked the morning and evening shifts. The direct care staff stated initial training was conducted with a trainer and then they were monitored on a frequent basis following their initial training. All direct care staff stated they received continued training through staff meetings and one-on-one with the trainer if they had questions. Additionally, all direct care staff denied ever being instructed to perform differently depending on who was present in the facility. All direct care staff stated implementation of programs and training needed to be consistent for individuals residing in the facility.

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

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Individuals' choices are directed by staff preferences.

Findings #4: During the investigation, observations, review of records and staff interviews were conducted with the following results:

Observations were conducted at the facility on 3/16/15 from 6:00 to 6:30 p.m. and on 3/17/15 from 1:10 to 1:40 p.m. During the observations, staff were noted to encourage individuals to communicate independently whenever possible. At no time were staff observed to make choices for individuals without their input.

On 3/17/15 interviews were conducted with 11 direct care staff who worked the morning and evening shifts. The direct care staff stated four individuals in the facility required communication devices to express their wants and needs. The staff stated one individual was not currently using her device due to physical limitations, however, the other three individuals utilized their communication devices regularly and independently. Each of the direct care staff stated they had not witnessed any staff member making a choice for an individual without communicating with them.

Four individuals were selected for further review. Each of the individuals had a communication program in their record. None of the communication programs included instructions for staff to make choices for the individual.

During an interview on 3/19/15 from 8:05 - 8:50 a.m., the Home Supervisor stated that staff were permitted to aid individuals using hand over hand assistance to make a selection on communication devices. However, she stated staff could only assist with hand over hand once the staff member knew the individual's choice. The Home Supervisor stated she had not heard of any staff directing individuals' choices.

It could not be determined that staff preferences directed individuals' choices. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Individuals' positioning and toileting needs are not met.

Findings #5: During the investigation, observations and staff interviews were conducted and individual records and incident reports were reviewed with the following results:

Incident/Accident Reports from 12/1/14 to 3/15/15 as well as investigations of alleged abuse, neglect and mistreatment from 9/8/14 to 3/15/15 were reviewed. There were no documented incidents of toileting or positioning needs being unmet.

Observations were conducted at the facility on 3/16/15 from 6:00 to 6:30 p.m. and on 3/17/15 from 1:10 to 1:40 p.m. Staff were observed to provide individuals with toileting and positioning assistance as needed with no concerns noted.

On 3/17/15 interviews were conducted with 11 direct care staff who worked the morning and evening shifts. The direct care staff stated individuals were assisted to change positions approximately every 30 minutes. The staff stated there were exceptions, including during mealtimes and outside appointments. The direct care staff stated at an absolute minimimum, individuals would re-position every two hours when they were assisted with changing their attends. Direct care staff interviewed stated that attends changes took place every two hours and as needed, including extra times requested by the individual or after a seizure.

Four individuals were selected for review. Positioning and attends change tracking from 12/1/14 to 3/16/15 was reviewed. The tracking documented each of the individuals were assisted with positioning and toileting in the specified timeframes, except when special circumstances arose, as described by the direct care staff (mealtimes, appointments, etc).

During an interview on 3/19/15 from 8:05 - 8:50 a.m., the Home Supervisor stated individuals were supposed to change positions every 20 to 30 minutes. She stated exceptions included mealtimes, specifically for those individuals who utilized a feeding tube, as they could not lie down immediately after meals. The Home Supervisor stated she monitored the documentation of positions and would cross-reference prolonged position use with appointments, meals and outings. The Home Supervisor stated if needed, she would interview staff to understand the positioning concern.

During the same interview, the Home Supervisor stated individuals' attends were changed a minimum of every 2 hours. She stated occassionally attends changes extended to 3 hours for individuals who utilized feeding tubes and were required to stay seated a certain amount of time after meals.

It could not be determined that individuals' positioning and toileting needs were not met. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Individuals are subjected to psychological abuse.

Findings #6: During the investigation, observations and staff interviews were conducted and staff training records, facility policy and individual records were reviewed with the following results:

The facility's Resident Abuse, Neglect, or Mistreatment Policy, dated 12/14/12, documented "...residents shall not be subjected to any form of abuse..." The policy defined psychological abuse as "The verbal or nonverbal infliction of anguish, pain, or distress that results in mental or emotional suffering."

Incident/Accident Reports from 12/1/14 to 3/15/15 as well as investigations of alleged abuse, neglect and mistreatment from 9/8/14 to 3/15/15 were reviewed. There were no documented incidents of abuse, or alleged abuse, by facility staff.

Staff training records from 12/1/14 to 3/17/15 were reviewed. The training records documented staff were regularly trained on abuse, with the most recent training taking place on 2/4/15.

Observations were conducted at the facility on 3/16/15 from 6:00 to 6:30 p.m. and on 3/17/15 from 1:10 to 1:40 p.m. During the observations, staff were observed to interact appropriately with individuals.

On 3/17/15 interviews were conducted with 11 direct care staff who worked the morning and evening shifts. The direct care staff stated they had never witnessed any staff abuse an individual. Each of the staff stated if they witnessed abuse, they would intervene to protect the individual(s) and notify a member of the supervisory team.

During an interview on 3/19/15 from 8:05 - 8:50 a.m., the Home Supervisor stated any concerns of inappropriate staff behavior had been addressed with written counseling or termination. The Home Supervisor provided an example of a staff communicating details of the shift with another staff at shift change in front of the individuals.

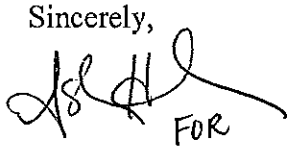
It could not be determined that individuals were being subjected to psychological abuse. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #6: 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,



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