



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

April 8, 2015

Steve Young, Administrator  
Yellowstone Group Home #5 Burke  
560 West Sunnyside  
Idaho Falls, ID 83402

RE: Yellowstone Group Home #5 Burke, Provider #13G067

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #5 Burke, which was conducted on March 26, 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

Steve Young, Administrator  
April 8, 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 21, 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.

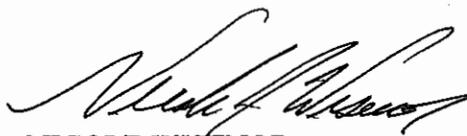
This request must be received by April 21, 2015. If a request for informal dispute resolution is received after April 21, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

# Yellowstone Group Homes

560 W Sunnyside  
Idaho Falls, ID 83402

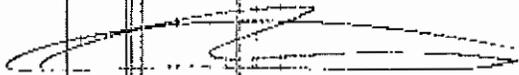
April 22, 2015

Jim Troutfetter  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
3232 Elder St  
Boise, ID 83720-0036

Dear Mr. Troutfetter,

This is the Plan of Correction for the survey concluded at Yellowstone group Home #5, namely Burke, on March 26, 2015. I would like to take the opportunity to thank you for the helpful information you always share. The survey process is always a learning experience, and you certainly made it helpful as well as pleasant. I relayed your observations and positives to the staff and they are very appreciative. Thank you very much for your effort.

Sincerely,



Nicholas Schmitt  
QIDP

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

PRINTED: 04/07/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/26/2015
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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83406
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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) COMPLETION DATE
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W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey conducted from 3/23/15 to 3/26/15.  The surveyor conducting your survey was:  Jim Troutfetter, QIDP  Common abbreviations used in this report are:  IPP - Individual Program Plan LPN - Licensed Practical Nurse	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure guardians were provided with comprehensive information necessary to make informed decisions for 3 of 3 individuals (Individuals #1 - #3) whose Written Informed Consents were reviewed. This resulted in insufficient information being provided to guardians on which to base consent decisions. The findings include:  1. Individual #1 - #3's Written Informed Consents were reviewed. The consents did not contain	W 124	See attached Plan of Correction -	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Nicholas Schmidt</i>	TITLE  QIDP	(X6) DATE  4/22/15
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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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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE			STREET ADDRESS, CITY, STATE, ZIP CODE 4514 EAST BURKE DRIVE AMMON, ID 83406		
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W 124	<p>Continued From page 1</p> <p>sufficient information related to the side effects of psychotropic medications, as follows:</p> <p>a. Individual #1's IPP, dated 12/18/14, documented he was an 18 year old male whose diagnoses included mild mental retardation and bipolar disorder.</p> <p>Individual #1's Physician's Recap Orders, dated 2/2/15, documented he received Risperdal (an antipsychotic drug), Abilify (an antipsychotic drug), Clonidine (an antihypertensive drug), Seroquel (an antipsychotic drug), Geodon (an antipsychotic drug), Lamictal (an anticonvulsant drug) and Haldol (an antipsychotic drug) daily. Individual #1's Written Informed Consents did not include comprehensive information related to the potential side effects of his medications. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Individual #1's consent for Risperdal, dated 12/10/14, documented side effects included "Dry mouth, nausea, vomiting, constipation, change in sleep patterns, headache and confusion."</li> </ul> <p>The 2015 Nursing Drug Handbook included both neuroleptic malignant syndrome (a potentially fatal syndrome) and suicide attempt as possible adverse reactions to Risperdal.</p> <ul style="list-style-type: none"> <li>- Individual #1's consent for Seroquel, dated 3/10/15, documented side effects included "Dizziness, nausea, vomiting, diarrhea, change in sleep patterns, sedation, and weight gain or loss, and cramps."</li> </ul> <p>The 2015 Nursing Drug Handbook included neuroleptic malignant syndrome, seizures and</p>	W 124			

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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83406
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W 124	<p>Continued From page 2</p> <p>leukopenia (a low white blood cell count) as possible adverse reactions to Seroquel.</p> <p>- Individual #1's consent for Geodon, dated 12/10/14, documented side effects included anxiety or restlessness, changes in vision, constipation, upset stomach, dry mouth, headache, sleepiness or unusual drowsiness, sneezing, cough, runny or stuffy nose, tiredness, weight gain and tardive dyskinesia.</p> <p>The 2015 Nursing Drug Handbook included suicide attempt, bradycardia (very slow heart rate), QT-interval prolongation (an irregular heartbeat) and rectal hemorrhage as possible adverse reactions to Geodon.</p> <p>- Individual #1's consent for Haldol, dated 11/26/14, documented side effects included dry mouth, nausea, dizziness and lightheadedness.</p> <p>The 2015 Nursing Drug Handbook included neuroleptic malignant syndrome, seizures, QT-interval prolongation-torsades de pointes and leukopenia as possible adverse reactions to Haldol.</p> <p>However, Individual #1's informed consents did not include information related to the potentially severe adverse reactions documented in the Nursing Drug Handbook.</p> <p>b. Individual #2's IPP, dated 7/31/14, documented he was a 17 year old male whose diagnoses included mild mental retardation and bipolar disorder.</p> <p>Individual #2's Physician's Recap Orders, dated 2/2/15, documented he received Geodon and</p>	W 124		
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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 4341 EAST BURKE DRIVE AMMON, ID 83406
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W 124	<p>Continued From page 3</p> <p>Prozac (an antidepressant drug) daily. Individual #2's Written Informed Consents did not include comprehensive information related to the potential side effects of his medications, as follows:</p> <ul style="list-style-type: none"> <li>- Individual #2's consent for Prozac, dated 7/2/14, documented side effects included "Dry mouth, nausea, vomiting, constipation, change in sleep patterns, and weight gain."</li> <li>The 2015 Nursing Drug Handbook included suicidal behavior and respiratory distress as possible adverse reactions to Prozac.</li> <li>- Individual #2's consent for Geodon, dated 7/2/14, documented side effects included anxiety or restlessness, changes in vision, constipation, upset stomach, dry mouth, headache, sleepiness or unusual drowsiness, sneezing, cough, runny or stuffy nose, tiredness, weight gain and tardive dyskinesia.</li> <li>The 2015 Nursing Drug Handbook included suicide attempt, bradycardia, QT-interval prolongation and rectal hemorrhage as possible adverse reactions to Geodon.</li> <li>However, Individual #2's informed consents did not include information related to the potentially severe adverse reactions documented in the Nursing Drug Handbook.</li> <li>c. Individual #3's IPP, dated 3/21/14, documented he was a 20 year old male whose diagnoses included moderate mental retardation.</li> <li>Individual #3's Physician's Recap Orders, dated 2/2/15, documented he received Geodon, Abilify</li> </ul>	W 124		
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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83406
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W 124	<p>Continued From page 4</p> <p>and Depakote (an anticonvulsant drug) daily. Individual #3's Written Informed Consents did not include comprehensive information related to the potential side effects of his medications, as follows:</p> <ul style="list-style-type: none"> <li>- Individual #3's consent for Abilify, dated 12/9/14, documented side effects included anxiety or restlessness, changes in vision, constipation, upset stomach, dry mouth, headache, sleepiness or unusual drowsiness, sneezing, cough, runny or stuffy nose, tiredness, weight gain and tardive dyskinesia.</li> <li>The 2015 Nursing Drug Handbook included increased suicide risk, neuroleptic malignant syndrome, seizures, suicidal thoughts and bradycardia as possible adverse reactions to Abilify.</li> <li>- Individual #3's consent for Geodon, dated 12/9/14, documented side effects included anxiety or restlessness, changes in vision, constipation, upset stomach, dry mouth, headache, sleepiness or unusual drowsiness, sneezing, cough, runny or stuffy nose, tiredness and weight gain.</li> <li>The 2015 Nursing Drug Handbook included suicide attempt, bradycardia, QT-interval prolongation and rectal hemorrhage as possible adverse reactions to Geodon.</li> <li>However, Individual #3's informed consents did not include information related to the potentially severe adverse reactions documented in the Nursing Drug Handbook.</li> <li>In an interview on 3/25/15 from 8:35 - 9:22 a.m.,</li> </ul>	W 124		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 2541 EAST BURKE DRIVE AMMON, ID 83406
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W 124	Continued From page 5 the LPN stated no additional information was provided with the consents and the consents as written were not informed.	W 124		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW  A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the pharmacist conducted routine comprehensive drug regimen reviews for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in a lack of quarterly pharmacy reviews being completed. The findings include:  1. Individual #1's IPP, dated 12/18/14, documented a 18 year old male whose diagnoses included mild mental retardation.  Individual #1's record included pharmacy reviews dated 2/17/15, 8/15/14, and 11/26/14. However, his record did not contained a quarterly pharmacy review for the second quarter (April - June) of 2014.  During an interview on 3/24/15 at 1:30 p.m., the LPN stated she did not know where the pharmacy review for the second quarter was.	W 362		

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W 362	Continued From page 6 The facility failed to ensure a second quarter pharmacy review was completed for Individual #1.	W 362		
W 481	483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days.  This STANDARD is not met as evidenced by: Based on observation, review of menus and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days which directly impacted 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:  1. A meal observation was conducted at the facility on 3/23/15 from 4:20 - 6:15 p.m. The facility's menu, dated 3/23/15 - 3/29/15, was reviewed and documented the evening meal for 3/23/15 was to consist of the following:  - 3 ounces of meatloaf - 1/2 cup sour cream potatoes - 1/2 cup of green beans - 1 slice of garlic bread  However, Individuals #1 - #4 and #6 were noted to have Subway sandwiches and a bag of chips. Individual #5 was noted to have Chinese take out.  When asked, on 3/24/15 at approximately 2:17 p.m., the Lead Worker stated the substitutions for the 3/23/15 dinner had not been documented.  The facility failed to ensure accurate	W 481		

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NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #5 BURKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4541 EAST BURKE DRIVE AMMON, ID 83408</b>
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W 481	Continued From page 7 documentation of food actually served was kept.	W 481		
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Bureau of Facility Standards

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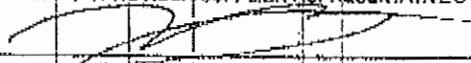
NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83408
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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensure survey conducted from 3/23/15 to 3/26/15.  The surveyor conducting your survey was:  Jim Troutfetter, QIDP	M 000		
MM164	16.03.11.075.04 Development of Plan of Care  To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124	MM164		
MM428	16.03.11.120.10(c) Temperature of hot water  The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 6 of 6 individuals, (Individuals #1 - #6) residing at the facility. This resulted in an increased risk of scald injuries	MM428		

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Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE  
QIDP

(X6) DATE  
4/22/15

Bureau of Facility Standards

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MM428	Continued From page 1  during hand washing and bathing. The findings include:  1. An environmental survey was conducted at the facility on 3/24/15 from 2:05 - 2:30 p.m. During that time, hot water temperatures (Fahrenheit) were measured and showed the following:  - The kitchen sink was 125.6 degrees.  - The hall bathroom was 128.1 degrees.  The Lead Worker was notified of the elevated water temperatures at the time the temperatures were taken and stated the temperatures should not have been that high.  On 3/25/15 at 12:40 p.m., the hot water temperatures (Fahrenheit) were rechecked as follows:  - The kitchen sink was 105.7 degrees.  - The hall bathroom was 103.8 degrees.  The facility failed to ensure water temperatures were maintained between 105 and 120 degrees Fahrenheit.	MM428		
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MM672	16.03.11.07(a) Menu Preparation  Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by:	MM672		
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Bureau of Facility Standards

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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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MM672	Continued From page 2 Refer to W481.	MM672		
MM758	16.03.11.270.02(f)(iv) Medication System Monitored  The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362.	MM758		

## Burke Survey Dated 3/26/15 Plan of Correction

W 124: Facility will add a print-out of any possible side effects, food and drugs to avoid, and specific warnings for all psychotropic medications obtained from United States National Library of Medicine and Pub Med Health powered by Truven Health Analytics to all consents to both Human Rights Committee and guardians. Consents will be corrected to reflect all possible side effects, food and drugs to avoid, and specific warnings. Responsible parties include RN, LPN, QIDP, and Program Manager. Will be completed by 5/1/2015.

W 362: Facility will schedule Quarterly Pharmacy reviews with new assigned Pharmacist. Responsible parties include RN, LPN, QIDP, and Program Manager. Will be completed by 5/1/15.

W 481: QIDP will train on utilization of replacement for menu logs with RD. Responsible parties include RD, QIDP, and Program Manager. Will be completed by 5/1/2015.

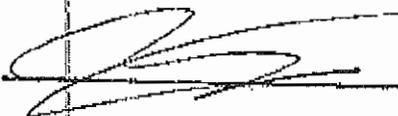
MM 164: See Plan of Correction for W 124.

MM 428: Maintenance will check temperature logs each week to ensure temperature is within an accepted range. Group Home Lead will check temperature logs daily and report to maintenance and QIDP if not within accepted range. Responsible parties include: QIDP, Maintenance Supervisor and Program Manager. Will be completed by 5/1/2015.

MM 672: See Plan of Correction for W 481.

MM 758: See Plan of Correction for W 362.

Program Supervisor:



Date:

4/22/15