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 9, 2015

Steve Young, Administrator
Yellowstone Group Home #3 Hoopes
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #3 Hoopes, Provider #13G065

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #3 Hoopes, 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

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 22, 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 22, 2015. If a request for informal dispute resolution is received after April 22, 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,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

Yellowstone
Group Homes

560 W Sunnyside
Idaho Falls, ID 83402

April 22, 2015

Michael Case and Karen Marshall
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder St
Boise, ID 83720-0036

Dear Mr. Case and Ms. Marshall,

This is the Plan of Correction for the survey concluded at Yellowstone group Home #3, namely Hoopes, on March 26, 2015 I would like to take the opportunity to thank you both 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. Thank you so much.

Sincerely,

Victor Campos
Program Supervisor/QIDP

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

PRINTED: 04/08/2015
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
	13G065		03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

(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	W 000		
	The following deficiencies were cited during the recertification survey conducted from 3/23/15 to 3/26/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: CT Scan - Computerized Tomography Scan HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record OCD - Obsessive Compulsive Disorder PICA - Ingestion non-edible items QIDP - Qualified Intellectual Disabilities Professional SIB - Self Injurious Behavior		RECEIVED APR 22 2015 FACILITY STANDARDS	
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	W 124	See attached plan of Correction —	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: QIDP | (X6) DATE: 4/22/15

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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W 124	Continued From page 1 information necessary to make informed decisions for 1 of 3 individuals (Individual #1) 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's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation. Individual #1's record included a Written Informed Consent for Psychotropic Drugs, dated 1/27/15, for Risperdal (an antipsychotic drug). The consent documented side effects included "Dry mouth, nausea, vomiting, constipation, change in sleep patterns, headache and confusion, there is also risk of tardive dyskensia [sic]." The 2015 Nursing Drug Handbook included both neuroleptic malignant syndrome (a potentially fatal syndrome) and suicide attempt as possible adverse reactions to Risperdal. However, Individual #1's consent did not include information related to the potentially fatal side effects documented in the Nursing Drug Handbook. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP and LPN both stated no additional information had been provided with the consent. The facility failed to ensure Individual #1's consent contained comprehensive information on which to base consent decisions.	W 124		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		

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W 214	Continued From page 2 The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 1 of 3 individuals (Individual #1) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation. Individual #1's Behavioral Assessment, dated 3/18/14, documented she engaged in maladaptive behaviors including aggression, SIB and PICA. Her assessment did not include accurate, comprehensive information, as follows: a. Individual #1's assessment documented in "Resident Strengths," "If given time to respond and process she is able to complete directions." However, the assessment did not contain any additional information related to how much processing time Individual #1 required. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's processing time had not been assessed. b. The behavior assessment documented Individual #1's diagnoses included autism,	W 214		

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W 214	Continued From page 3. tuberous sclerosis (benign tumors that grow in the brain and other organs), seizure disorder and stereotypic movement disorder with SIB. The assessment documented Individual #1 "maintains a diagnosis of Tuberous Sclerosis and seizure disorder; both conditions impact her pattern of behavior." However, the assessment did not contain any additional information related to how, or if, Individual #1's diagnoses impacted her maladaptive behaviors. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP they had not assessed how Individual #1's medical diagnoses impacted her maladaptive behaviors. c. Aggression was defined as pinching, scratching, and/or pushing others, or attempts to do so. The "Presumed Function of Behavior" section for aggression stated "It is important to note that [Individual #1] will engage in pre-ictal (before seizure) aggressive behavior." SIB was defined as hitting herself with an open hand to face, arm or chest, pinching self or biting self, usually on the hand or arm, and scratching self, usually on the hand, arm or face. The assessment documented Individual #1 would also pull her hair and head bang on the wall or an object. The assessment documented "It is important to note that [Individual #1] will engage in pre-ictal (before seizure) self-injurious behavior." However, the assessment did not contain additional information clarifying how to determine when Individual #1's aggression or SIB was	W 214		

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W 214	Continued From page 4 related to seizure activity versus being maladaptive. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated they had not assessed how to distinguish between SIB and aggression as part of Individual #1's seizure disorder versus being maladaptive behavior. The QIDP stated it was all being looked at as maladaptive but needed to be separated. d. The functions of Individual #1's aggression, as well as Individual #1's SIB, were documented as "to gain attention of staff and/or to escape non-preferred activities and tasks." The function of PICA for Individual #1 was documented as "to gain attention of staff and/or from being bored and feels like she has nothing to do and/or as sensory satisfaction." However, information related to how, or if, the behaviors were different for the various functions could not be found. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's Behavioral Assessment was not sufficient and needed to be revised. e. Individual #1's IPP documented "Current Medications" included Topamax (an anticonvulsant drug), Keppra (an anticonvulsant drug), Neurontin (an anticonvulsant drug), Risperdal (an antipsychotic drug) and Diastat (an anxiolytic drug). However, the assessment did not include information related to the impact Individual #1's medications had on her maladaptive behavior.	W 214		

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W 214	Continued From page 6 During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the impact of Individual #1's medications needed to be included in the assessment. f. Individual #1's IPP documented "Limitations To Programming" which included "Property destruction will tear paperwork and attempt to eat it, break items and throws items," "Will take other's belongings," "Can be uncooperative" and "Runs off on occasion." However, Individual #1's assessment did not contain additional information, such as the function of the behavior, etc., related to property destruction, theft, uncooperative behavior or elopement. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's Behavioral Assessment needed to be revised to include information about all maladaptive behaviors. g. Individual #1's record documented she engaged in PICA behavior which included eating her incontinence briefs. Her Behavior Summary, dated 12/29/14, indicated her PICA behavior had increased and stated "More body suits?" During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the body suits were used for behavioral intervention to prevent Individual #1 from gaining access to her incontinence briefs during the night. However, the assessment did not address "body suits" as an intervention for Individual #1's PICA.	W 214		

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W 214	Continued From page 6 During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's Behavioral Assessment needed to be revised to include the use of body suits. The facility failed to ensure Individual #1's behavior assessment included comprehensive information.	W 214		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 1 of 3 individuals (Individual #1) whose behavior assessments were reviewed. This resulted in an individual not receiving functional training to replace her maladaptive behaviors. The findings include: 1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation. Individual #1's Behavioral Assessment, dated 3/18/14, documented she engaged in maladaptive behaviors including aggression, SIB and PICA. Individual #1's replacement behaviors	W 239		

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W 239	Continued From page 7 were reviewed and were not functionally related to the maladaptive behavior, as follows: a. Aggression was defined as pinching, scratching, and/or pushing others, or attempts to do so. Information related to the function of the behavior included "to gain attention of staff and/or to escape non-preferred activities and tasks." The Behavioral Assessment included a replacement behavior for aggression which stated Individual #1 "will accept sensory ball from staff with specific verbal cues." b. SIB was defined as hitting herself with an open hand to face, arm or chest, pinching self or biting self, usually on the hand or arm, and scratching self, usually on the hand, arm or face. The assessment documented Individual #1 would also pull her hair and head bang on the wall or an object. Information related to the function of the behavior included "to gain attention of staff and/or to escape non-preferred activities and tasks." The Behavioral Assessment included a replacement behavior for SIB which stated Individual #1 "Will choose an offered leisure activity (see 'Likes' list in IPP) between a choice of two with specific verbal cues." c. PICA was defined as eating objects that are not edible. Information related to the function of the behavior included "to gain attention of staff and/or from being bored and feels like she has nothing to do and/or as sensory satisfaction." The Behavioral Assessment included a replacement behavior for PICA which stated Individual #1 "Will accept sensory item ('chew'	W 239		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1349 HOOPES IDAHO FALLS, ID 83404

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W 239	Continued From page 8 sensory item) from staff when offered with specific verbal cues." Individual #1's replacement behaviors of accepting a sensory ball, selecting an activity and accepting a sensory item did not match the functional motivation of "to gain attention" or to escape. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's replacement behavior objectives needed to be revised to more accurately match the function of her maladaptive behaviors. The facility failed to ensure Individual #1's replacement behaviors were appropriate for the function of the maladaptive behaviors.	W 239		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews it was determined the facility failed to ensure the individual program plan described relevant interventions to support independence for 1 of 3 Individuals (Individual #1) whose IPPs were reviewed. This resulted in insufficient information being available to staff related to an individual's supervision needs. The findings include: 1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included	W 240		

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W 240	Continued From page 9 severe mental retardation and autism with OCD signs and symptoms. During observations conducted at the facility on 3/23/15 from 5:00 - 6:00 p.m., and on 3/24/15 from 6:00 - 8:05 a.m., from 10:35 - 11:45 a.m., and from 2:50 - 3:35 p.m., Individual #1 was observed to have one staff working with her at all times. Individual #1's IPP stated she had 1:1 staffing during day treatment hours. However, the IPP did not clearly indicate what the 1:1 staff was for (i.e., behavioral issues or medical issues). Additionally, the record did not include information describing how direct care staff were to implement Individual #1's 1:1 staff (i.e., during waking hours, within arms length, within line of site, in all areas of the facility, etc.). During an interview on 3/26/15 from 9:30 - 11:45 a.m., the City Director and QIDP both stated Individual #1's 1:1 staff was due to her seizure disorder. The City Director stated the use of the 1:1 staff needed to be clarified. The facility failed to ensure Individual #1's IPP included specific information related to her 1:1 supervision needs.	W 240		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.	W 262		

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W 262	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 2 of 3 individuals (Individual #1 and #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approval of restrictive interventions. The findings include: 1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation and autism with OCD signs and symptoms. Individual #1's record documented she engaged in PICA behavior which included eating her incontinence briefs. Her Behavior Summary dated 12/29/14 indicated her PICA behavior had increased and stated "More body suits?" During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the body suits were used for behavioral intervention to prevent Individual #1 from gaining access to her incontinence briefs during the night. The facility's Behavior Support Method Hierarchy & Definitions policy, revised 10/9/14, defined "Mechanical restraints and Odd usage of clothing" as any material "attached or adjacent to the individual's body that he/she can or cannot remove easily and that restricts freedom of movement or normal access to his/her body for behavioral reasons." However, Individual #1's record did not include	W 262		

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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
W 262	Continued From page 11 HRC approval for the use of the body suits. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated HRC approval had not been obtained for the use of the body suits. The facility failed to ensure HRC approval was obtained prior to the use of Individual #1's body suits. 2. Individual #2's 4/17/14 IPP stated she was a 51 year old female whose diagnoses included moderate mental retardation, seizure disorder, and depressive disorder. Individual #2's record was reviewed and contained a 2/18/14 physician's order for Valium (an anxiolytic drug) 10 mg prior to CT Scan. Her record documented the drug was used on 2/18/14. However, Individual #2's record did not include HRC approval for the use of Valium. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated HRC approval had not been obtained for the use of the drug for Individual #2. The facility failed to ensure HRC approval was obtained prior to the use of Valium for Individual #2.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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	13G065		03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1049 HOOPES IDAHO FALLS, ID 83404

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W 263	Continued From page 12	W 263		

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure guardian consent was obtained prior to the implementation of restrictive interventions for 2 of 3 individuals (Individual #1 and #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include:

1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation and autism with OCD signs and symptoms.

Individual #1's record documented she engaged in PICA behavior which included eating her incontinence briefs. Her Behavior Summary dated 12/29/14 indicated her PICA behavior had increased and stated "More body suits?"

During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the body suits were used for behavioral intervention to prevent Individual #1 from gaining access to her incontinence briefs during the night.

The facility's Behavior Support Method Hierarchy & Definitions policy, revised 10/9/14, defined "Mechanical restraints and Odd usage of clothing" as any material "attached or adjacent to the individual's body that he/she can or cannot remove easily and that restricts freedom of movement or normal access to his/her body for behavioral reasons."

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W 263	Continued From page 13 However, Individual #1's record did not include guardian consent for the use of the body suits. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the CIDP stated guardian consent had not been obtained for the use of the body suits. The facility failed to ensure guardian consent was obtained prior to the use of Individual #1's body suit. 2. Individual #2's 4/17/14 IPP stated she was a 51 year old female whose diagnoses included moderate mental retardation, seizure disorder, and depressive disorder. Individual #2's record was reviewed and contained a 2/18/14 physician's order for Valium (an anxiolytic drug) 10 mg prior to CT Scan. Her record documented the drug was used on 2/18/14. However, Individual #2's record did not include guardian consent for the use of Valium. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated guardian consent had not been obtained for the use of the drug for Individual #2. The facility failed to ensure guardian consent was obtained prior to the use of Valium for Individual #2.	W 263		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be	W 289		

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W 289	Continued From page 14 incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 3 individuals (Individual #1) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include: 1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation. Individual #1's Behavioral Assessment, dated 3/18/14, documented she engaged in maladaptive behaviors including aggression, SIB and PICA. Individual #1's Positive Behavior Support Intervention Plans for each assessed behavior were reviewed. Individual #1's behavior plan for SIB and plan for aggression, both dated 5/5/14, documented if Individual #1 engaged in the identified behavior staff were to "redirect [Individual #1] to initiate her coping skills program." However, a coping skills program for Individual #1 could not be found.	W 289		

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W 289	Continued From page 15 Additionally, the behavior plan for PICA, dated 5/5/14, documented if Individual #1 engaged in PICA "Verbally ask [Individual #1] to stop, spit the item out of her mouth, and place it in your hand." Further, Individual #1's Behavior Summary dated 12/29/14 indicated her PICA behavior had increased and stated "More body suits?" During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the body suits were used for behavioral intervention to prevent Individual #1 from gaining access to her incontinence briefs during the night. However, the plan did not include instructions for staff to intervene prior to Individual #1 placing an object in her mouth. Additionally, the plan did not include information regarding the use of the body suit (i.e., when it was to be used, how frequently it was to be checked, etc.). During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's behavioral interventions needed to be clarified. The facility failed to ensure techniques to manage Individual #1's maladaptive behaviors were sufficiently incorporated into her behavior plans.	W 289		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 322		

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W 322	Continued From page 16 was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual not receiving health care services in accordance with her needs. The findings include: 1. Individual #1's 7/11/14 IPP stated she was a 21 year old female whose diagnoses included severe mental retardation, and seizure disorder. Individual #1's record documented she had a VNS (Vagus Nerve Stimulator) implant to assist with seizure control. Her record included a VNS protocol, dated 3/29/12, which stated if Individual #1 was having a seizure, staff were to "Hold magnet on the device in [Individual #1's] chest for 3 seconds." The American Epilepsy Foundation website (www.epilepsy.com) stated a VNS implant consisted of a generator implanted under the skin with electrodes attached to the Vagus nerve in the neck. The generator would send electrical stimulation to the nerve to assist with seizure control. The website stated a burst of stimulation could be sent from the generator by swiping a VNS magnet across the generator. This burst of stimulation could stop or shorten a seizure. The website also stated holding the VNS magnet over the generator temporarily turned the unit off and prevented it from providing stimulation. As written, the instructions in Individual #1's VNS Protocol would cause the VNS generator to be	W 322		

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W 322	Continued From page 17 deactivated rather than send a burst of stimulation to stop the seizure activity. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated Individual #1's VNS Protocol was inaccurate and needed to be revised. The facility failed to ensure Individual #1's VNS Protocol included accurate information for the use of the device.	W 322		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to obtain special studies as recommended for 2 of 3 individuals (Individual #2 and #3) whose records were reviewed. This resulted in individuals not receiving bone density screenings or colorectal cancer screenings as recommended. The findings include: 1. The National Center for Biotechnology Information (www.ncbi.nlm.nih.gov) published an article by the American Epilepsy Society in 2009 summarizing bone density studies on individuals receiving long term antiepileptic drug therapy. The article stated "Antiepileptic drug (AED) therapy for epilepsy is associated with metabolic bone disease and high risk for fractures. Reduced bone mineral density (BMD) has been reported in 20 to 75 percent of patients taking AEDs in cross-sectional studies." The article	W 326		

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W 326	Continued From page 18 stated 3 to 5 years of AED therapy was a reasonable interval before assessing BMD. Individual #2's 4/17/14 IPP stated she was a 51 year old female whose diagnoses included moderate mental retardation and seizure disorder. Her 2/2/15 Physician Recap Orders stated she received Depakote (an anticonvulsant drug) 750 mg twice a day and 500 mg once a day. However, Individual #2's record did not include information related to bone density screening being completed or discussed with her physician. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated Individual #2 had been taking the Depakote since 6/9/10. The LPN also stated she was not aware of a bone density screening being completed or discussed with Individual #2's physician. The facility failed to ensure Individual #2 received special studies for bone density screening in accordance with her needs. 2. The Centers for Disease Control and Prevention (www.cdc.gov/cancer/colorectal/basic_info/screening/guidelines.htm) recommendations include "regular screening, beginning at age 50, is the key to preventing colorectal cancer." The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 years and continuing until age 75 years. a. Individual #2's 4/17/14 IPP stated she was a 51	W 326		

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #3 HOOPES		STREET ADDRESS, CITY, STATE, ZIP CODE 1949 HOOPES IDAHO FALLS, ID 83404	

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W 326	Continued From page 19 year old female whose diagnoses included moderate mental retardation and seizure disorder. Her medical record did not include information related to a fecal occult blood test, sigmoidoscopy, or colonoscopy being completed or discussed with her physician. b. Individual #3's 1/15/15 IPP stated she was a 59 year old female whose diagnoses included moderate intellectual disability and cerebral palsy. Her medical record did not include information related to a fecal occult blood test, sigmoidoscopy, or colonoscopy being completed or discussed with her physician. When asked during an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated she was not aware of a fecal occult blood test, sigmoidoscopy, or colonoscopy being completed or discussed with Individual #2 or Individual #3's physicians. The facility failed to ensure Individuals #2 and #3 received special studies for fecal occult blood test, sigmoidoscopy, or colonoscopy in accordance with their needs.	W 326		
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 drug regimen reviews at least quarterly for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed.	W 362		

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W 362	Continued From page 20 This resulted in the potential for negative health outcomes due to unidentified medication problems. The findings include: 1. Individual #1 - #3's medical records were reviewed. Their records documented the pharmacist had reviewed their drug regimens on 3/10/14, 8/15/14, 11/26/14, and 2/17/15. However, reviews for the second quarter (April - June) of 2014 could not be found. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated the second quarter 2014 pharmacy reviews were not completed for Individuals #1 - #3. The facility failed to ensure the pharmacist conducted drug regimen reviews at least quarterly.	W 362		
W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure only authorized persons had access to the key to the drug storage area for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for unauthorized persons to access individuals' drugs. The findings include: 1. An environmental review was completed on 3/24/15 from 11:20 - 11:45 a.m. During that time,	W 383		

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W 383	Continued From page 21 the keys to the medication cart were observed to be stored in a locked hall closet. When asked who had access to the closet, the Lead Worker and a direct care staff who were present both stated the keys to the closet were stored in the pantry and accessible to all staff, including those who were not certified to assist with medication administration routines. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN and QIDP both stated only staff certified to assist with medication administration were supposed to have access to the medication keys. The LPN and QIDP both stated not all staff were medication certified, and the facility's current practice would not preclude a non-certified staff from accessing the keys. The facility failed to ensure only authorized persons had access to the keys to the medication storage area.	W 383		
W 388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure all medications were correctly labeled for 1 of 2 individuals (Individual #4) observed to receive medications during the drug administration observation. This resulted in the potential for medication administration errors and subsequent negative impacts to the individual.	W 388		

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W 388	Continued From page 22 The findings include: 1. Individual #4's 2/24/15 IPP stated she was a 72 year old female whose diagnoses included moderate intellectual disability. Individual #4's medical record was reviewed. Her 2/2/15 Physician's Recap Orders contained an order for Singulair (an antiasthmatic drug) 10 mg by mouth every day. Her 2/1/15 - 2/28/15 and 3/1/15 - 3/31/15 MARs contained an order for Singulair 10 mg tablet by mouth daily "in the evening" for allergies. However, the administration time printed on the MARs was noted as "07:00 a.m." During a drug pass observation and interview on 3/24/15 from 6:53 - 7:30 a.m., a direct care staff assisted Individual #4 with her medication administration program and stated the Singulair medication time was "7:00 a.m." The surveyor observed the Singulair bubble pack. The bubble pack pharmacy label documented the medication was to be administered once a day "in the evening" for allergies. However, at the top left of the bubble pack there was a yellow colored sticker that stated "mornings" in black letters. When asked during an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated the pharmacy printed the MARs. The LPN reviewed Individual #4's physician's orders and MARs and stated there was a pharmacy labeling issue for the medication and Singulair was to be administered in the mornings, not in the evenings. The facility failed to ensure Individual #4's Singulair medication was appropriately labeled by the pharmacy.	W 388		

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Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 3/23/15 to 3/26/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD	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 or 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		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent	MM196		

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FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: QIDP | (X6) DATE: 4/22/15

PRINTED: 04/08/2015
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G065		03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #3 HOOPES	1949 HOOPES IDAHO FALLS, ID 83404

(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
MM196	Continued From page 1 or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations	MM750		

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MM750	Continued From page 2 Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W326.	MM750		
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W383.	MM753		
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		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident.	MM855		

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MM855	Continued From page 3 This Rule is not met as evidenced by: Refer to W239 and W240.	MM855		

Aspire Human Services Yellowstone
560 W. Sunnyside Idaho Falls, ID 83402
Phone: 208.523.9839 **Fax:** 208-522-0224

~~[Your Name]~~ Aspire Yellowstone
560 W. Sunnyside
Idaho Falls, ID 83402
208.523.9839
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RECEIVED
MAY 11 2015
DIV OF LIC & CERT

May 4, 2015

Michael Case
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
Boise, ID 83720-0009

RE: Plan of Correction
Hoopes, Provider # 13G065

Dear Michael Case:

Thank you for your supportive approach during the recent annual recertification survey at the Hoopes home. As a new leader for our team, I appreciate the opportunity that your group provided for myself and the newest members of my team. Please see our responses below for each citation and contact us if you have any questions or concerns related to any item.

Tag: **W124**
Individual 1 has a revised written informed consent in the chart with HRC and Guardian approval that contains a print-out of side-effects, food and drugs to avoid, and specific warnings for all psychotropic medications obtained from the United States National Library of Medicine and Public Medical Health website. All charts are being reviewed at the facility to ensure that this information is included in any written informed consents related to psychotropic medications. Training is scheduled for the QIDP and Nursing staff of the facility on the policy and procedures for behavior management at the facility to ensure the understanding of informed consent. Aspire Human Services: Yellowstone is currently performing peer-completed chart reviews that contain review items verifying that informed consents contain sufficient information. Deficiencies identified during this review process are reported to the Program Manager who will identify an immediate plan of corrective action to remediate any discrepancies.
Person Responsible: QIDP, RN/LPN, Program Manager
Completion Date: 05/01/2015

Completion Date: 05/01/2015

Tag: **W214**

Individual #1 has a revised Functional Behavior Assessment that accurately reflects the medical conditions (or lack thereof) impacting the individual's manifestation of maladaptive behavior. Aspire Human Services Yellowstone is currently performing peer-completed chart reviews that contain review items assessing if the Functional Behavior Assessments accurately reflect the impact of existing medical conditions on an individual's maladaptive behavior. Deficiencies identified during this review process are reported to the Program Manager who will identify an immediate plan of corrective action to remediate any deficiencies. Training is scheduled for the QIDP team on the integration of DSM-5 information (specifically, diagnostic criteria) into the Functional Behavior Assessment in order to ensure that the psychotropic medication plan is aligned with accurate behavior programming and supported by the collection of valid behavior data.

Person(s) Responsible: PBSC, Program Manager, QIDP

Completion Date: 6/1/2015

Tag: **W239**

Individual 1 has a revised Functional Behavior Assessment that accurately reflects the functional relationship between the identified maladaptive behaviors and the recommended replacement behavior programming. This information was used to complete a revised behavior management program that includes training program(s) for specific appropriate replacement behaviors to substitute for the identified maladaptive behaviors. Aspire Human Services: Yellowstone is currently performing peer-completed chart reviews that contain review items assessing if the Functional Behavior Assessments accurately identify functional relationships between the identified maladaptive behaviors and the recommended replacement behavior objective, and to ensure that behavior programs are in place for all individuals when indicated. Deficiencies identified during this review process are reported to the Program Manager who will identify an immediate plan of corrective action to remediate any deficiencies. This process will be scheduled and monitored using a new tracking system to ensure that it occurs. Training is scheduled for the QIDP team on effective best-practice methods related to the assessment of functional behavior relationships, and the conversion of this information into behavior programming, including the requirement for training programs associated with all identified formal maladaptive behavior issues.
Person(s) Responsible: QIDP, PBSC, Program Manager
Completion Date: 6/1/2015

Tag: **W240**

Individual #1 has a revised 1:1 protocol stating "staff will be within arms length during waking hours" due to her siezure disorder. All other 1:1 individuals have revised 1:1 protocols as well to ensure instructions to staff are clear and followed. When completing the application for Special Rates, the team will evaluate the IPP, Functional Behavior Assessment and related consents. This information will be reviewed by the guardians and HRC committee members and will include specific protocols for use of restrictive levels of supervision,

including line- of- sight, arm's length, or others. The BMP and IPP will also include specific guidelines for the implementation of 1:1 supervision (or other restrictive levels of supervision) and other behavior management strategies used to prevent or protect the individual (or others) from harm. The QIDP will ensure that these practices correspond with information contained within the written consents.

Person(s) Responsible: QIDP, PBSC, Program Manager

Completion Date: 6/1/15

Tag: **W262**

Individual 1 has a revised Functional Behavior Assessment and related behavior program that accurately reflects the use of items, procedures, and systems which are potentially stigmatizing to Individual 1 to control or prevent the identified maladaptive behavior (body suit). This revised program will/has been provided to the guardian and HRC and has been reviewed and approved by the committee. All charts are being reviewed at the facility to ensure that programs designed to manage inappropriate behavior (and others) that involve risk to client protections and rights (such as the odd-usage of clothing), are based upon accurate functional behavior assessments and contain clear descriptions and guidelines related to any programming that could be viewed as restrictive in nature. In addition, peer-reviews will assess if the information presented to the guardian and HRC is written with sufficient specificity and detail to illustrate both the restrictive techniques as well as any less-restrictive strategies, prior to review and approval. Deficiencies identified during this review process are reported to the Program Manager, who will identify an immediate plan of corrective action to remediate any deficiencies. This process will be scheduled and monitored using a new tracking system to ensure that it occurs. Training is scheduled for the QIDP staff of the facility on the policy and procedures for behavior management at the facility to ensure the clear understanding of the use of restrictive techniques used to manage individual behavior and requirement for informed consent on these types of procedures.
Person(s) Responsible: QIDP, PBSC, Program Manager
Completion Date: 6/1/2015

Tag: **W263**

Refer to tag W262

Tag: **W289**

Individual 1 has a revised behavior management program that includes training program(s) for specific appropriate replacement behaviors to substitute for the identified maladaptive behaviors. This program includes the following guidance for the use of Individual 1's body suit:

- □□□□□□□□ -Individual 1 will be have the opportunity to choose preferred colors and styles of her bodysuits to the best of her ability.
- □□□□□□□□ -Currently, Individual 1 prefers one-piece- type of bodysuit; staff will ensure that no fewer than 10 bodysuits are laundered and available in the home at any time.
- □□□□□□□□ -Body Suit is to be used between the hours of 8:00 am and 10:00 pm.
- □□□□□□□□ -Staff assist her to put on her body suit using positive approach, verbal praise, and physical assistance.

- □□□□□□□□ -Individual 1 maintains the right to refuse the use of the body suit, refer to refusal guidelines. <u>Do not use force</u> with Individual 1 to dress her in the bodysuit.
- □□□□□□□□ -Staff will physically assist Individual 1 to remove bodysuit after waking up in the morning.
- □□□□□□□□ -QIDP will monitor and track use of the body suit on a monthly basis (at minimum) or sooner if indicated.

All charts are being reviewed at the facility to ensure that IPPs for all individuals incorporate specific programs for the use of any systematic interventions used to manage individual behavior. In addition, peer-reviews will assess the IPP to ensure that is contains any systematic interventions used to manage client behavior. Deficiencies identified during this review process are reported to the Program Manager, who will identify an immediate plan of corrective action to remediate any deficiencies. This process will be scheduled and monitored using a new tracking system to ensure that it occurs. Training is scheduled for the QIDP staff of the facility on the policy and procedures for behavior management at the facility to ensure the clear understanding of systematic interventions or techniques used to manage individual behavior and the requirement that these be incorporated into the individual's IPP.
Person(s) Responsible: QIDP, PBSC, Program Manager
Completion Date: 6/1/2015

Tag: **W322**

Individual #1 has a revised VNS protocol with updated and specific instructions to staff. Protocol was updated on the seizure reports as well. All other seizure protocols were reviewed and revised as needed. RN will review all charts at quarterly nursing reviews. LPN's will also review the protocols for seizures and seizure medication for all individuals during quarterly nursing review as well.

Person(s) Responsible: RN, LPN

Completion Date: 6/1/2015

Tag: **W326**

RN was replaced. New RN will work with LPN's one day weekly to ensure all necessary required medical procedures, labs, physicals, and so on, are being completed as needed. RN will review all nursing services provided to ensure accuracy. LPNs have a schedule of all necessary labs/procedures that are updated as needed. LPNs also do quarterly chart reviews and special studies/procedures/lab work will be part of the review to ensure completion. Quarterly chart reviews will be reviewed by RN. This was completed April 20, 2015.

Person(s) Responsible: RN, LPN's, Program Manager.

Completion Date: April 20, 2015

Tag: **W362**

The facility has replaced the pharmacist and has since completed quarterly pharmacy reviews on schedule. RN will review schedules, MARS, and ensure quarterly pharmacy reviews are completed per policy. LPNs will have schedule of when Pharmacy reviews are due and will schedule those reviews with the Pharmacist. Quarterly chart reviews that are done by LPNs with review by RN have Pharmacy reviews listed as part of the items to be identified as being completed. If Pharmacy reviews are missed then they will be completed as a make-up review and stated as such and then will resume reviews as scheduled.

Person(s) Responsible: RN, LPN

Completion Date: 5/1/2015

Tag: **W383**

The Lead staff will ensure only medication-certified staff will have access to keys to medications. The keys will be kept either on-person or securely locked in a lock box with combination where only med certified staff will have access to the combination. Lock box was purchased and keys put in. QIDP will have list of certified staff and monitor through Lead staff and nursing. Nursing will be conducting monthly reviews of each home and med certified staff. This will include the location of the keys and security of med carts. Nursing will also be conducting annual re-delegations of those med certified staff to ensure proper knowledge and policy is being implicated.

Person(s) Responsible: QIDP, LPN, RN, Lead staff

Completion Date: 6/1/2015

Tag: **W388**

Nursing will be cross checking bubble packs, and Medication Administration Records (MARs) each month when cycle meds are delivered to ensure accuracy. Lead staff will recheck Medication Administration Records against the bubble packs when checking meds in. Any discrepancies are to be reported to Nursing. Nursing will also be cross checking MARs, bubble packs and physician's recaps on a quarterly basis to ensure uniform documentation. Nursing will also be addressing at the May house meetings with all staff to report or question any discrepancies that may have been missed. A handout will be provided during the training.

Person(s) Responsible: LPN, RN, Lead staff

Completion Date: 6/1/2015

MM164-

Refer to W124.

MM194-

Refer to W262

MM196-

Refer to W263

MM197-

Refer to W289

MM730-

Refer to W214.

MM735-

Refer to W322.

MM750-

Refer to W326.

MM753-

Refer to W383.

MM758-

Refer to W362.

MM855-

Refer to W239 and W240.

5/04/15

Program Supervisor Date