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 #4 Fox Hollow
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #4 Fox Hollow, Provider #13G066

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #4 Fox Hollow, 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, Facility Surveyor
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder St
Boise, ID 83720-0036

Dear Michael Case:

This is the Plan of Correction for the survey that was conducted at Aspire Yellowstone Group Home #4 Fox Hollow, on March 26, 2015

I would like to take this opportunity to thank you and Karen Marshall for sharing all the information that you did during this time to help me with understanding and being able to continue to build a lot of insight during the survey processes. It has been quite a learning experience for me. Your expertise is always welcome, I found this to be a very helpful and pleasant experience with you and Karen. Thank you very much.

Sincerely,

Dennis Butler
QIDP/Program Supervisor

PRINTED: 04/08/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402	

(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: ADHD - Attention Deficit Hyperactive Disorder DCS - Direct Care Staff IPP - Individual Program Plan LPN - Licensed Practical Nurse OCD - Obsessive Compulsive Disorder PECS - Picture Exchange Communication System QIDP - Qualified Intellectual Disabilities Professional		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 information necessary to make informed	W 124	See attached Plan of Correction —	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIDP/PS (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 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 11/20/14 IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. Individual #1's record contained a Written Informed Consent for Psychotropic Medications for Depakote (an anticonvulsant drug) and Prozac (an antidepressant drug). The consent for Depakote, dated 11/14/14, documented side effects included dry mouth, nausea, vomiting, constipation, headache, change in sleep patterns, weight gain or loss, chest pain, hair loss, easy bruising and dark urine. The 2015 Nursing Drug Handbook included pancreatitis (inflammation of the pancreas), bone marrow suppression, hemorrhage, thrombocytopenia (low platelets), hepatotoxicity (liver damage), erythema multiforme (inflammatory skin eruption), hypersensitivity reactions and Stevens-Johnson syndrome (a life-threatening skin disorder). All of which were listed in black, italicized font, indicating "life-threatening reaction." Individual #1's consent for Prozac, dated 12/30/14, documented side effects included "Dry mouth, nausea, vomiting, constipation, change in sleep patterns, and weight gain." The 2015 Nursing Drug Handbook included	W 124		

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W 124	Continued From page 2 suicidal behavior and respiratory distress as possible adverse reactions to Prozac. However, Individual #1's informed consents 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 LPN and QIDP both stated no additional information had been provided with the consents. The facility failed to ensure informed consents contained comprehensive information on which to base consent decisions.	W 124		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN 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 behavior assessments contained comprehensive information for 1 of 3 individuals (Individual #1) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's 11/20/14 IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. Individual #1's Behavioral Assessment, revised 11/2014, did not include comprehensive information, as follows:	W 214		

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W 214	Continued From page 3 a. Individual #1's assessment included a section titled "Related Medical," which included diagnoses of Enuresis (an inability to control urination), constipation, and scalp dermatitis. The "Diagnosis" section of the assessment included autism and OCD. However, the assessment did not include information as to how the diagnoses impacted Individual #1's maladaptive behaviors. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the related medical diagnoses did not impact Individual #1's maladaptive behavior and needed to be removed from the assessment. The QIDP stated the impact of autism and OCD needed to be clarified in the assessment. b. Individual #1's Physician Recap Orders, dated 2/2/15, stated he received Prozac (an antidepressant drug) 30 mg daily. His Psychotropic Medication Plan for Prozac stated he received the drug for anxiety demonstrated by "restlessness, psychomotor agitation, exaggerated startled response, etc." However, Individual #1's Behavioral Assessment did not include information related to a diagnosis of anxiety, its symptoms, or how the symptoms were to be addressed. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated anxiety and its related symptoms had not been included in the assessment due to an oversight. c. Individual #1's Physician Recap Orders stated	W 214		

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W 214	Continued From page 4 he received Clonidine (an antihypertensive drug) 0.1 mg three times daily for SIB, and Haldol (an antipsychotic drug) 1 mg daily and Depakote (an anticonvulsant drug) 500 mg daily for aggression. However, Individual #1's assessment did not include information about the drugs and how they may impact his maladaptive behaviors. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the assessment needed to be revised. d. The assessment stated Individual #1 engaged in aggression, defined as hitting, kicking, biting, scratching, grabbing, pinching, or attempts. The assessment stated Individual #1 engaged in aggression when he was "being over cued, redirected and when he wants something that he is not getting...when he is given a difficult task, there are changes in his routine, or he feels he is not getting the attention he needs." However, the assessment did not include information as to how, or if, Individual #1's aggression changed depending on the function (i.e., task avoidance (being given a difficult task) versus communication (not getting something he wanted) versus attention seeking, etc.). Additionally, the assessment did not include information as to what over cuing was (e.g., cuing every 5 seconds, every 30 seconds, every 5 minutes, etc.). During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated he believed the only function of Individual #1's aggression was communication. The QIDP stated the assessment was not clear and needed to be	W 214		

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W 214	Continued From page 5 revised. e. The assessment stated Individual #1 engaged in self-injurious behavior, defined as hitting himself on the head, biting himself, and attempts. The assessment stated he engaged in self-injurious behavior as a way of "coping," to release frustration, to escape a non-preferred task or activity, due to changes in routine, or as a form of self-regulation. However, the assessment did not include information as to how, or if, Individual #1's self-injurious behavior changed depending on the function (i.e., task avoidance, frustration, self-regulation, etc.). During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the assessment was not sufficiently developed and needed to be revised. f. The assessment stated Individual #1 engaged in property destruction, defined as throwing and breaking objects, hitting walls, tearing objects off the walls, and messing up his room. The assessment stated he engaged in the behavior when he was asked to do something he didn't want to do or when he was over cued to take part in a task or activity. However, the assessment did not include information as to how, or if, Individual #1's property destruction changed depending on the function (i.e., task avoidance versus being over cued). Additionally, the assessment did not include information as to what over cuing was (e.g., cuing every 5 seconds, every 30 seconds, every 5 minutes, etc.).	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 cuing times had not been assessed for Individual #1. g. The assessment stated Individual #1 engaged in disruptive behavior, defined as moaning and yelling. The assessment stated he engaged in disruptive behavior when he wanted to gain attention, when something was bothering him, or to let off steam. However, the assessment did not include information as to how, or if, Individual #1's disruptive behavior changed depending on the function (i.e., attention seeking, communication, letting off steam, etc.). During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the function of Individual #1's disruptive behavior was not clearly assessed. The QIDP stated the assessment needed to be revised. autism and ADHD needed to be clarified in the assessment. The facility failed to ensure Individual #1's Behavioral Assessment included comprehensive information.	W 214		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by:	W 227		

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W 227	Continued From page 7 Based on record review and staff interview, it was determined the facility failed to ensure individuals' IPPs included objectives to meet their needs for 1 of 3 individuals (Individual #1) whose programs were reviewed. This resulted in a lack of program plans designed to address an individual's psychiatric diagnoses. The findings include: 1. Individual #1's IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. Individual #1's Physician Recap Orders, dated 2/2/15, stated he received Prozac (an antidepressant drug) 30 mg daily. His Psychotropic Medication Plan, revised 12/3/14, stated Prozac would be considered for reduction when anxiety symptoms decreased to 24 incidents per month for 3 consecutive months. However, Individual #1's record did not include an objective related to anxiety, and did not include information related to tracking anxiety symptoms. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1 did not have an objective related to anxiety or symptom tracking due to an oversight. The facility failed to ensure an objective was developed for Individual #1's anxiety symptoms.	W 227		
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	W 239		

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W 239	Continued From page 8 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 2 of 3 individuals (Individuals #1 and #3) whose behavior assessments were reviewed. This resulted in individuals not receiving functional training to replace their maladaptive behaviors. The findings include: 1. Individual #1's 11/20/14 IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. Individual #1's Behavioral Assessment, revised 11/2014, documented he engaged in maladaptive behaviors including aggression, self-injurious behavior, property destruction, and disruptive behavior. Individual #1's replacement behaviors were reviewed and were not functionally related to the maladaptive behavior, as follows: a. The assessment stated Individual #1 engaged in aggression, defined as hitting, kicking, biting, scratching, grabbing, pinching, or attempts. The assessment stated Individual #1 engaged in aggression when he was "being over cued, redirected and when he wants something that he is not getting...when he is given a difficult task, there are changes in his routine, or he feels he is not getting the attention he needs." The assessment included a replacement	W 239		

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W 239	Continued From page 9	W 239		

behavior for aggression that stated Individual #1 "will choose a sensory type activity from a list on visual schedule with specific verbal prompt..."

The replacement behavior was not functionally related to task avoidance, being over cued, communicating wants, or attention seeking.

b. The assessment stated Individual #1 engaged in self-injurious behavior, defined as hitting himself on the head, biting himself, and attempts. The assessment stated he engaged in self-injurious behavior as a way of "coping," to release frustration, to escape a non-preferred task or activity, due to changes in routine, or as a form of self-regulation.

The assessment included a replacement behavior for self-injurious behavior that stated Individual #1 would "choose a calming activity using his PECS book..."

The replacement behavior was not functionally related to task avoidance or adjusting to changes in routine.

c. The assessment stated Individual #1 engaged in property destruction, defined as throwing and breaking objects, hitting walls, tearing objects off the walls, and messing up his room. The assessment stated he engaged in the behavior when he was asked to do something he didn't want to do when he was over cued to take part in a task or activity.

The assessment included a replacement behavior for property destruction that stated Individual #1 would "identify and express his emotions in an appropriate manner by using his

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W 239	Continued From page 10 PECS book and pointing to faces with different emotions..." The replacement behavior was not functionally related to task avoidance or being over cued. d. The assessment stated Individual #1 engaged in disruptive behavior, defined as moaning and yelling. The assessment stated he engaged in disruptive behavior when he wanted to gain attention, when something was bothering him, or to let off steam. The assessment included a replacement behavior for disruptive behavior which stated Individual #1 would "choose a calming activity (go to a quiet area) with staff giving specific verbal prompt..." The replacement behavior was not functionally related to attention seeking or communicating frustration. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1's replacement behaviors did not match the identified function of the behaviors they were paired with. The QIDP stated the replacement behavior objectives needed to be revised. 2. Individual #3's 12/18/14 IPP stated he was a 35 year old male whose diagnoses included mild intellectual disability, autism and ADHD. Individual #3's Behavioral Assessment, revised 12/22/14, stated he engaged in socially offensive behavior defined as obsessing over females by staring at them, persistent gaze at females' breasts and buttocks, and invading their personal	W 239		

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NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE: 370 HOLLOW DRIVE IDAHO FALLS, ID 83402	

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W 239	Continued From page 11 space. The assessment stated he engaged in the behavior to get attention or when staff were not engaging or interacting with him. The assessment included a replacement behavior which stated Individual #3 "will remain a distance of three feet or more with a specific verbal cue..." The replacement behavior was an intervention with no training component. Additionally, the replacement behavior was not functionally related to attention seeking, and did not address Individual #3's targeting females. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #3's replacement behavior did not match the identified function of the behavior it was paired with. The QIDP stated the replacement behavior objective needed to be revised. The facility failed to ensure Individual #1 and Individual #3's replacement behaviors were appropriate for the function of their maladaptive behaviors.	W 239		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be 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:	W 289		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 379 HOLLOW DRIVE IDAHO FALLS, ID 83402	

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W 289	Continued From page 12 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 11/20/14 IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. Individual #1's Behavioral Assessment, revised 11/2014, documented he engaged in maladaptive behaviors including aggression, self-injurious behavior, property destruction, and disruptive behavior. His Positive Behavioral Support Intervention Plans for each assessed behavior were reviewed and did not include clear, comprehensive information, as follows: a. Individual #1's plan for aggression, revised 11/2014, stated if he engaged in aggression and required physical restraint, "Staff may also direct [Individual #1] to use one of his coping skills at this time." However, a coping skills program for Individual #1 could not be found. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1 did not have a coping skills program and he was not sure what Individual #1's coping skills would be. The QIDP stated the interventions for aggression needed to be revised.	W 289		

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	13G066		03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLLOW	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

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W 289	Continued From page 13	W 289		
	b. Individual #1's plan for self-injurious behavior, revised 11/2014, stated if he engaged in aggression and required physical restraint, "Staff may also direct [Individual #1] to use one of his coping skills at this time." Additionally, the plan documented staff were to use blocking pads as needed to prevent injury during self-injurious behavior.			
	However, a coping skills program for Individual #1 could not be found. Additionally, a description of the blocking pads, their location, or the manner in which they were to be used was not included in the plan.			
	During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the interventions for self-injurious behavior needed to be revised.			
	The facility failed to ensure techniques to manage Individual #1's maladaptive behaviors were sufficiently incorporated into his behavior plan.			
W 312	483.450(e)(2) DRUG USAGE	W 312		
	Drugs used for control of inappropriate behavior must be used only as an integral part of the client's Individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.			
	This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were			

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402	

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W 312	Continued From page 14 directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 2 of 2 individuals (Individuals #1 and #2) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drug usage and how it may change in relation to progress or regression. The findings include: 1. Individual #1's 11/20/14 IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. a. Individual #1's Physician Recap Order, dated 2/2/15, stated he received lorazepam (a anxiolytic drug) 1 mg 1 hour prior to dental visits. His record documented the drug was last used on 10/29/14. However, Individual #1's record did not include a plan to teach Individual #1 how to cope with dental appointments and eventually eliminate the need for the drug. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated he believed Individual #1 used to have a plan related to dental appointments, but stated no current plan was in place. b. Individual #1's Physician Recap Order, dated 2/2/15 stated he received Depakote (an anticonvulsant drug) 500 mg daily and Haldol (an antipsychotic drug) 1 mg each evening. Individual #1's Psychotropic Medication Plan, revised 12/3/14, stated both drugs were prescribed to address his aggression. The plan	W 312		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLLOW	970 HOLLOW DRIVE IDAHO FALLS, ID 83402

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W 312	Continued From page 15 stated the criteria for both drugs was 3 incidents or less of aggression per month for 3 consecutive months. However, the plan did not indicate which drug would be reduced first, or if both drugs would be reduced at the same time, when criteria was met. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated the plan was inaccurate and should provide specific information about each drug and the order of reduction. The QIDP stated the plan needed to be revised. The facility failed to ensure Individual #1's drugs for maladaptive behavior were sufficiently incorporated into a plan. 2. Individual #2's 11/20/14 IPP stated he was an 18 year old male whose diagnoses included mild intellectual disability and autism. Individual #2's medical record was reviewed and contained a 2/27/15 physician's order for Valium (an anxiolytic drug) 10 mg 30 minutes prior to a dental visit. His record documented the drug was last used on 3/2/15. However, Individual #2's record did not include a plan to teach him how to cope with dental appointments and eventually eliminate the need for the drug. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated no current plan was in place for Individual #2. The facility failed to ensure Individual #2's Valium was sufficiently incorporated into a plan.	W 312		

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W 326	Continued From page 16	W 326		
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 1 of 2 individuals (Individual #1) who received anticonvulsant drugs. This resulted in an individual not receiving bone density 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 stated 3 to 5 years of AED therapy was a reasonable interval before assessing BMD. Individual #1's 11/20/14 IPP stated he was a 25 year old male whose diagnoses included moderate intellectual disability, autism and OCD. His Physician Recap Orders, dated 2/2/15, stated he received Depakote (an anticonvulsant drug) 500 mg each evening. However, Individual #1's record did not include information related to bone density screening	W 326		

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W 326	Continued From page 17 being completed or discussed with his physician. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated Individual #1 received Depakote as a mood stabilizer and had been taking it when he was admitted to the facility on 11/5/10. The LPN, who was present during the interview, stated she was not aware of a bone density screening being completed or discussed with Individual #1's physician. The facility failed to ensure Individual #1 received special studies for bone density screening in accordance with his 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. 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.	W 362		

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	13G066		03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLLOW	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

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W 362	Continued From page 18 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 observation was conducted at the facility on 3/24/15 from 6:35 - 7:55 a.m. During that time, DCS C was observed to assist individuals with their medication administration programs. The keys to the medication cart were observed to be unsecured, as follows: At 6:55 a.m., DCS C rolled the medication cart from the dining area to the hall bathroom and unlocked the cart. Individual #1 was present to complete his medication routine. After Individual #1 completed his routine, DCS C locked the medication cart and placed the keys on top of the	W 383		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLLOW	570 HOLLOW DRIVE IDAHO FALLS, ID 83402

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W 383	Continued From page 19 cart. DCS C then left the room with the keys unattended. At 7:04 a.m., DCS C returned to the bathroom to package a pill that had been dropped. After placing the pill in a plastic bag and putting it in the medication cart, DCS C left the room to cue another individual for medications. The keys remained hanging in the lock of the unlocked cart. At 7:05 a.m., Individual #4 completed his medication routine, followed by Individual #6. At 7:09 a.m., DCS C locked the medication cart and placed the keys on top of the cart. DCS C then left the room with the keys unattended. At 7:10 a.m., Individual #2 entered the room with DCS C and completed his medication routine. DCS C locked the cart and placed the keys on top of the cart. DCS C left the room with the keys unattended to cue another individual. At 7:16 a.m., Individual #4 entered the room with DCS C and completed his medication routine. At 7:21 a.m., DCS C wheeled the medication cart to the kitchen area and passed the keys to DCS D to check the medications. At 7:34 a.m., DCS D completed the medication check and locked the cart. DCS D placed the keys into a hall closet and locked the closet door. DCS D hung the keys to the closet in the pantry. When asked during the observation, DCS D stated the keys to the medication cart were to be with a DCS or locked in the hall closet. DCS D stated the keys to the hall closet were accessible to all staff, including those who were not certified	W 383		

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W 383	Continued From page 20 to assist with medication administration. 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 LPN also stated the keys should not be left unattended on the cart during medication administration programs as observed. The facility failed to ensure only authorized persons had access to the keys to the medication storage area.	W 383		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. The facility's evacuation drills were reviewed and did not include documentation that evacuation drills had been completed for the night shift (10:00 p.m. - 6:00 a.m.) during the second	W 440		

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NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE: 370 HOLLOW DRIVE IDAHO FALLS, ID 83402	

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W 440	Continued From page 21 quarter (April - June), third quarter (July - September) or fourth quarter (October - December) of 2014. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the QIDP stated he could not find evidence that the evacuation drills for the night shift had been completed. The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 3 of 6 individuals (Individuals #2 - #4) residing at the facility and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. An observation was conducted at the facility on 3/24/15 from 6:25 - 7:55 a.m. During that time, DCS were not observed to engage in hand washing for infection control. Examples included, but were not limited to, the following: - From 6:38 - 6:55 a.m.: Individual #3 entered the	W 455		

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 570 HOLLOW DRIVE IDAHO FALLS, ID 83402	

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W 455	Continued From page 22 kitchen and was assisted to cook his breakfast with DCS A. DCS A was observed to place pork sausage in a skillet on the stove and assist Individual #3 to cook a fried egg. DCS A was observed to use her bare hands to repeatedly push her hair behind her ear and into the knit cap she was wearing. While the egg and sausage were cooking, DCS A opened a bag of bread and pulled out two slices with her bare hand and gave them to Individual #3. Individual #3 used the bread to make a sandwich which he packed for lunch. DCS A was not observed to wash her hands or to cue Individual #3 to wash his hands. Once Individual #3 completed packing his lunch, DCS A used a paper towel to wipe the counter, took a drink from a soda can that was sitting on the counter, pushed her hair back with her bare hand, then obtained a fork for Individual #3 from a drawer. DCS A was not observed to wash her hands prior to the meal preparations, or at any time while she was assisting Individual #3. - From 7:21 - 7:40 a.m., DCS A was observed to prepare fried eggs for Individual #4, 3 DCS, and herself. DCS A prepared each egg individually by cracking a raw egg into a skillet, disposing of the egg shell, wiping her hands on a paper towel, then placing the cooked egg on a plate on the counter. DCS A repeated the routine for each egg cooked. DCS A also obtained a bowl and spoon for Individual #2 and assisted him to pour cereal and milk into the bowl for breakfast.	W 455		

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W 455	Continued From page 23 Throughout the process, DCS A repeatedly used her bare hands to push her hair back behind her ear into her knit cap and scratch her eye. However, DCS A was not observed to wash her hands after touching her hair, her eye, or handling the raw eggs. - At 7:34 a.m., DCS B entered the kitchen with Individual #4 and asked him what he wanted for breakfast. Individual #4 indicated he wanted cereal rather than the egg cooked by DCS A. DCS B was observed to scratch her head with her bare hand, then smooth her hair back prior to obtaining a bowl, spoon, and measuring cup for Individual #4. DCS B then assisted Individual #4 to pour cereal and milk into the bowl. DCS B was not observed to wash her hands. - At 7:40 a.m., DCS A exited the facility to smoke a cigarette. DCS A returned at 7:50 a.m., placed her cigarettes in a locked cabinet, then went to assist Individual #2 with his oral care routine. DCS A was not observed to wash her hands. During an interview on 3/26/15 from 9:30 - 11:45 a.m., the LPN stated DCS should be washing their hands before and after working with each individual, and should be using gloves for meal preparation and personal cares. The LPN and QIDP, who was also present during the interview, both stated appropriate hand washing was not taking place during the observed meal activities. The facility failed to ensure staff were completing appropriate hand hygiene.	W 455		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLL	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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
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		
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 and W312.	MM197		
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills	MM337		

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FACILITY STANDARDS

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G066	A. BUILDING B. WING	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLL	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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
MM337	Continued From page 1 must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Based on review of evacuation drills and staff interview, it was determined the facility failed to ensure a minimum of 12 annual evacuation drills were completed for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This failure resulted in sufficient drills not being completed. The findings include: 1. The facility's evacuation drills were reviewed on 3/25/14. The record documented only 9 evacuation drills had been conducted from January - December of 2014. During an interview on 3/26/14 from 9:30 - 11:45 a.m., the QIDP stated drills had not been completed due to an oversight. The facility failed to ensure a minimum of 12 evacuation drills were completed during 2014. 2. Refer to W440.	MM337		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by:	MM380		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #4 FOX HOLL	STREET ADDRESS, CITY, STATE, ZIP CODE: 370 HOLLOW DRIVE IDAHO FALLS, ID 83402		

(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
MM380	Continued From page 2 Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. During an environmental review conducted on 3/24/15 from 1:50 - 2:42 p.m., the following was noted: - The hall bathroom light fixture was missing 2 of 6 light bulbs. - There was a razor blade located between the sheet rock and an electrical outlet cover plate in the hallway. - There were brown colored spots on the carpet at the entrance to the hall bathroom that numbered 50 plus. The spots ranged in size from one-half inch in diameter to one and one-half inch in length. - There were more than 41 brown colored spots on the carpet that continued from the hallway into Individual #2 and #6's room.. The spots ranged in size from one-half inch in diameter to one and one-half inch in length. - The side-by-side refrigerator/freezer located in the garage had food debris and build-up on the inside. The debris ranged in color from brown to yellow and orange. On 3/24/15 at 2:40 p.m., DCS E stated the side-by-side refrigerator/freezer in the garage needed to be cleaned. - Individual #1's dresser had 5 drawers, two of	MM380		

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	13G066		03/26/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #4 FOX HOLL

STREET ADDRESS, CITY, STATE, ZIP CODE: 370 HOLLOW DRIVE IDAHO FALLS, ID 83402

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MM380	Continued From page 3 which were not on tracks. The metal guide rails were not attached to the sides of the drawers causing the drawers to fall out when opened. - The 5-light floor lamp located in Individual #2 and Individual #3's room was missing 2 of 5 globes/shades. The facility failed to maintain the building and equipment in good repair.	MM380		
MM659	16.03.11.250.04(d) Preparation Not assist with the preparation or serving of food in the kitchen without first having clean clothing or gown and a hairnet or cap. Hands must be thoroughly washed. This Rule is not met as evidenced by: Refer to W455.	MM659		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729		
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	MM735		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #4 FOX HOLL

STREET ADDRESS, CITY, STATE, ZIP CODE: 370 HOLLOW DRIVE IDAHO FALLS, ID 83402

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MM735	Continued From page 4 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 W326.	MM735		
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	MM855		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G066		03/26/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #4 FOX HOLL

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MM855	Continued From page 5 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. This Rule is not met as evidenced by: Refer to W239.	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
steveyo@aspirehumanservices.com

April 23, 2015

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

RE: Plan of Correction
Fox Hollow, Provider # 13G066

Dear Michael Case:

Thank you for your supportive approach during the recent annual recertification survey at the Fox Hollow home. As a fairly new leader for our team, I appreciate the learning 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

Tag: **W214**

Individual #1 has a revised Functional Behavior Assessment that accurately reflects the medical conditions (or lack thereof) and diagnosis 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 and diagnosis's 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. Anxiety was added in the assessment for individual #1 and anxiety tracked on anxiety tracking forms.

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

Completion Date: 6/1/2015

Tag: **W227**

Individual #1 has a revised IPP and Functional Behavior Assessment adding Anxiety and objectives addressing anxiety. This has also been added to individual #1's Behavior plan as well. Aspire Human Services Yellowstone team will review the psychotropic Medication Plans monthly at Psychotropic Review to ensure psychotropic medications line up with the Psychotropic Medication Plans and that objectives are in place, as well as quarterly peer reviews. The peer review checklist will have a section stating "does psychotropic medications line up with Psychotropic Medication Plans, and objectives implemented"? added.

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: **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 now includes the guidance for the use of Individual 1's blocking pads written out with location of pads, when to use, training how to use, etc. The use of blocking pads will be recorded on behavior tracking forms.
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 (coping skills, etc). Replacement behavior objectives will be added per Functional Behavior Assessment replacement behaviors. Data will be recorded for these programs with instructions given. 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: **W312**

The facility will ensure medications to control inappropriate behavior will be used only as a integral part of the individual's IPP that is directed specifically towards the reduction of, and eventual elimination of the behaviors for which the medications are employed. All Medication Reduction Plans will be reviewed or implemented to ensure they accurately reflect and define the criteria for reduction. Data collection documents will be implemented or reviewed to ensure accurate information based on the individual's plan is being collected. All IPP's will be reviewed to ensure objectives related to each diagnosis with a medication to control inappropriate behavior are implemented. The QIDP will review all IPP's and documentation related to the number of incidents for medications used to control inappropriate behaviors. These will be cross-referenced monthly with the medication reduction plans. These have been reviewed and revised.

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

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 **W440**

Evacuation drills will be turned in monthly to QIDP and a copy turned in to Program Manager. Evacuation drills will be tracked on a Evacuation drill tracking sheet and reviewed monthly by both, QIDP and Program Manager to ensure drills are accurate and timely per evacuation drill protocol. This was started April 6, 2015.

Person(s) responsible: QIDP, Program Manager

Completion Date: 5/1/2015

Tag **W455**

New hire orientation was revised to include detailed instructions for infection control. An in-service was provided for staff on April 16, 2015 by Nursing refreshing infection control procedures. QIDP will schedule weekly home checks to ensure infection control is being performed. This will be documented on the home checklist. Nursing will also be attending monthly behavior meetings and will be conducting a 5-10 minute presentation on a portion of infection control that will vary each month. Nursing will be providing a handout for each staff and for the home. Each staff that is not present will be required to read the handout and sign and return the handout. During monthly Nursing review, infection control will be addressed as part of the survey as well.

Person(s) Responsible: QIDP, LPN, RN, Program Manager

Completion Date: 5/1/2015

Tag **MM164-**

Refer to **W**124.

Tag **MM197-**

Refer to **W**289 and W312

Tag **MM337-**

Refer to W440

Tag **MM380-**

The monthly universal checklist will be completed monthly by Lead staff, reviewed by QIDP and then turned in to the Program Manager for review monthly to ensure repairs are being performed. All repairs needed are given to maintenance supervisor, program supervisor as well as a copy to the program manager to ensure these repairs are being performed. This was completed April 20, 2015

Person(s) Responsible: Lead Worker, QIDP, Program Manager

Completion Date: 4/20/2015

Tag **MM659-**

Refer to W455.

Tag **MM729-**

Refer to W227.

Tag **MM730-**

Refer to W214.

Tag **MM735-**

Refer to W326.

Tag **MM753-**

Refer to W383.

Tag **MM758-**

Refer to W362.

Tag **MM855-**

Refer to W239.

5/4/15

Program Supervisor Date