



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 20, 2015

Dayna Wilhite-Grow, Administrator
Southwest Idaho Treatment Center
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Southwest Idaho Treatment Center, Provider #13G001

Dear Ms. Wilhite-Grow:

This is to advise you of the findings of the Medicaid/Licensure survey of Southwest Idaho Treatment Center, which was conducted on April 10, 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

Dayna Wilhite-Grow, Administrator
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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 **May 3, 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 May 3, 2015. If a request for informal dispute resolution is received after May 3, 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,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures

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

PRINTED: 04/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2015
NAME OF PROVIDER OR SUPPLIER SOUTHWEST IDAHO TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 4/6/15 to 4/10/15. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Michael Case, LSW, QIDP Ashley Henscheid, QIDP Jim Troutfetter, QIDP Common abbreviations used in this report are: CFA - Comprehensive Functional Assessment CPI - Crisis Prevention Intervention (a restraint system) CS - Client Services DCS - Direct Care Staff DD - Developmental Disabilities HCL - Hydrochloride LPN - Licensed Practical Nurse PCP - Person Centered Plan PRN - As needed QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility's governing body failed to provide sufficient	W 104		

RECEIVED
MAY - 4 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **DDpm** (X6) DATE **5/1/15**

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 104	Continued From page 1 monitoring and oversight that identified and resolved systematic problems. This failure directly impacted 13 of 20 individuals (Individuals #1 - #4, #6, #7, #9, #10, and #12 - #16), and had the potential to impact all individuals (Individuals #1 - #20) residing in the facility. This failure resulted in the governing body providing insufficient direction and control over the facility necessary to ensure individuals' rights were protected. The findings include: 1. Refer to W125 as it relates to the governing body's failure to ensure restrictions were not implemented without justification or due process. The facility was previously cited at W125 during the annual recertification survey, dated 3/17/14. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance.	W 104			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 13 of 20 individuals (Individuals #1 - #4, #6, #7, #9, #10, and #12 - #16) residing at the facility. This resulted in implementation of restrictions not	W 125			

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W 125	<p>Continued From page 2</p> <p>based on individual need and without assuring due process protections. The findings include:</p> <p>1. The facility was previously cited at W125 during the annual recertification survey dated 3/17/14 for locking knives and glass baking dishes without justification or due process.</p> <p>The facility submitted a Plan of Correction, dated 4/9/14, which alleged compliance with W125. The Plan of Correction stated the facility would ensure cooking and food preparation items were unlocked and that clients would have free access to them, that the CS Manager would do monthly reviews and report to the DD Program Manager who would complete a report. The Plan of Correction stated the corrective action would be completed as of 5/15/14.</p> <p>However, on 4/6/15 from 1:40 - 2:02 p.m., an environmental review was conducted on the Aspen 1 living unit. During that time, all sharp knives were observed to be locked in a cabinet below the oven.</p> <p>On 4/6/15 from 2:02 - 2:30 p.m., an environmental review was conducted on the Aspen 2 living unit. During that time, all sharp knives were observed to be stored in locked wall boxes inside a locked storage room.</p> <p>When asked during the observations, DCS stated the knives were locked for safety as some individuals could use them for weapons.</p> <p>During a subsequent observation, on 4/8/15 from 2:55 - 3:15 p.m., all knives, with the exception of one plastic rocker knife, were observed to be stored in locked wall boxes in the storage closets</p>	W 125		

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W 125	<p>Continued From page 3</p> <p>on the Aspen living unit. When asked during the observation, DCS who were present gave the following reasons for the knives being locked:</p> <ul style="list-style-type: none"> - DCS B stated only rocker knives were used on the unit for safety reasons, and that all were supposed to be locked with the exception of a couple that could be kept in the drawer. - DCS C stated knives and sharp objects had to be locked for safety reasons due to the maladaptive behavior of several individuals on the Aspen living unit. - DCS D stated all knives, including butter knives, had to be locked on the Aspen living unit due to individuals' maladaptive behaviors. <p>During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the DD Program Manager stated knives were not supposed to be locked on the Aspen living unit, but should be available for staff and individuals to use during meal preparations. The DD Program Manager stated the CS Manager was completing monthly reviews utilizing a form that had been developed as part of the facility's 4/9/14 Plan of Correction. However, the form did not specifically address the locking of items such as knives. As a result, the reviews did not identify that knives were still being locked on the Aspen living unit. The DD Program Manager stated the form needed to be revised to ensure CS Managers reviewed for locked items. She stated as a result of the missing data, she was unsure how long the knives had been locked up.</p> <p>The governing body failed to ensure the Plan of Correction was sufficiently implemented in order</p>	W 125			

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W 125	Continued From page 4	W 125		
W 225	<p>to achieve and sustain regulatory compliance, resulting in individuals' rights to free access of knives continuing to be restricted without justification or due process.</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was completed for 1 of 8 individuals (Individual #7) whose vocational assessments were reviewed. Without a comprehensive assessment, the facility would be unable to assist the individual with his vocational training needs, through the development of objectives designed to optimize his abilities. The findings include:</p> <p>1. Individual #7's 11/17/14 PCP stated he was a 50 year old male whose diagnoses included severe intellectual disability.</p> <p>The Vocational Skills section of Individual #7's CFA, dated 10/28/14, stated "[Individual #7's] vocationally-related skills were not assessed as his general functioning does not indicate that vocational assessment is warranted. [Individual #7] does not have the required pre-vocational skills required to work."</p> <p>However, the Medical and Health section of his CFA, dated 11/7/14, stated "[Individual #7] learns and remembers well by repetitive and visual cues and instructions."</p>	W 225		

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W 225	Continued From page 5	W 225			
W 227	<p>When asked about the vocational assessment, during an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the QIDP stated they had not assessed vocational skills for Individual #7, but should have.</p> <p>The facility failed to ensure a comprehensive vocational assessment was completed for Individual #7.</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals' records included objectives to meet their needs for 2 of 8 individuals (Individuals #3 and #5) whose PCPs were reviewed. This resulted in a lack of program plans designed to address individuals' needs. The findings include:</p> <p>1. Individual #3's PCP, dated 6/26/14, documented he was a 21 year old male whose diagnoses included mild to moderate mental retardation.</p> <p>Individual #3's Medication Management Plan, dated 2/20/15, stated he was to receive Thorazine (an antipsychotic drug) 100 mg every 6 hours as needed for anxiety symptoms.</p>	W 227			

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W 227	<p>Continued From page 6</p> <p>Individual #3's 2/20/15 plan to "Reduce Physical Assault and Property Destruction" stated he demonstrated anxiety symptoms, which were divided into two groups. Group 1 anxiety symptoms included sweating, tremors, excessive worrying and/or fear, pacing, wringing hands, negative self-talk and perseveration. Group 2 anxiety symptoms included defying directives and intentionally doing what he is asked not to do. The plan stated "If he is demonstrating (1) [sic] or more or symptoms from each group, it's time to contact nursing to assess the need for PRN [sic] to address anxiety."</p> <p>However, an objective related to anxiety symptoms could not be found in Individual #3's PCP.</p> <p>When asked, during an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the QIDP stated Individual #3 did not have an anxiety objective. He stated any additional information related to anxiety would be obtained by completing a mood scale or reading Individual #3's behavior reports.</p> <p>The facility failed to ensure Individual #3's PCP included an objective for his anxiety symptoms.</p> <p>2. Individual #5's PCP, dated 8/13/14, documented he was a 26 year old male whose diagnoses included moderate mental retardation.</p> <p>Individual #5's record included a CFA for behaviors, dated 11/2012, which stated he engaged in maladaptive behaviors which included isolation, taking the property of others and destruction of property.</p> <p>However, objectives related to isolation, taking</p>	W 227			

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W 227	Continued From page 7 the property of others, and destruction of property could not be found in Individual #5's PCP. During an interview on 4/9/15, from 10:00 a.m. - 12:50 p.m., the QIDP stated Individual #5 needed objectives for isolation, taking the property of others and destruction of property and they had been missed due to an oversight.	W 227			
W 249	The facility failed to ensure Individual #5's PCP included objectives for each assessed need. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 2 of 9 individuals (Individuals #3 and #10) whose behavior programs were reviewed. This resulted in individuals' behavior programs not being implemented. The findings include: 1. Individual #3's PCP, dated 6/26/14, documented he was a 21 year old male whose diagnoses included mild to moderate mental retardation.	W 249			

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W 249	<p>Continued From page 8</p> <p>Individual #3's PCP included an objective to reduce the ingestion of inedible objects. His behavior plan, dated 2/20/15, stated if he was threatening to ingest an inedible object, staff were to remain calm and neutral, scan the area for any small objects and remove them, and position themselves to be able to intervene if necessary. The plan further stated if Individual #3 was attempting to ingest an item that was in his possession, staff were to ask him for the item. If Individual #3 refused, staff were to tell him they would remove it and physically remove the item from his possession using CPI safety standards.</p> <p>An LPN note, dated 3/20/15 and timed 3:10 p.m., documented Individual #3 "claims he accidentally [sic] swallowed [sic] a guitar pick." A subsequent note, dated 3/21/15 and timed 4:35 a.m., stated Individual #3 "...has been asleep, in 'clean room' tonight due to swallowing a guitar pick earlier..."</p> <p>However, Individual #3's behavior plan did not include instructions for using a "clean room" as an intervention to be implemented when Individual #3 swallowed inedible objects.</p> <p>During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the QIDP stated Individual #3's behavior plan should have been followed as written.</p> <p>The facility failed to ensure Individual #3 received interventions consistent with his behavior plan.</p> <p>2. Individual #10's PCP, dated 9/26/14, documented he was a 17 year old male whose diagnoses included moderate mental retardation.</p>	W 249			

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W 249	Continued From page 9 Individual #10's behavior plan, dated 3/2/15, documented "Staff needs to be able to visually monitor [Individual #10] from head to toe when he is out of his room and in the same area as any vulnerable person. This would include all clients..." However, during an observation conducted on 4/6/15 from 4:20 - 6:10 p.m., Individual #10 was noted to be away from staff, as follows: - At 5:10 p.m., Individual #10 was noted to be in the kitchen with Individual #13. The two individuals exited the kitchen and went around the corner into Individual #10's bedroom. A direct care staff noticed shortly after and went into the bedroom and cued Individual #13 to leave the room. - From approximately 5:52 - 5:58 p.m., Individual #10 and Individual #13 were together alone in the kitchen. During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the QIDP stated Individual #10 was supposed to be in staff's line of sight at all times. The QIDP stated Individual #10 and Individual #13 should not have been observed to be alone at any time. The facility failed to ensure Individual #10 received interventions consistent with his behavior plan.	W 249			
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	<p>Continued From page 10</p> <p>incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>This STANDARD is not met as evidenced by: Based on review of abuse and neglect investigations, record review, and staff interviews, it was determined the facility failed to ensure interventions to manage inappropriate behavior were incorporated into program plans for 1 of 8 individuals (Individual #4) whose PCPs were reviewed. This resulted in an individual's right to use the telephone being restricted without specific instructions to staff being available regarding the restriction. The findings include:</p> <p>1. Individual #4's PCP stated he was a 23 year old male whose diagnoses included moderate mental retardation, intermittent explosive disorder, and bipolar disorder type 1.</p> <p>The facility's abuse and neglect investigations from 11/11/14 to 3/30/15 were reviewed. One of 6 investigations documented, on 3/19/15, Individual #4 was sitting in the day hall. He asked to call his mother who lived out-of-state and staff told him not today due to his earlier behavior.</p> <p>Individual #4's 5/13/14 behavior management programs were reviewed. None of the plans included instructions to staff regarding restricting Individual #4's phone use contingent on his behavior.</p> <p>During an interview on 4/8/15 from 9:52 - 10:15 a.m., the Lead Worker stated Individual #4 had an informal program to call his mom every night</p>	W 289			

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W 289	Continued From page 11 at approximately 7:00 p.m. The Lead Worker reviewed Individual #4's programs and said she could not locate a program for him to call his mom every night or any restrictions related to the use of the telephone. At 10:04 a.m., the CS Manager joined the interview and stated Individual #4's mom did not want him to call her when he has had a bad day. During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the Acting Administrator, provided additional information that documented, Individual #4's mom requested one telephone call per day after 7:00 p.m. only if he had a good day with no bad behaviors. During an interview on 4/8/15 at 10:45 a.m., the DD Program Manager stated that no individual should have a phone use restriction unless the restriction was in their behavior plan.	W 289			
W 370	483.460(k)(3) DRUG ADMINISTRATION The facility failed to ensure all interventions to manage Individual#4's inappropriate behavior were incorporated into his program plans. The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure only licensed personnel administered medications to 1 of 6 individuals (Individual #9) who were observed taking medications. This resulted in staff administering medications	W 370			

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W 370	<p>Continued From page 12 contrary to state law. The findings include:</p> <p>1. The Rules of the Idaho Board of Nursing, Idaho Administrative Code 23.01.01.490, dated 2011, defined Unlicensed Assistive Personnel (UAP) as unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses. Additionally, Idaho Administrative code 23.01.01.490.05(e) outlined assistance with medication as including giving medications through a gastric tube and assisting with oral or topical medications.</p> <p>Further, the Rules of the Idaho Board of Nursing, Idaho Administrative Code 23.01.01.490.06 stated UAP were prohibited from performing any licensed nursing functions that were specifically defined in Section 54-1402, Idaho Code which relates to the professional practice of nurses. Idaho Code 54-1402(3)(d) stated licensed nurses were responsible for implementing the appropriate aspects of the strategy of care as defined by the board, including administering medications and treatments as prescribed by those health care providers authorized to prescribe medications.</p> <p>During observations, the facility failed to ensure medications were administered in accordance with state law, as follows:</p> <p>Individual #9's 12/16/14 PCP stated he was a 34 year old male whose diagnoses included moderate intellectual disability. His 2/20/15 Physician's Order stated he received the following medications in the morning:</p> <p>- Calcium Citrate + D3 (a supplemental drug) 500 mg/400 IU, 2 tablets</p>	W 370			

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W 370	<p>Continued From page 13</p> <ul style="list-style-type: none"> - Fish Oil (a supplemental drug) 1000 mg, 1 tablet - Banzel (an anticonvulsant drug) 400 mg, 1 tablet - Amiloride HCL (a diuretic drug) 5 mg, 2 tablets - Bzotropine (an antiparkinsonian drug) 2 mg, 1 tablet - Clonazepam (an anticonvulsant drug) 1 mg, 1 tablet - Depakote (an anticonvulsant drug) 125 mg, 6 capsules - Folic Acid (a supplemental drug) 1 mg, 1 tablet - Haloperidol (an antipsychotic drug) 10 mg, 1 tablet - Levothyroxine (a thyroid hormone) 25 mcg, 1 tablet - Magnesium Oxide (an antacid drug) 400 mg, 2 tablets - Metoprolol Tartrate (an antihypertensive drug) 25 mg, 1/2 tablet - Quetiapine Fumarate (an antipsychotic drug) 200 mg, 1 tablet <p>During an observation on 4/7/15 from 6:55 - 8:20 a.m., Individual #9 was observed to participate in his medication administration routine. During that time, DCS A prepared Individual #9's medications by crushing larger pills, opening capsules, and mixing them in yogurt. DCS A then spoon fed Individual #9 his medications in the yogurt without eliciting Individual #9's participation.</p> <p>When asked during the observation, DCS A stated Individual #9 could spoon feed himself. DCS A stated Individual #9 was not allowed to spoon feed himself his medications because he may not finish them or he could potentially set the yogurt container down and another individual might ingest the medications.</p>	W 370		

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W 370	Continued From page 14 During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the RN stated the staff should not be spoon feeding Individual #9 his medications as he is able to feed himself. The RN stated staff needed to ensure Individual #9 consumed all of the yogurt his medications were mixed in. She stated staff could assist to ensure he received all of his medications, but only after Individual #9 participated to his full ability. The RN stated staff should not be handing the yogurt container to Individual #9 and allowing him to eat it outside the medication area without supervision. During a follow-up interview on 4/10/15 at 8:55 a.m., the RN stated there was not a detailed delegation that specified which staff could assist Individual #9 by spoon feeding his medications to him.	W 370			
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility failed to ensure Individual #9's drugs were not administered by unlicensed personnel without appropriate delegation. The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 1 of 6 individuals (Individual #9) observed to take medications. This failure had the potential to impact 7 of 7 individuals (#1, #6, #7, #9, #14 #15, and #16), residing on the living	W 382			

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W 382	<p>Continued From page 15</p> <p>unit, in the event individuals accessed and ingested drugs which were not prescribed. The findings include:</p> <p>1. An observation was conducted at the facility on 4/7/15 from 6:55 - 8:20 a.m. on the Aspen 2 living unit, where individuals #1, #6, #7, #9, #14 #15, and #16 resided. During that time, medications were observed to be left unlocked and unattended, as follows:</p> <p>At 7:55 a.m., DCS A entered the medication area to prepare Individual #9's morning medications. The medications included the following:</p> <ul style="list-style-type: none"> - Calcium Citrate + D3 (a supplemental drug) 500 mg/400 IU, 2 tablets - Fish Oil (a supplemental drug) 1000 mg, 1 tablet - Banzel (an anticonvulsant drug) 400 mg, 1 tablet - Amiloride HCL (a diuretic drug) 5 mg, 2 tablets - Benztropine (an antiparkinsonian drug) 2 mg, 1 tablet - Clonazepam (an anticonvulsant drug) 1 mg, 1 tablet - Depakote (an anticonvulsant drug) 125 mg, 6 capsules - Folic Acid (a supplemental drug) 1 mg, 1 tablet - Haloperidol (an antipsychotic drug) 10 mg, 1 tablet - Levothyroxine (a thyroid hormone) 25 mcg, 1 tablet - Magnesium Oxide (an antacid drug) 400 mg, 2 tablets - Metoprolol Tartrate (an antihypertensive drug) 25 mg, 1/2 tablet - Quetiapine Fumarate (an antipsychotic drug) 200 mg, 1 tablet 	W 382		

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W 382	Continued From page 16 After punching the medications from the blister packs, DCS A crushed the larger pills, opened the capsules, and mixed them in yogurt with the remaining medications. DCS A then set the container of yogurt with the crushed medications on top of the medication cart, propped the door to the medication room open and left the area to cue Individual #9 to take his medications. Individual #1, Individual #6, Individual #9, Individual #14, and Individual #15, were in the common area of the living unit, in the vicinity of the medication room where the unattended and unlocked medications were located. During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the RN stated the medications mixed in yogurt should not have been left unattended on top of the medication cart. The RN stated the staff should have labeled the yogurt as containing Individual #9's medications and locked the container in the refrigerator in the medication room if he needed to leave the area.	W 382			
W 481	483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 4 of 20 individuals (Individuals #10 - #12 and #20) residing at the facility, and had the potential to impact 20 of 20	W 481			

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W 481	<p>Continued From page 17</p> <p>individuals (Individuals #1 - #20) residing in the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:</p> <p>1. An observation was conducted at the facility on 4/6/15 from 4:20 - 6:10 p.m. During that time, individuals were observed to eat the evening meal. The meal consisted of a stuffed pepper, cream corn, cottage cheese, mandarin oranges and milk.</p> <p>Not all individuals were observed to eat the evening meal, as follows:</p> <ul style="list-style-type: none"> - Individual #20 did not want the stuffed pepper and made a peanut butter and jelly sandwich. Individual #20 ate the sandwich, but decided to eat the pepper as well. - Individual #11 stated he did not want the stuffed pepper and requested a peanut butter and jelly sandwich from the staff. - Individual #10 did not want the stuffed pepper and made a sandwich. Individual #10 ate the sandwich, but decided to eat the pepper as well. - Individual #12 stated he did not want the stuffed pepper and made himself a peanut butter and jelly sandwich. <p>During an interview on 4/9/15 at 9:53 a.m., DCS E stated all meal substitutions, either for entire menu items or individual choice, should be documented on the living unit menu for the week.</p> <p>The menus for all living units were reviewed. None of the menus documented meal</p>	W 481		

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W 481	<p>Continued From page 18 substitutions for the night of 4/6/15.</p> <p>During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the RN and QIDP both stated substitutions should have been documented on the unit menus. The Acting Administrator, who was present during the interview, stated the food services staff may have additional documentation and would check.</p> <p>On 4/13/15, the facility provided two Alternate Meal Information Logs. At the top of the logs, the form included "Whenever a resident chooses an alternate meal - log the information here."</p> <p>However, the submitted forms did not include any documentation related to the observed substitutions.</p> <p>The facility failed to ensure accurate documentation of meals actually served was kept.</p>	W 481			

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 4/6/15 to 4/10/15. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Michael Case, LSW, QIDP Ashley Henscheid, QIDP Jim Troutfetter, QIDP Common abbreviations used in this report are: PCP - Person Centered Plan RN - Registered Nurse	M 000		
MM111	16.03.11.050.01(c) Medical History A medical history and a physical examination must be completed by a physician not more than ninety (90) days before admission. The medical history and the record of the physical examination must include information concerning the resident's activity limitations and the results of a tuberculin skin test or chest x-ray. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate tuberculin testing had occurred for 1 of 8 individuals (Individual #3) whose records were reviewed. This resulted in the potential for an infected individual to be admitted to the facility undetected. The findings include: 1. Individual #3's PCP, dated 6/26/14, documented he was a 21 year old male whose diagnoses included mild to moderate mental retardation. He was admitted to the facility on 5/28/14.	MM111		

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MM111	<p>Continued From page 1</p> <p>Individual #3's record was reviewed and did not contain documentation that tuberculin testing had occurred as part of his pre-admission or admission process.</p> <p>During an interview on 4/9/15 from 10:00 a.m. - 12:50 p.m., the RN stated Individual #3 did not receive tuberculin testing at the time of his admission and he should have.</p> <p>The facility failed to ensure appropriate tuberculin testing had taken place related to Individual #3's admission.</p>	MM111		
MM167	<p>16.03.11.075.07 Exercise of Rights</p> <p>Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal.</p> <p>This Rule is not met as evidenced by: Refer to W125.</p>	MM167		
MM212	<p>16.03.11.075.17(a) Maximize Developmental Potential</p> <p>The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by:</p>	MM212		

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MM212	Continued From page 2 Refer to W249.	MM212		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W104.	MM520		
MM672	16.03.11.07(a) Menu Preparation Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to W481.	MM672		
MM724	16.03.11.270.01(a) Assessments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by:	MM724		

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MM724	Continued From page 3 Refer to W225.	MM724		
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. Refer to W289.	MM729		
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 W382.	MM753		
MM755	16.03.11.270.02(f)(ii)(a) Resident unable to Self-Administrate If the resident is not capable of self-administration of medications under staff supervision, this fact must be documented in the resident's assessment. Such residents cannot be accepted by facilities unless a licensed nurse is on duty to administer and record such medications. This Rule is not met as evidenced by: Refer to W370.	MM755		

**Plan of Correction
Southwest Idaho Treatment Center**

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FACILITY STANDARDS

W104	Refer to W125
W125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>POC: The facility will ensure that knives are unlocked and clients have free access to them. Any restrictions or limitations to this would require due process including guardian consent and HRC approval.</p> <p>Supervisors will provide training to their staff that our clients have the right to free access to knives and that restriction of this access requires due process including guardian consent and HRC approval.</p> <p>The CS Manager and Dietary Services Manager will add to their monthly review/observation a review to ensure that clients have free access to cooking and food preparation items, including knives. The results of this review/observation along with any corrective actions taken will be forwarded to the Administrator.</p> <p>Completion Date: 5/29/15</p>
W225	<p>The comprehensive functional assessment must include, as applicable, vocational skills.</p> <p>POC: The QIDP will review all clients' comprehensive functional assessments to ensure that all required sections are completed.</p> <p>DD Program Manager will review a sample client each month to ensure that the comprehensive functional assessments are completed. The DD Program Manager will report any concerns to the Administrator.</p> <p>Completion Date: 5/29/15</p>
W227	<p>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.</p> <p>POC: Objectives will be developed and incorporated into the PCP for the identified needs for Individuals #3 and #5.</p> <p>The QIDP will review all clients' assessments/PCPs to ensure that there are objectives to meet the needs or clear justification why an identified need was not prioritized.</p> <p>DD Program Manager will review a sample client each month to ensure that the comprehensive functional assessments are completed. The DD Program Manager will report any concerns to the Administrator.</p> <p>Completion Date: 5/29/15</p>

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W249	<p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</i></p> <p>POC: Staff will be retrained in the expectations of the Behavior Support Plans (BSPs) for Individuals #3 and #10.</p> <p>Risk Management Techs (RMTs) will review one sample BSP per month each (4 total per month) and observe staff implementation of the BSP. Any concerns regarding staff implementation of the BSP will be reported to the CS Manager, DD Program Manager, and the Administrator, who will ensure that training appropriate to the concern is provided to staff.</p> <p>Completion Date: 5/29/15</p>
W289	<p><i>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.</i></p> <p>POC: All staff will be retrained on the requirements of this regulation and on our facility's Behavioral Intervention Policy.</p> <p>RMTs will review on sample BSP per month each (4 total per month) and observe staff implementation of the BSP. Any concerns regarding interventions that are not incorporated in the client's PCP will be reported to the CS Manager, DD Program Manager, and the Administrator, who will ensure that training appropriate to the concern is provided to staff.</p> <p>Completion Date: 5/29/15</p>
W370	<p><i>The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits.</i></p> <p>POC: Immediate corrective action on 4/29/15 all licensed nurses will only administer medications to Individual #9. On 4/28/15, the RN reviewed with DCS A and his supervisor the medication certified staff expectations to assist in administering client medication(s) and MCS cannot spoon feed medications to Individuals unless they are trained by an RN and adhere to written delegated guidelines. Individual #9's "Assisted Medication/Treatment administration" service program will be written as a training program for self-administration of medications to teach him to take his medications independently.</p> <p>At a minimum of every six (6) months nursing staff will conduct observations (licensed nurse to licensed nurse and licensed nurse to medication certified staff) which will include observation to ensure that all training programs for self-administration of medication programs are trained according to the instructions.</p> <p>RN will provide a quarterly report to the Administrator the number of observations completed for the previous quarter and a summary of what was done to address any issues identified in those observations. The RN will document on the current medication certified staff excel file which medication certified staff may assist Individuals up to and including spoon feeding their medications and the date of their training.</p> <p>Completion Date: 5/29/15</p>
W382	<p><i>The facility must keep all drugs and biologicals locked except when being prepared for</i></p>

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	<p><i>administration.</i></p> <p>POC: Immediate corrective action taken on 4/9/15 verbally counseling to DCS A that it is unacceptable to leave medications mixed in a medium out on top of the medication cart with the door propped open. All medications are to be locked and/or under constant visual until the client takes the medication(s). The RN will review with DCS A and his supervisor the medication certified staff expectations to assist in administering client medication(s) as an additional personnel action.</p> <p>The RN will provide training for all nurses on this expectation. The RN or LPN(s) will provide training for all medication certified staff on these expectations.</p> <p>At a minimum of every six (6) months nursing staff will conduct observations (licensed nurse to licensed nurse and licensed nurse to medication certified staff) which will include observation to ensure medications are kept locked in between medication passes.</p> <p>RN will provide a report to the Administrator outlining the number of observations completed and a summary of what was done to address any issues identified in those observations.</p> <p>Completion Date: 5/29/15</p>
W481	<p><i>Menus for food actually served must be kept on file for 30 days.</i></p> <p>POC: Any food substitutions that are for the whole group will be noted on the menu for that particular meal, by striking through the item and writing in the substitution next to it, with the staff who makes the entry initialing and dating it. Individual substitutions will be recorded on a meal substitution record that will be kept in the individual client books on the unit. These will be pulled each week by the NOC shift lead and kept on file for at least 30 days.</p> <p>The CS Manager and Dietary Services Manager will add to their monthly review/observation a review of these meal substitution documents. The results of this review/observation along with any corrective actions taken will be forwarded to the Administrator.</p> <p>Completion Date: 5/29/15</p>
MM111	<p><i>A medical history and physical examination must be completed by a physician not more than ninety (90) days before admission. The medical history and the record of the physical examination must include information concerning the resident's activity limitations and the results of a tuberculin skin test or chest x-ray.</i></p> <p>POC: Individual #3 was administered a two-step tuberculin skin test, per physician's order on 4/9/15. The result was negative. Per the physician's order the second TST was administered on 4/16/15. The result was negative.</p> <p>RN will develop physician admission checklist to be completed for all client admissions which will include immunizations as well as the two step tuberculin skin test and will ensure all steps are completed. A licensed nurse will check that the client's immunization is current for their annual history and physical and will notify physician if immunizations are needed.</p> <p>RN will provide a report to the Administrator outlining any missed steps from the checklist and what will be done to correct the issue.</p> <p>Completion Date: 5/29/15</p>
MM167	Refer to W125

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<i>MM212</i>	Refer to W249
<i>MM520</i>	Refer to W104
<i>MM672</i>	Refer to W481
<i>MM724</i>	Refer to W225
<i>MM729</i>	Refer to W227 and W289
<i>MM753</i>	Refer to W382
<i>MM755</i>	Refer to W370