IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7012 3050 0001 2125 5907

September 11, 2015

Steve Young, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

Due to Yellowstone Group Home #1 Springfield failure to provide an acceptable Allegation of Compliance to the survey completed August 3, 2015, the facility remains out of compliance with the Medicaid Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) Conditions of Participation of **Governing Body and Management (42 CFR 483.410), Client Protections (42 CFR 483.420), Active Treatment Services (42 CFR 483.440) and Client Behavior and Facility Practices (42 CFR 483.450).**

The deficiencies were described on the Statement of Deficiencies/Plan of Correction (CMS-2567) dated August 3, 2015.

In our letter to you dated August 17, 2015, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid program."

Because of your failure to correct, we have made that recommendation. The Medicaid Agency will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/pmt
Enclosure

ec: Lisa Hettinger, Administrator
Debby Ransom, Bureau Chief
Gary Keopanya, CMS Region X

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LISA HETTINGER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

CERTIFIED MAIL: 7012 3050 0001 2125 5891

September 11, 2015

Steve Young, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

The Bureau of Facility Standards has advised us your facility is out of compliance with the Conditions of Participation of **Governing Body and Management (42 CFR 483.410), Client Protections (42 CFR 483.420), Active Treatment Services (42 CFR 483.440) and Client Behavior and Facility Practices (42 CFR 483.450).** To participate as a provider of services in the Medicaid program, an Intermediate Care Facility for Persons with Intellectual Disabilities (ICD/ID) must meet all of the requirements established by the Secretary of Health and Human Services. The deficiencies are described on the Statement of Deficiencies/Plan of Correction (CMS-2567) dated August 3, 2015.

Based on this information, the Department has scheduled termination of your Provider Agreement with the Idaho Medicaid Program effective November 1, 2015. The Medicaid Program will not make payments for client days when there is not a Medicaid Provider Agreement in effect.

You have the opportunity to make corrections of those deficiencies that led to the finding of non-compliance with the Conditions of Participation referenced above by submitting an acceptable written Credible Allegation of Compliance/Plan of Correction. To resolve the deficiencies, the facility must submit a letter of Credible Allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problems corrected.

It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

- What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- How you will identify other individuals having the potential to be affected by the same deficient practice;

- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 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; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction;
- Include dates when corrective action(s) will be completed; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office before November 1, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than October 13, 2015

Please complete your Allegation of Compliance/Plan of Correction and submit to the Medicaid Agency and Survey Agency by **October 7, 2015.** Please keep in mind that once the Department receives the letter of Credible Allegation, an unannounced visit could be made at the facility at any time. If you fail to notify us, we will assume you have not made corrections.

Please be advised that you have the right to appeal this action as described in 42 CFR Subpart B, Sections 431.151 through 431.154. The appeal procedures are described in the Department's Contested Case Rules (IDAPA 16.05.03.300). The first step in the appeal process is an administrative review. **To be entitled to an administrative review, your request must be submitted in writing within twenty-eight (28) days after the date of this letter.** A request for administrative review must be signed by the facility's administrator, identify the challenged decision(s), and state specifically the grounds for your contention that the decision was in error.

If you wish to request an administrative review, please submit your written request to:

Debby Ransom, Bureau Chief
Department of Health & Welfare
Licensing & Certification Section
P.O. Box 83720
Boise, ID 83720-0009

Additionally, 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:

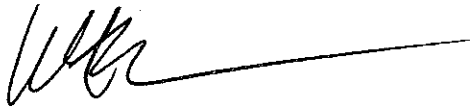
www.icfmr.dhw.idaho.gov

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 **October 7, 2015**. If a request for informal dispute resolution is received after **October 7, 2015** the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions, please feel free to contact Nicole Wisenor, Non-Long Term Care Co-Supervisor, Bureau of Facility Standards.

Sincerely,



Lisa Hettinger
Administrator

LH/pmt

ec: Debby Ransom, Chief, Bureau of Facility Standards
Gary Keopanya, Centers for Medicare and Medicaid Services, Region X Office

ASPIRE
HUMAN SERVICES, LLC

September 09, 2015

Nicole Wisenor
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RE: Springfield, Provider #13G063

Dear Ms. Wisenor:

Aspire Human Services – Yellowstone Group Homes is requesting a formal extension to the full 90 days for the plan of correction for Springfield.

We anticipate that the credible date will be within the first part of the extended 45 days.

Thank you for your time and consideration and if you have any further questions, please feel free to contact me at 208-972-5259.

Sincerely,

Shelly Brubaker
State Operations Manager

COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7000 1670 0011 3315 1521

August 17, 2015

Steve Young, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

Based on the Medicaid/Licensure and complaint survey completed at Yellowstone Group Home #1 Springfield on August 3, 2015, we have determined that Yellowstone Group Home #1 Springfield is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/ID) Condition of Participation of **Governing Body and Management (42 CFR 483.410), Client Protections (42 CFR 483.420), Active Treatment Services (42 CFR 483.440) and Client Behavior and Facility Practices (42 CFR 483.450)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Yellowstone Group Home #1 Springfield to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/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.

Sign and date the form(s) in the space provided at the bottom of the first page.

Such corrections must be achieved and compliance verified by this office, before September 17, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 4, 2015.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **August 30, 2015**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Yellowstone Group Home #1 Springfield ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective August 3, 2015, through December 1, 2015. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **September 14, 2015**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT
Licensing and Certification Administration, DHW
PO Box 83720
Boise, ID 83720-0009
Phone: (208)334-6626
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 August 30, 2015. If a request for informal dispute resolution is received after August 30, 2015 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me 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/pt
Enclosures

RECEIVED
SEP 16 2015
FACILITY STANDARDS

RECEIVED
SEP 18 2015
FACILITY STANDARDS

9/18/15

Karen Marshall, Health Facility Surveyor
Idaho Department of Health and Welfare
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

Dear Karen Marshall:

Aspire Human Services – Springfield alleges that corrections are in process to be compliant with Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions for Conditions of Participation of Governing Body and Management (42 CFR 483.410), Client Protections (42 CFR 483.420), Active Treatment Services (42 CFR 483.440) and Client Behavior and Facility Practices (42 CFR 483.450).

Please see the attached Plan of Correction for specific details on the actions taken by the facility to achieve compliance.

If you have any further questions, please feel free to contact Steve Young at 208-523-9839 ext. 23.

Steve Young
ICF Program Manager

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey and complaint investigation conducted from 7/27/15 to 8/3/15. The survey was conducted by: Karen Marshall, MS, RD, LD, Team Lead Ashley Henscheid, QIDP Michael Case, LSW, QIDP Common abbreviations used in this report are: 1:1 - One-on-one ABC - Antecedent, Behavior, Consequence ADL - Activity of Daily Living CFA - Comprehensive Functional Assessment DCS - Direct Care Staff DT - Day Treatment HDL - High Density Lipids HRC - Human Rights Committee IED - Intermittent Explosive Disorder IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record mg/dL - milligrams per deciliter NKDA - No Known Drug Allergies PECS - Picture Exchange Communication System PRN - As needed QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000	RECEIVED SEP 21 2015 FACILITY STANDARDS	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: QIDP — (X6) DATE: 9/18/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 102	Continued From page 1 body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the facility's Governing Body failed to take actions that identified and resolved systematic problems. This failure resulted in inadequate protections, active treatment and behavior interventions being provided to individuals. The findings include: 1. Refer to W104 as it relates to the facility's failure to ensure the Governing Body provided sufficient operating direction over the facility.	W 102		
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, policy review, record review and staff interview, it was determined the facility's Governing Body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. This failure directly impacted 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed and had the potential to impact 6 of 6 individuals (#1 - #6) residing at the facility. This failure resulted in the Governing Body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include:	W 104		9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

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W 104	Continued From page 2 1. Refer to W111 as it relates to the Governing Body's failure to ensure a record keeping system that contained complete information was maintained. 2. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they to relate the failure of the Governing Body to provide sufficient monitoring and oversight to ensure policies were adequately implemented and monitored necessary to ensure individuals were not subjected to ongoing abuse or neglect. 3. Refer to W149 as it relates to the Governing Body's failure to ensure policies and procedures related to suicide and abuse investigations were implemented. 4. Refer to W154 as it relates to the Governing Body's failure to ensure allegations of potential abuse, neglect, and mistreatment were thoroughly investigated. 5. Refer to W157 as it relates to the Governing Body's failure to ensure appropriate corrective action was completed as a result of abuse investigations. 6. Refer to W159 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight. 7. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the Governing Body's failure to ensure the facility provided each individual with continuous active	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

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W 104	Continued From page 3 treatment designed to meet their individualized needs. 8. Refer to W266 Condition of Participation: Client Behavior and Facility Practices and associated standard level deficiencies as they relate to the Governing Body's failure to ensure the facility ensured techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet the individuals' health, safety, and active treatment needs.	W 104		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate information for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in a lack of comprehensive information being available regarding the individuals' experiences at the facility. The findings include: 1. At 2:25 p.m., the City Director stated the electronic data collection system the facility had been using was discontinued. As a result, the facility had to revert to a paper data collection	W 111		9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 111	Continued From page 4 system. When asked when the system was discontinued, the City Director stated he was not sure. During the paper data review, it was noted that Individual #1's record did not include raw ADL data collection prior to 2/22/15. Individual #2's record did not include raw ADL data collection prior to 2/23/15 and Individual #3's record did not include raw ADL data collection prior to 1/26/15. On 7/28/15 at 1:30 p.m., the City Director provided an email from the corporate office stating the electronic data collection system had been discontinued at the end of February 2015, and that backup files were obtained for data collected prior to 2/28/15. However, the City Director stated he did not have a way to view or print the backup files. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated when the facility was notified the electronic data collection system was being discontinued, it was discovered no paper data collection system was present to accommodate the loss of the electronic system. As a result, paper data collection sheets had to be created for each of the individuals' training programs. The facility failed to ensure the QIDP had a system was in place to collect program data in the event the electronic data collection system was inoperable. 2. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability.	W 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 111	Continued From page 5 a. Individual #2's record contained documentation of the following restrictive interventions: - The use of blocking techniques and a supportive escort as interventions for Individual #2's aggression, and - One-on-one line-of-sight supervision during waking hours. However, documentation of guardian consent for the restrictives could not be found. Individual #2's guardian was interviewed on 7/30/15 from 1:58 - 2:12 p.m. She stated things were going well and she had regular contact with the QIDP, including monthly phone calls and additional communication as needed. Individual #2's guardian stated she was not always diligent in returning items for signatures, and stated she had paperwork that she had approved over the phone she needed to sign and return. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated he was waiting for the guardian to return the signed consents. The QIDP stated verbal consent was obtained and would typically be documented in the record, however, he could not locate such documentation. b. Individual #2's Physician Standing Medication Orders, dated 1/12/15, included PRN orders, as follows: - Acetaminophen (an analgesic drug) "650mg to 1000mg" every four hours PRN for pain or temperature	W 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 111	Continued From page 6 - Milk of Magnesia (a laxative drug) was ordered for "30-60 cc PRN" for constipation Individual #2's MARs, dated 1/2015 - 6/2015, were reviewed and did not include sufficient information. Examples of incomplete MAR documentation included, but were not limited to, the following: - 1/8/15, 1/10/15, 3/22/15 and 5/20/15: Individual #2's MARs documented he received acetaminophen. None of the documentation included the dose administered. - 3/21/15, 4/24/15, 4/26/15, 5/21/15 and 5/23/15: Individual #2's MARs documented he received acetaminophen. None of the documentation included results of efficacy to evaluate the need for further PRN administration. - 4/22/15, 4/22/15 (a second time), 4/23/15 and 4/26/15: Individual #2's MARs documented he received 500 mg of acetaminophen. Further, on 4/24/15, Individual #2's MARs documented he received 1000 mg of acetaminophen. None of the documentation included information related to how the doses were determined. - 1/20/15 and 3/22/15: Individual #2's MARs documented he received Milk of Magnesia. None of the documentation included the dose administered. - 1/10/15, 1/26/15, 3/10/15, 3/23/15 and 4/10/15: Individual #2's MARs documented he received Milk of Magnesia. None of the documentation included results of efficacy to evaluate the need for further PRN administration.	W 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	Continued From page 7 During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated accurate MAR documentation was an ongoing issue and she would address the concerns through staff training. The facility failed to ensure Individual #2's record contained comprehensive information.	W 111		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on policy review, observation, record review and staff interview, it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals' rights. These failures resulted in a lack of effective systems to uphold individuals' rights. The findings include: 1. Refer to W124 as it relates to the facility's failure to ensure sufficient information was provided to guardians on which to base consent decisions. 2. Refer to W129 as it relates to the facility's failure to ensure each individual was provided with personal privacy. 3. Refer to W137 as it relates to the facility's failure to ensure each individual had unrestricted access to personal possessions. 4. Refer to W149 as it relates to the facility's	W 122		9/23/15

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	13G063		08/03/2015

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W 122	Continued From page 8 failure to ensure written policies and procedures that prohibited abuse, neglect and mistreatment were adequately implemented and monitored. The cumulative effect of these deficient practices resulted in individuals' rights being violated.	W 122		
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 observations, record review and staff interview, it was determined the facility failed to ensure a guardian was provided with comprehensive information necessary to make informed decisions for 2 of 3 individuals (Individual #1 and #2) whose consents were reviewed. This resulted in insufficient information being provided to guardians on which to base consent decisions. The findings include: 1. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's record contained 1:1 Supervision Guidelines, dated 11/11/14, which documented Individual #2 would require line-of-sight supervision during all waking hours, except when he was in his bedroom alone or in the bathroom.	W 124		9/23/15

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W 124	Continued From page 9 A Written Informed Consent for 1:1 supervision, dated 11/11/14, was included in Individual #2's record. Individual #2's record contained a second copy of 1:1 Supervision Guidelines, revised 4/27/15, which documented the addition of line-of-sight supervision when Individual #2 was in the bathroom. However, Individual #2's record did not contain documentation of updated consent for line-of-sight supervision while he was in the bathroom. Additionally, observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to enter the restroom with staff no less than three times. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated updated consent to include the new information had not been obtained. The facility failed to ensure informed guardian consent was obtained for Individual #2's increased supervision level. 2. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 5:10 p.m., it was noted Individual #1's other belongings (e.g.	W 124		

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W 124	Continued From page 10 puzzles, blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Behavior Intervention Plan for socially offensive behavior, revised 5/1/15, stated he " ...displays socially offensive behavior by urinating on the floor/clothing, dipping his clothing in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." His behavior plan and the corresponding 5/1/15 Written Informed Consent for socially offensive behavior, signed by Individual #1's guardian on 6/12/15, were reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in either the plan or the consent. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated information regarding Individual #1's possessions being stored in the garage was not included in Individual #1's consents or plans that were reviewed by the guardian. The facility failed to ensure Individual #1's guardian was fully informed of the intervention strategies used to manage his socially offensive	W 124		

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W 124	Continued From page 11 behavior.	W 124		
W 129	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure personal privacy was provided for 1 of 6 individuals (Individual #1) residing at the facility. This resulted in an individual's right to privacy being violated. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. During observations conducted on 7/27/15 and 7/28/15, Individual #1's privacy was not observed to be consistently protected. Examples included, but were not limited to, the following: a. Observations were conducted on 7/27/15, at which time the following was noted: At 2:50 p.m., Individual #1 was in room getting dressed. His bedroom door was open and his windows were not covered in order to protect his privacy. At 3:15 p.m., Individual #1 was in his bedroom with the door open and his windows uncovered.	W 129		9/23/15

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W 129	Continued From page 12 He was observed to remove his shoes and his pants and was not observed to be wearing underwear. Individual #1 then walked down the hallway and into the garage, without pants on. DCS noticed Individual #1 in the garage and redirected him back to his bedroom. The DCS was not observed to offer Individual #1 anything with which to cover himself in order to protect his privacy prior to redirecting him back down the hallway and to his bedroom. At 3:20 p.m., Individual #1 was observed to be in his room putting on a pair of pants. His bedroom door was open and his windows were not covered in order to protect his privacy. At 3:35 p.m., Individual #1 was in the hallway. Individual #1 became incontinent and his pants were observed to be wet. Individual #1 removed his pants while in the hallway and went into his bedroom. Individual #1 then walked out of his room, without pants on, and back into the hallway carrying his soiled pants. A DCS, who was coming out of the laundry room, noticed Individual #1, took the soiled pants from him and redirected Individual #1 back to his bedroom. The DCS was not observed to assist Individual #1 to close his door or cover his windows in order to protect his privacy. At 3:40 p.m., Individual #1 was observed to leave his bedroom, enter the hallway bathroom, wash his hands and return to his bedroom. Individual #1 was not observed to be wearing clothes. b. Observations were conducted on 7/28/15, at which time the following was noted: At 3:56 p.m., Individual #1 came out of the	W 129		

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W 129	Continued From page 13 restroom with soiled pants. He went to his bedroom, sat on his bed, took off his pants and put on clean pants. The DCS was not observed to assist Individual #1 to close his door or cover his windows in order to protect his privacy. It was also noted an electrician, from outside the company, was in the home, repairing an outlet in the hall bathroom at the time. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #1's nudity and need for privacy was an ongoing issue. The City Director stated they made modifications to try to best provide Individual #1 with privacy (e.g. adding Velcro to the bedroom curtains to ensure they could easily be hung when needed), however, he stated they recognized his dignity and privacy was still a concern. The facility failed to ensure Individual #1's right to privacy was upheld.	W 129		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. 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 had appropriate access to personal possessions for 1 of 6 individuals (Individual #1) residing at the facility. This resulted in an individual's right to his personal	W 137		9/23/15

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W 137	Continued From page 14 possessions not being upheld. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 3:15 p.m., Individual #1 was in his bedroom with the door open and his windows uncovered. He was observed to remove his shoes and his pants and was not observed to be wearing underwear. Individual #1 then walked down the hallway and into the garage, without pants on. DCS noticed Individual #1 in the garage and redirected him back to his bedroom. Individual #1 was not able to independently access his clothes without compromising his privacy. Additionally, on 7/27/15 at 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment,	W 137		

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W 137	Continued From page 15 dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair of clothing..." Individual #1's Functional Behavior Assessment and the corresponding Behavior Intervention Plan for socially offensive behavior, revised 5/1/15, were reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in either the assessment or the plan. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated they tried programming and environmental changes before choosing to store Individual #1's clothing in the garage. The City Director stated they struggled with ensuring Individual #1 had clean clothes available when he was engaging in maladaptive behavior with the clothing. When asked about his other possessions, the City Director stated he was not sure why they were stored in the garage. The QIDP, who was present during the interview, stated he assumed it was also due to Individual #1's maladaptive behaviors. The facility failed to ensure Individual #1's right to	W 137		

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W 137	Continued From page 16 retain personal possessions and clothing was upheld.	W 137		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored. This failure directly impacted 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed, and had the potential to impact all individuals residing at the facility (Individuals #1 - #6). This resulted in a lack of implementation of the suicide policy, and a lack of thorough investigations and appropriate corrective action. The findings include: 1. The facility's Suicide Policy, revised 6/4/15, was reviewed. The policy stated "It is the goal of the company to prevent individual harm, including self-harm. It is the responsibility of every employee to ensure that individuals are not allowed to harm themselves. As employees we are required to actively strive to prevent and report any incidents of threatening or attempting to harm themselves." The policy was not sufficiently implemented, as follows: a. The policy stated if an individual showed signs of suicidal ideation or threats of suicide (such as stating "I'm going to kill myself"), staff were to	W 149		9/23/15

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W 149	Continued From page 17 "immediately stop the individual from hurting himself or herself...then place that individual under Arm's Length supervision or follow their suicide guideline if applicable. Remove any potentially dangerous items from the individual and/or their environment." The policy stated to perform a body check if it was a part of the individual's suicide guidelines. The policy defined "Arm's Length" supervision as "The individual is no further away from the staff than a literal arm's length." The policy stated the Administrator or Administrator on Duty was to be notified immediately of all suicidal ideation or threats of suicide. Staff were then to notify everyone on the shift that the individual was on increased supervision and complete an Incident/Accident form. The policy stated the Administrator or Designee would assign an employee trained to complete the suicide assessment, and the Administrator was to also contact the QIDP. The policy stated "The QIDP or the designated person with an equivalent degree will make the decision to either place the individual on Line of Sight supervision, Arm's Length supervision or contact the house to discuss the results of the suicide assessment with the staff member completing the form." The policy stated "Only the QIDP or the designated person with an equivalent degree if the QIDP is not available has the authority to remove supervision and to give the individual their belongings back." Individual #3's 8/21/14 IPP stated he was a 30	W 149		

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W 149	Continued From page 18 year old male whose diagnoses included mild mental retardation, bipolar disorder, and IED. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for suicidal ideation (defined as making threats to injure himself or stating he was going to kill himself). Interventions for suicidal ideation included: - Follow suicide guidelines - Follow suicide protocol including placing Individual #3 on 1:1 line-of-sight, notifying Program Supervisor or QIDP, and remaining on 1:1 line-of-sight until it is determined he is not at risk His Suicide Guidelines, revised 4/3/14, stated if Individual #3 stated he wanted to die, staff were to ensure he was within arm's length and encourage him to use problem solving. Staff were then to implement the Suicide Policy. Individual #3's suicidal ideation documentation was reviewed. The documentation did not provide sufficient information to demonstrate suicide protocols were implemented according to policy or his plans. Examples included, but were not limited to, the following: - 3/10/15 at 9:25 a.m., a Behavior Log documented Individual #3 arrived at DT upset. Under the "Behavior" section, staff documented "he said he was going to kill himself and all staff." Staff then documented "Staff tried talking to him and he wouldn't listen so staff extincted him giving him time to calm down." The facility utilized a Suicide Risk Assessment	W 149		

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W 149	Continued From page 19 Sheet that included a place to document the individual's name, the date, the time of day, and the person completing the form. A list of options with check boxes was included for sex, age, intellectual disability, psychiatric diagnosis, physical pain, suicide history, and self-injurious behavior history. The person completing the form could then circle one of two options to describe intent, plan, lethal potential, and how it was discovered. There were two sections that allowed narrative data, labeled "Summarize the event of concern" and "Staff Response." A Suicide Risk Assessment Sheet for Individual #3, completed on 3/10/15 at 9:24 a.m. by the same staff completing the Behavior Log, stated "he said he would just kill himself." The Staff Response section stated "Staff asked him if he wanted to talk about what was bothering him and he said no. Then he said he was going to kill himself again and kill staff, staff extincted him and put him on suicide watch." The documentation did not explain how Individual #3 could be placed on extinction and suicide watch at the same time. Additionally, the form did not include information related to how, or if, the suicide policy or suicide protocols for Individual #3 had been implemented, by whom, and how or when Individual #3 was released from the suicide watch. - 3/25/15 at 9:50 a.m., a Behavior Log documented Individual #3 was looking at the newspaper. Under the "Behavior" section, staff documented "When he was asked to follow his schedule he refused and said he was going to kill himself and everybody at Day Treatment....Threatened to injure himself x7..."	W 149		

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W 149	Continued From page 20 A Suicide Risk Assessment Sheet, completed by the same staff on 3/25/15 at 9:50 a.m., stated "He said he was going to kill himself and everyone else. Fifth time he said he's going to kill himself tonight." The Staff Response section stated "Staff asked him to follow his schedule and he refused. Staff tried talking to him and he turned his music up so staff extincted him." There was no indication the suicide policy was implemented. - 4/18/15 at 6:10 p.m., a Behavior Log documented Individual #3 stated he did not want to eat his Mandarin oranges. Under the "Behavior" section, staff documented Individual #3 stated "how about 'I just kill myself' and slammed his door. I went and checked on him and he was just sitting on his bed watching T.V. he said he didn't want to talk to anyone he would go talk to [City Director] on Monday. I did appropriate paperwork and Notified chain of command." A Suicide Risk Assessment Sheet, dated 4/18/15 at 6:10 p.m. but unsigned, stated "refused to eat fruit at dinner after seeing cookies on counter. Told staff they could not make him do anything and cannot refuse him treats, staff is not his guardian so they can't boss him around only mom can. When his b-day comes he will get cake and not share w/anyone. I am going to kill myself." There was no indication the suicide policy was implemented. - 6/11/15 at 10:05 p.m., a Behavior Log stated Individual #3 asked if it was too late to take his	W 149		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 21 medications. Under the "Behavior" section, staff documented Individual #3 "came out and asked if it was too late for meds. Staff said yes because of refusing earlier. He began to threaten to kill himself and staff." A Suicide Risk Assessment Sheet, dated 6/11/15 at 10:00 p.m. and unsigned, stated "He was upset and wanted his meds after already refusing and proper paperwork had been done and so he stated 'I will just go kill myself.'" The Staff Response section stated "followed Suicide protocol and contacted proper chain of command." However, there was no documentation indicating who was contacted, what direction if any was given, how the suicide protocol was implemented, or when Individual #3 was released from suicide precautions or by whom. None of the documentation reviewed contained information demonstrating how or if the Suicide Policy had been implemented (arm's length or line-of-sight supervision being initiated, Administrator or Designee being contacted, QIDP being notified, harmful objects removed, reassessment completed, when the suicide watch was terminated and by whom, etc.). During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation was not sufficient to demonstrate the Suicide Policy had been implemented or followed. b. The policy stated "In the event that an individual displays any signs of depression or hopelessness for more than 2 consecutive hours	W 149		

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	13G063		08/03/2015

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W 149	Continued From page 22 treat this as possible suicidal activity." The policy stated "Please respond by placing that individual under Arm's Length supervision or follow their suicide guidelines if applicable and following the instructions below to notify the Administrator or Designee." The policy was not implemented, as follows: Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for depression (defined as sleeping more or less than usual, losing interest in previously enjoyed activites, refusing ADLs, medications, or DT, and being more irritable or agitated). The programs stated ABC data would be used to track each episode of depression. However, Individual #3's record included "Depression Tracking Sheet" forms on which staff tracked total time of identified depression symptoms. Staff were to document an "I" for an increase or decrease in sleep pattern, or an "S" for social withdrawal and loss of interest in typically enjoyed activites or reinforcements. Staff were to document the start and end time of the episode. The forms documented Individual #3's total depressive symptoms, as follows: January = 43 hours and 15 minutes February = 45 hours and 20 minutes March = 57 hours and 15 minutes April = 25 hours May = 74 hours and 43 minutes June = 64 hours The entries documented signs and symptoms of depression lasting anywhere from 25 minutes to 8 hours at a time. However, there was no	W 149		

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W 149	Continued From page 23 indication the Suicide Policy had been implemented for those episodes lasting 2 hours or more. Examples included, but were not limited to, the following: - 1/12/15 from 2:00 - 6:30 p.m., staff documented "I" and "S" on the form, for a total of 4.5 hours. - 1/23/15 from 3:00 - 5:30 p.m., staff documented "I" and "S" on the form, for a total of 2.5 hours. - 2/11/15 from 3:00 - 6:30 p.m., staff documented "I" and "S" on the form, for a total of 3.5 hours. - 3/31/15 from 2:00 - 10:00 p.m., staff documented "S" on the form, for a total of 8 hours. - 4/5/15 from 8:30 a.m. - 2:00 p.m., staff documented "S" on the form, for a total of 5.5 hours. - 5/22/15 from 10:00 a.m. - 2:00 p.m., staff documented "I" and "S" on the form, for a total of 4 hours. - 6/30/15 from 7:30 - 9:30 a.m., staff documented "S" on the form, for a total of 2 hours. However, none of the forms documented suicide assessments had been completed as per the policy. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the City Director stated the policy should have been implemented and suicide assessments should have been completed for Individual #3 if depressive symptoms were being exhibited for 2 or more hours. The QIDP, who	W 149		

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W 149	Continued From page 24 was present during the interview, stated the entries on the Depression Tracking Sheets were not triggering the completion of a suicide assessment. The facility failed to ensure the Suicide Policy was implemented for Individual #3. 2. Refer to W154 as it relates to the facility's failure to ensure thorough investigations were conducted. 3. Refer to W157 as it relates to the facility's failure to ensure appropriate corrective action was taken in response to allegations of abuse, neglect and/or mistreatment.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of the facility's policy, review of investigations and staff interview, it was determined the facility failed to ensure thorough investigations were conducted. That failure directly impacted 2 of 2 individuals (Individuals #1 and #2) for whom investigations were conducted, and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in a lack of sufficient information being collected on which to base corrective action decisions. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 5/21/13, stated "The Company and/or	W 154		9/23/15

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W 154	Continued From page 25 Administrator will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are thoroughly investigated..." a. An Investigation, undated and unsigned, documented, under the Description of Allegation section, "Unauthorized restraints on [Individual #1] to perform Blood [sic] tests." The form documented incidents took place on 1/13/15 and 3/3/15. The form stated the LPN who performed the blood draws was terminated for having authorized restraints without proper consents. Attached to the Investigation was an Incident/Accident Report which stated Individual #1 received a carpet burn to his right arm when staff assisted the nursing staff during a blood draw. The report documented the incident took place on 1/13/15 at 11:45 a.m., and stated the form was completed on 1/14/15 at 10:45 a.m. The QIDP documented on the back of the form, Individual #1 "had to go see the nurse to get his blood drawn. He didn't want to, so he had to be restrained by multiple people. He was laid on a mat, but his arm rubbed against the floor, thus causing the carpet burn." The Corrective Action section of the report stated "If restrain [sic] is necessary, it must be done in a careful manner so that he doesn't hurt himself or others." Also attached to the Investigation were 3 staff statements. One statement from another LPN, dated 5/12/15, stated Individual #1 was assisted by 5 staff to have his blood drawn on 1/13/15, and by 2 staff and the nurse on 3/3/15. The LPN documented she had limited involvement on 1/13/15 and no involvement on 3/3/15 due to her pregnancy.	W 154		

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W 154	Continued From page 26 A second statement, dated 5/20/15 and signed by the staff who completed the Incident/Accident Report, stated 3 staff held Individual #1 on a mat on the floor to accomplish the blood draw on 1/13/15. The statement documented another blood draw was completed 4/29/15. The third statement, dated 5/20/15, stated the staff was not involved but witnessed two staff holding Individual #1 in a restraint on 3/3/15 for a blood draw. It was not clear from the Investigation or the attached staff statements which staff were involved in restraining Individual #1 during which blood draw date, if there were two or three separate incidents, or the specific type of restraint that was completed during each blood draw. Additionally, no information related to lack of timely reporting, why the restraint was not identified as inappropriate following the 1/13/15 incident that resulted in the Incident/Accident Report, information indicating all staff involved had been interviewed including the LPN that was terminated, or how the incident was eventually determined to be an inappropriate restraint was present in the Investigation documentation. b. An Investigation, undated and unsigned, stated "Unauthorized restraints on [Individual #2] to perform Blood [sic] tests." The Investigation stated incidents took place 1/13/15, 3/3/15 and 4/29/15. Attached to the Investigation were 3 staff statements. One statement, dated 5/20/15 and signed by a direct care staff, stated she had been present but did not see the blood draw for	W 154		

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W 154	Continued From page 27 Individual #2 on 1/13/15. The statement indicated four people were present during the 3/3/15 blood draw, but it was not clear how Individual #2 was restrained, or by how many people. The statement indicated 3 people were involved with the blood draw on 4/29/15. A second statement from an LPN, dated 5/12/15, documented Individual #2 was taken home rather than having his blood drawn on 4/29/15 due to agitation. The statement documented Individual #2 was "assisted by 3 staff and a lab tech" during a blood draw in March 2015, and by 2 staff on 1/13/15. A third statement, dated 5/28/15, documented the staff witnessed two staff holding Individual #2's arms while an LPN attempted to draw his blood on 1/13/15. It was not clear from the Investigation or the attached staff statements which staff were involved in restraining Individual #2 during which blood draw date, or the specific type of restraint that was completed during each blood draw. Additionally, no information related to lack of timely reporting, why there were discrepancies between staff statements, information indicating all staff involved had been interviewed including the LPN that was terminated, or how the incident was eventually determined to be an inappropriate restraint was present in the Investigation documentation. During an interview on 7/31/15 from 8:30 a.m. - 11:45 a.m., the QIDP stated the incidents were not initially identified as potential abuse because he assumed the nurse could authorize restraint for medical purposes. The QIDP stated there	W 154		

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W 154	Continued From page 28 was no additional information related to the incidents. The RN, who was present during the interview, stated she identified the inappropriate restraints during a chart review in May 2015, which was what initiated the investigations. The City Director, who was also present, confirmed the means of identifying the concerns and stated the investigations were not thorough. The facility failed to ensure all allegations of potential abuse, neglect and mistreatment were thoroughly investigated.	W 154		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of investigations, policy review and staff interview, it was determined the facility failed to ensure appropriate corrective action was taken. That failure directly impacted 2 of 2 individuals (Individuals #1 and #2) for whom investigations were conducted, and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in a lack of sufficient corrective action being identified and implemented. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 5/21/13, stated the Administrator or designee would document all corrective action taken. a. An Investigation, undated and unsigned, stated unauthorized restraints had been used for Individual #1 during blood draws. The form	W 157		9/23/15

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W 157	Continued From page 30 Attached to the Investigation were 3 staff statements which documented up to 5 other staff were involved or present during the use of the unauthorized restraints. However, no corrective action related to failure to protect Individual #2, or failure to report the use of unauthorized restraints, could be found. During an interview on 7/31/15 from 8:30 a.m. - 11:45 a.m., the QIDP and City Director both stated no additional corrective action related to the incident had been completed. The facility failed to ensure appropriate corrective action was completed for Individual #1 and Individual #2's investigations.	W 157		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 4 of 4 individuals (Individuals #1 - #4), and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include: 1. The QIDP's program review and revision process was reviewed. During an interview on	W 159		9/23/15

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W 159	Continued From page 31 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated data from the previous month had to be summarized by the 25th of the current month. As implemented, an individual could meet criteria on a training program, but a month would pass prior to revisions to the program being made and implemented. The City Director, who was present during the interview, stated company policy dictated data summation for the previous month was to be completed by the 10th of the month, and program revisions made at that time. The facility failed to ensure the QIDP ensured a process for timely data review and program revision was implemented. 2. Individuals #1 - #3's raw data for ADLs was reviewed. Data sheets for multiple programs included the compilation of total task data. By compiling the score for all steps of the program, the data did not reflect individuals' actual performance in relation to the identified objective. Examples included, but were not limited to, the following: a. Individual #3's 8/21/14 IPP stated he was a 30 year old male whose diagnoses included mild mental retardation, bipolar disorder, and IED. - Eat Slowly: Individual #3's program objective stated he would take a drink after 3 - 4 bites of food with a gesture cue in 40% of trials. Data was collected on six steps which included takes a bite of food, chews the food, swallows the food, sets his utensil down, takes a drink after 3 - 4 bites, and repeats steps 1 - 5. Each step was	W 159		

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W 159	Continued From page 32 scored as successful if Individual #3 completed the step with a gesture cue or better. The total task score was then recorded as Individual #3's progress for the month. However, when compared to his score for the identified step that matched the objective (takes a drink after 3 - 4 bites), the total task data was not reflective of his actual progress, as follows: January: total task = 67%, step identified in objective = 0% February: total task= 95%, step identified in objective = 91% March: total task = 80%, step identified in objective = 0% April: total task = 64%, step identified in objective = 66% May: total task = 96%, step identified in objective = 80% June: total task = 55%, step identified in objective = 0% - Tooth brushing January: total task = 80%, step identified in objective = 80% February: total task = 70%, step identified in objective = 70% March: total task = 89%, step identified in objective = 83% April: total task = 67%, step identified in objective = 82% May: total task = 83%, step identified in objective = 80% June: total task = 59%, step identified in objective = 25% - Budgeting/Money Management January: total task = 0%, step identified in	W 159		

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W 159	Continued From page 33 objective = 0% February: total task = 25%, step identified in objective = 0% March: total task = 100%, step identified in objective = 100% April: total task = 100%, step identified in objective = 100% May: total task = 25%, step identified in objective = 0% June: total task = 67%, step identified in objective = 100% Individual #3's total task data did not accurately indicate his progress, or lack thereof, related to his training objectives. b. Individual #2's 11/6/14 IPP stated he was a 24 year old male whose diagnoses included profound intellectual disability and autism. - Tooth Brushing: Individual #2's program objective stated he would place a tooth brush inside his mouth with light physical assistance in 15% of trials. Data was collected on 5 steps which included placing the tooth brush inside his mouth, moving the tooth brush against his teeth for 3 seconds, brushing his upper teeth, brushing his lower teeth, and rinsing his mouth. Each step was scored as successful if Individual #2 completed the step with a light physical cue or better. The total task score was then recorded as Individual #2's progress for the month. However, when compared to his score for the identified step that matched the objective (places tooth brush inside of mouth), the total task data was not reflective of his actual progress, as follows:	W 159		

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W 159	Continued From page 34 January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 46%, step identified in objective = 100% March: total task = 81%, step identified in objective = 100% April: total task = 100%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 85%, step identified in objective = 92% - Toileting January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 76%, step identified in objective =100% March: total task = 82%, step identified in objective = 96% April: total task = 100%, step identified in objective = 100% May: total task = 34%, step identified in objective = 78% June: total task = 72%, step identified in objective = 100% - Hand Washing January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 29%, step identified in objective = 100% March: total task = 78%, step identified in objective = 100% April: total task = 85%, step identified in objective = 100%	W 159		

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W 159	Continued From page 35 May: total task = 45%, step identified in objective = 91% June: total task = 60%, step identified in objective = 100% Individual #2's total task data did not accurately indicate his progress, or lack there of, related to his training objectives. c. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability and Down Syndrome. - Hand Washing: Individual #1's program objective stated he would place his hands under running water with a light physical cue in 75% of trials. Data was collected on 4 steps which included placing his hands under running water, applying soap, lathering hands, and rinsing hands. Each step was scored as successful if Individual #1 completed the step with a light physical cue or better. The total task score was then recorded as Individual #1's progress for the month. However, when compared to his score for the identified step that matched the objective (places his hands under running water), the total task data was not reflective of his actual progress, as follows: January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 66%, step identified in objective = 66% March: total task = 62%, step identified in objective = 30%	W 159		

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W 159	Continued From page 36 April: total task = 100%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 45%, step identified in objective = 90% - Eating January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 100%, step identified in objective = 100% March: total task = 91%, step identified in objective = 100% April: total task = 84%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 83%, step identified in objective = 100% - Shaving January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 100%, step identified in objective = 100% March: total task = 52%, step identified in objective = 64% April: total task = 25%, step identified in objective = 20% May: total task = 50%, step identified in objective = 66% June: total task = 35%, step identified in objective = 46% Individual #1's total task data did not accurately indicate his progress, or lack there of, related to	W 159		

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	13G063		08/03/2015

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W 159	Continued From page 37 his training objectives. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the data should match individuals' objectives. The QIDP and City Director both stated the total task data was not reflective of individuals' abilities or progress. The facility failed to ensure Individual #1 - #3's ADL data was analyzed sufficient to demonstrate the individuals' actual performance on objectives. 2. The Behavior Tracking, dated 2/2015 - 6/2015, for Individual #3 was reviewed. The documentation did not include all maladaptive behaviors, resulting in the potential for inaccurate behavior numbers to be reported to the physician, as follows: Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. a. The assessment defined Individual #3's socially offensive behavior as making rude remarks, arguing, yelling and bossing or teasing others. Individual #3's Behavior Tracking forms included arguing, bossing and teasing others under the socially offensive category. However, the tracking form included "rude gestures" and yelling	W 159		

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W 159	Continued From page 38 under the category of "Informal Behaviors." Individual #3's maladaptive behavior numbers were totaled from the tracking sheet and transferred to the QIDP Tracking form. The two tracking forms were compared, and the numbers on the QIDP Tracking form did not include the numbers from the "Informal Behaviors" category. b. Individual #3's assessment defined depressive symptoms as sleeping more or less than usual, losing interest in previously enjoyed activities, refusing ADLs, medications or DT and being more irritable or agitated. The assessment documented the symptoms were tracked by the amount of time they were exhibited. Individual #3's 2/2015 Behavior Tracking included ignoring under the "Informal Behaviors" category. Further, the Behavior Tracking forms, dated 3/2015 - 6/2015, included "Ignores/Refuses Program" under Informal Behaviors. However, the Informal Behaviors were tracked by number of occurrence, not by time exhibited. c. Individual #3's assessment defined anxiety symptoms as repeating himself, obsessing over an activity or event, restlessness, pacing and "being keyed up/overly excited or on edge." The assessment documented the symptoms were tracked by the amount of time they were exhibited. However, Individual #3's Behavior Tracking forms included obsessing under Informal Behaviors. Further, the "Informal Behaviors" were tracked by number of occurrence, not by time exhibited.	W 159		

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W 159	Continued From page 39 When asked, during an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated all of the maladaptive behaviors exhibited should have been added to the total number for the corresponding objective and reflected on Individual #3's QIDP Tracking. The facility failed to ensure the QIDP ensured behavior tracking was completed in such a way to monitor each maladaptive behavior comprehensively. 4. Refer to W124 as it relates to the facility's failure to ensure the QIDP ensured sufficient information was provided to guardians on which to base consent decisions. 5. Refer to W129 as it relates to the facility's failure to ensure the QIDP ensured an individual's right to privacy was promoted. 6. Refer to W137 as it relates to the facility's failure to ensure the QIDP ensured an individual's ability to maintain and use personal possessions was promoted. 7. Refer to W196 and related deficiencies as they relate to the facility's failure to ensure the QIDP ensured an individual was provided with an aggressive and consistent active treatment program. 8. Refer to W278 as it relates to the facility's failure to ensure the QIDP ensured less restrictive interventions were attempted and proven ineffective prior to the implementation of restrictive interventions. 9. Refer to W289 as it relates to the facility's	W 159		

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W 159	Continued From page 40 failure to ensure the QIDP ensured behavioral interventions were sufficient to address individuals' maladaptive behaviors. 10. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured individuals' drugs used to address maladaptive behaviors were appropriately incorporated into a plan. 11. Refer to W313 as it relates to the facility failure to ensure the QIDP ensured the risk of an individual's maladaptive behavior outweighed the potential risk of side effects for restrictive drugs. 12. Refer to W481 as it relates to the facility's failure to ensure the QIDP ensured menus were maintained for foods actually served.	W 159		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of necessary services and supports being provided to individuals in order to adequately address their individualized needs. The findings include: 1. Refer to W196 as it relates to the facility's failure to ensure each individual was provided with continuous and consistent active treatment services in accordance with their identified needs.	W 195		9/23/15

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W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. 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 were provided with continuous and consistent active treatment services in accordance with their individualized needs for 1 of 4 individuals (Individual #4) whose active treatment programs were reviewed. That failure resulted in individuals' not receiving services and supports necessary to meet their identified needs. The findings include: 1. Individual #4's IPP, dated 1/15/15, documented a 39 year old male whose diagnoses included severe intellectual disability, autism, stereotypic/repetitive disorder, and seizure disorder. a. Individual #4 was observed on 7/27/15 from 2:30 - 3:40 p.m. During the 50 minute observation period, the following was noted: 2:30 - 2:55 p.m.: Individual #4 was observed to be sitting on the couch in the living room. At 2:35 p.m., he walked down the hallway, then returned	W 196		9/23/15

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W 196	Continued From page 42 to the couch in the living room, where he remained unengaged in activities until 2:55 p.m. 2:55 - 3:10 p.m.: Individual #4 looked out the front window, walked to the kitchen and then walked to the back of the house to the bathroom. At 3:00 p.m., Individual #4 came out of hall restroom and stood in the hallway buttoning his shorts. Individual #3 verbally directed him to his bedroom. Individual #4 did not respond and went into the living room. At 3:03 p.m., a DCS verbally prompted him twice to go to his room, change his clothes and wash his hands. Individual #4 then went to his bedroom, where he remained until 3:10 p.m. 3:10 - 3:25 p.m.: Individual #4 returned to the living room, sat on the couch, and was noted to be holding a pencil. At 3:20 p.m. a DCS said "hi" to Individual #4 and he walked with the staff and Individual #1 to the staff closet. Individual #4 then went back to his bedroom, where he remained until 3:25 p.m. 3:25 - 3:40 p.m.: At 3:25 p.m. Individual #4 returned to the couch and sat, unengaged in activites until 3:40 p.m. At 3:40 p.m., he went to the staff closet, obtained a blank sheet of paper then returned to the couch, where he remained when the observation ended. Other than using the restroom, Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 50 minute observation period. b. Individual #4 was observed on 7/27/15 from 5:00 - 5:50 p.m. During the 50 minute observation period, the following was noted:	W 196		

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W 196	Continued From page 43 5:00 - 5:30 p.m.: Individual #4 was sitting on the couch in the living room, intermittently holding a pencil. 5:30 - 5:45 p.m.: Individual #4 sat at the dining table and ate the evening meal. At 5:37 p.m., DCS prompted Individual #4 to take a drink, which he did. Individual #4 then continued eating, finished his meal, and took his plate to the kitchen at 5:40 p.m. He returned to the dining table, finished his drink and then went to sit on the living room couch at 5:45 p.m. 5:45 - 5:50 p.m.: At 5:45 p.m., Individual #4 was sitting on the couch in the living room, intermittently holding a pencil, where he remained when the observation ended. Other than eating dinner and taking his plate to the kitchen, Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 50 minute observation period. c. Individual #4 was observed on 7/28/15 from 6:26 - 7:35 a.m. During the 1 hour and 9 minute observation period, the following was noted: 6:26 - 7:00 a.m.: Individual #4 came out of his bedroom and sat on the couch in the living room, where he remained until 6:30 a.m. Individual #4 stood up, then sat back down until 6:54 a.m. At that time, Individual #4 walked to the refrigerator, and then returned to the couch. At 6:58 a.m., he walked down the hallway with a DCS, then returned to the living room couch at 7:00 a.m. 7:00 - 7:10 a.m.: Individual #4 was sitting on the	W 196		

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W 196	Continued From page 44 living room couch. A DCS offered him the remote control for the television. Individual #4 did not respond. He was then prompted to take his morning medications and he went down the hall and into the bathroom, where he remained until 7:10 a.m. 7:10 - 7:30 a.m.: Individual #4 came out of the bathroom and returned to the couch, where he remained intermittently holding a pencil and smelling his fingers until the observation ended at 7:30 a.m. Other than taking his medications, Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 1 hour and 9 minute observation period. d. Individual #4 was observed on 7/28/15 from 11:05 - 11:45 a.m. During the 40 minute observation period, the following was noted: 11:05 - 11:45 a.m.: Individual #4 was standing in the kitchen. At 11:10 a.m., he went to the living room and was sitting on the couch. He was observed intermittently holding a pencil. A DCS prompted him to do laundry. Individual #4 did not respond and remained on the couch. At 11:35 a.m., a DCS prompted Individual #4 to go outside with her for pedestrian safety. Individual #4 did not respond and remained on the couch until 11:44 a.m. At 11:44 a.m., Individual #4 went to the front door. A DCS told him he needed to wait for staff and prompted him to help sweep the floor. Individual #4 did not respond to the request and returned to the couch, remaining seated until the observation ended at 11:45 a.m.	W 196		

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W 196	Continued From page 45 Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives during the 40 minute observation period. Additionally, Individual #4's IPP stated he required 1:1 line-of-sight supervision between the hours of 6:00 a.m. and 2:00 p.m. However, during the observations conducted on 7/28/15 from 6:26 - 7:35 a.m. and from 11:05 - 11:45 a.m., Individual #4 was not observed to be consistently provided with a 1:1 staff. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #4 should have been offered activities per his programming throughout the observations. The City Director stated his 1:1 staff should not have left him alone during his hours of increased supervision and the staff should have been continuously attempting to engage Individual #4. The facility failed to ensure Individual #4 was consistently encouraged or prompted to participate in functional, meaningful activities. 2. Refer to W212 as it relates to the facility's failure to ensure that evaluation data was available to support each individual's diagnoses. 3. Refer to W214 as it relates to the facility's failure to ensure assessments contained comprehensive information. 4. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs included objectives to meet their needs. 5. Refer to W234 as it relates to the facility's	W 196		

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W 196	Continued From page 46 failure to ensure individuals' training programs included sufficient direction to staff regarding how to implement the intervention strategies. 6. Refer to W239 as it relates to the facility's failure to ensure individuals' programs included provisions for training of replacement behaviors. 7. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their IPPs. 8. Refer to W250 as it relates to the facility's failure to ensure active treatment schedules were consistent with the individuals' objectives. 9. Refer to W252 as it relates to the facility's failure to ensure sufficient data was collected to determine the efficacy of intervention strategies for each individual. 10. Refer to W257 as it relates to the facility's failure to ensure program plans were revised when individuals failed to progress towards their identified objectives. 11. Refer to W262 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the approval of the human rights committee. 12. Refer to W263 as it relates to the facility's failure to ensure restrictive interventions were implemented only with guardian consent.	W 196		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities	W 212		9/23/15

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W 212	Continued From page 47 and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure that evaluation data was available to support the diagnoses for 1 of 3 individuals (Individual #1) whose assessments were reviewed. This resulted in the potential for an individual to receive unnecessary interventions based on inaccurate diagnoses. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. a. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's 4/10/12 psychiatric evaluation did not include a diagnosis of depression and no additional evaluation data such as when the symptoms started, the frequency, severity and duration of the symptoms, etc. was present in Individual #1's records. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated Individual #1's depressive symptoms had not been assessed and the decision to initiate the medication was based on anecdotal information provided a	W 212		

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W 212	Continued From page 48 couple of months prior to the initiation of the medication. The facility failed to ensure comprehensive evaluation data was present to support the diagnosis of depression for Individual #1. b. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair	W 212		

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W 212	Continued From page 49 of clothing..." When asked during an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the City Director stated Individual #1's urination issues were believed to be more related to dementia than to maladaptive behavior. However, Individual #1's records did not include evaluation data to support the diagnosis of dementia. When asked, during a follow-up interview on 8/4/15 from 9:45 - 9:50 a.m., the City Director stated there was no assessment information or other type of documentation related to Individual #1's dementia. The facility failed to ensure comprehensive evaluation data was present to support the diagnosis of dementia for Individual #1.	W 212		
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 observation, record review and staff interview, it was determined the facility failed to ensure assessments contained comprehensive information for 3 of 3 individuals (Individuals #1 - #3) whose assessments were reviewed. This resulted in a lack of behavioral and developmental information on which to base program intervention decisions. The findings include:	W 214		9/23/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 50 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. a. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's 3/28/14 Functional Behavioral Assessment did not include information related to the depressive symptoms such as when the symptoms started, the frequency and duration of the symptoms, less restrictive interventions attempted and found to be ineffective prior to the initiation of the medication, etc. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated Individual #1's depressive symptoms had not been assessed and the decision to initiate the medication was based on anecdotal information provided a couple of months prior to the initiation of the medication. The facility failed to ensure Individual #1's depressive symptoms were adequately assessed. b. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage.	W 214		

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	13G063		08/03/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 51 When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair of clothing..." The assessment did not address the function of Individual #1's other socially offensive behavior, including walking naked through the house, invading others' privacy, turning lights off or throwing his wet clothing on others. The assessment did not include information related to storing Individual #1's clothing and possessions in the garage. Further, when Individual #1 had soiled his clothing and wanted to access his clean clothes independently, he was required to walk naked, from his bedroom, down	W 214		

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W 214	Continued From page 52 the hallway and to the garage. The assessment did not address if his attempts to independently access his clothes would also be counted as socially offensive behavior, defined, in part, as "walking naked through the house." The "Recommended Proactive/Replacement Behavioral Objective" section of the assessment stated "[Individual #1] will be provided with 2 clothing options at the beginning of the day or following an incident of incontinence. This will give him the ability to choose that which he wants to wear and thus the incidents of urinating in his pants and other maladaptive behaviors that follow it will be prevented and/or decreased." However, the relationship between Individual #1's episodes of incontinence and invading others' privacy and turning lights off was not evident. When asked during an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the City Director stated Individual #1's urination issues were believed to be more related to dementia than to maladaptive behavior. However, Individual #1's Functional Behavior Assessment did not include information related to Individual #1's dementia or its impacts on his socially offensive behaviors. When asked, during a follow up interview on 8/4/15 from 9:45 - 9:50 a.m., the City Director stated there was no assessment information or other type of documentation related to Individual #1's dementia. The facility failed to ensure Individual #1's socially offensive behavior was comprehensively	W 214		

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W 214	Continued From page 53 assessed. 2. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. His assessment did not include accurate, comprehensive information, as follows: a. Individual #3's Behavioral Assessment documented he could not control his depression. The assessment documented Individual #3 engaged in the other maladaptive behaviors to: - Control the environment - Escape or avoid non-preferred activities and tasks - Get a reaction or attention from staff Information related to how, or if, the behaviors were different for the various functions could not be found. Individual #3's Positive Behavior Support Intervention Plan for socially offensive behavior, dated 8/15/14, and for suicidal ideation and aggression, both dated 4/1/15, documented under the Positive Intervention(s) section, Individual #3 was to use exercise, relaxation (such as listening to music in his room, playing video games, reading magazines or watching a movie) and positive self-talk as coping skills. The plans each stated when Individual #3 began exhibiting anxiety or depression symptoms,	W 214		

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W 214	Continued From page 54 defined as precursor behaviors, staff were to offer Individual #3 materials to utilize as coping skills (such as headphones, video games, etc.) and to assist him to use the materials as necessary. It was not clear how engaging in preferred activities was not reinforcing Individual #3's desire to "control his environment and/or to escape non-preferred activities and tasks." Further, Individual #3's Positive Behavior Support Intervention Plan for depression, dated 4/1/15, documented he "demonstrates the following symptoms: isolating in his room..." The assessment did not specify how to determine when Individual #3's time in his room was task avoidance, a need to cope or isolation from depression. b. Individual #3's Positive Behavior Support Intervention Plan for depression documented the definition included "sleeping more or less than usual." However, Individual #3's Behavioral Assessment did not contain additional information clarifying how to determine when Individual #3's change in sleep was related to environmental changes, medical concerns or being maladaptive. c. Individual #3's Positive Behavior Support Intervention Plan for aggression included the following in the interventions: "Please note, staff should not mention [Individual #3's] eyeglasses or try to remove them during a behavior as this escalates the behavior and draws attention to his glasses and they typically	W 214		

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W 214	Continued From page 55 end up broken. Staff should verbally praise [Individual #3] for removing them himself and/or handing them to staff." However, information regarding Individual #3's eyeglasses in relation to his maladaptive behavior could not be found in his assessment. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated the assessment needed revised. The facility failed to ensure Individual #3's Behavioral Assessment included comprehensive information. 3. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's Behavioral Assessment, dated 11/5/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, disruptive behaviors and physical aggression. a. Individual #2's Behavior Tracking, dated 3/2015 - 6/2015, documented Individual #2 engaged in self-abuse defined as biting or hitting himself, as follows: March: 16 times April: 67 times May: 36 times June: 5 times However, no information related to self-abuse could be found in Individual #2's Behavioral Assessment.	W 214		

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W 214	Continued From page 56 b. The Behavioral Assessment documented following disruptive behavior, Individual #2 typically had "Time to himself, outside." However, Individual #2's record contained 1:1 Supervision Guidelines, dated 4/27/15, which documented Individual #2 required line-of-sight supervision during all waking hours, except when he was in his bedroom alone. The assessment did not include additional information regarding how time alone affected his 1:1 supervision needs. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated the Behavioral Assessment needed revised. c. Individual #2's CFA, dated 11/1/14, was reviewed and contained multiple sections of tasks that were deemed "not applicable" and were subsequently not assessed. Examples of areas marked as "N/A" included, but were not limited to, the following: - Money Management: All 18 tasks - Money Management and Shopping: All 37 tasks - Writing Skills: 14 tasks - Time Management: 18 tasks - Phone Skills: 13 tasks During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated the assessment did not get completed.	W 214		

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W 214	Continued From page 57 The facility failed to ensure Individual #2's assessments 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: Based on record review and staff interview, it was determined the facility failed to ensure each individual's IPP included objectives to meet their identified needs for 2 of 4 individuals (Individuals #1 and #2) whose IPPs were reviewed. This resulted in a lack of program plans designed to promote individuals' independence and maximize their developmental potential. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's IPP did not include an objective related to his depressive symptoms.	W 227		9/23/15

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W 227	Continued From page 58 When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no objective in place to address Individual #1's depressive symptoms. The facility failed to ensure a specific objective for Individual #1's depressive symptoms was developed and implemented. 2. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's Behavior Tracking, dated 3/2015 - 6/2015, documented Individual #2 engaged in self-abuse defined as biting or hitting himself, as follows: March: 16 times April: 67 times May: 36 times June: 5 times However, Individual #2's IPP did not include an objective for self-abuse. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated an objective for self-abuse needed to be developed. The facility failed to ensure Individual #2's IPP included specific objectives necessary to meet his identified behavioral needs.	W 227		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be	W 234		9/23/15

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W 234	Continued From page 59 used. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 3 of 4 individuals (Individuals #1 - #3) whose training plans were reviewed. This resulted in a lack of instructions to staff being included in an individual's programs. The findings include: 1. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's IPP contained 25 priority training objectives. The corresponding training programs were reviewed and 10 were found to contain insufficient instructions for staff. The Teaching Procedure section in each of the 10 programs, including tooth brushing, spelling and paraphrasing, contained blanks where the suggested prompts staff were to use should have been identified. The programs did not specify how, when, or how often, staff were to prompt Individual #3. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated a staff would not know which cues to use or the steps of the program based on the information written. The facility failed to ensure Individual #3's training programs included sufficient direction to staff. 2. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the individuals' program	W 234		

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W 234	Continued From page 60 plans.	W 234		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 2 of 3 individuals (Individual #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 IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. a. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's record did not include a program plan, including replacement behavior training, related to his depressive symptoms.	W 239		9/23/15

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W 239	Continued From page 61 When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no program plan in place to address Individual #1's depressive symptoms. The facility failed to ensure plans, including replacement behavior training, were developed and implemented to address Individual #1's depressive symptoms. b. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair of clothing..." The "Recommended Proactive/Replacement Behavioral Objective" section of the assessment stated "[Individual #1] will be provided with 2 clothing options at the beginning of the day or following an incident of incontinence. This will give him the ability to choose that which he wants to wear and thus the incidents of urinating in his pants and other maladaptive behaviors that follow it will be prevented and/or decreased." However, the relationship between Individual #1's episodes of incontinence and invading others'	W 239		

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W 239	Continued From page 62 privacy and turning lights off was not evident. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated there was no functional replacement behavior developed for Individual #1's invading others' privacy or turning off lights. The facility failed to ensure replacement behaviors were established based on the function of Individual #1's socially offensive behaviors of invading others' privacy and turning lights off. 2. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. Individual #3's replacement behaviors were reviewed and were not appropriate replacements for the maladaptive behavior, as follows: a. The assessment stated Individual #3 engaged in socially offensive behavior, defined as making rude remarks to others, arguing or yelling at others, bossing or teasing others and threatening others. The assessment stated Individual #3 engaged in socially offensive behavior in an "attempt to control his environment and/or to escape non-preferred activities and tasks and/or to gain attention and/or get a reaction from staff." The assessment included a replacement behavior for socially offensive behavior that stated Individual #3 would remove himself from	W 239		

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W 239	Continued From page 63 the situation and choose a coping skill, such as listening to music or playing video games. It was not clear how removing himself from the situation and engaging in a leisure activity was not reinforcing Individual #3's desire to "control his environment and/or to escape non-preferred activities and tasks." Further, the replacement behavior was not functionally related to gaining attention from staff. b. The assessment stated Individual #3 engaged in aggression, defined as hitting others or objects (walls), pushing others, kicking others, scratching others and attempts. The assessment stated he engaged in aggression to get a reaction or attention from staff, to escape an undesirable task and to control his environment. The assessment included a replacement behavior for aggression which stated Individual #3 would utilize a punching bag. The replacement behavior was not functionally related to gaining a reaction or attention from staff or escaping an undesirable task. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #3's assessment and replacement behavior objectives needed revised. The facility failed to ensure Individual #3's replacement behaviors were functionally related to his maladaptive behaviors.	W 239		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has	W 249		9/23/15

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W 249	Continued From page 64 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 3 of 4 individuals (Individuals #2 - #4) whose programs were reviewed. This resulted in individuals' programs not being implemented. The findings include: 1. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. a. Individual #2's record contained 1:1 Supervision Guidelines, dated 4/27/15, which documented Individual #2 would require line-of-sight supervision during all waking hours, except when he was in his bedroom alone. The guidelines included "This means that staff should be able to see any part of [Individual #2's] body. Staff must also maintain closer proximity to [Individual #2] than any other resident." However, during observations completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes, Individual #2 was noted to be away from staff. Examples included, but were not limited to, the following:	W 249		

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	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 65 - 7/27/15 at 3:15 p.m., Individual #2 was noted to exit the facility to the back and began swinging on the swing set. No door or window to the backyard was open. Individual #2's staff, DCS G, was in the dining area monitoring Individual #5 on the computer. DCS G joined Individual #2 in the backyard briefly at approximately 3:23 p.m. before coming back inside the facility, again closing the door, and offering Individual #1 assistance. Individual #2 came inside and joined DCS G at approximately 3:27 p.m. - 7/28/15 at 9:35 a.m., Individual #2 was noted to be in the backyard of the facility swinging on the swing set with DCS F. DCS F was observed to come inside the facility to get a beverage, closing the door behind her. No window was noted to remain open. DCS F took the beverage to Individual #2, who remained outside during this time. - 7/28/15 at 11:35 a.m., Individual #2 was noted to be in the backyard of the facility swinging on the swing set with DCS F and Individual #1. At 11:38 a.m., DCS F and Individual #1 were noted to come into the facility, leaving Individual #2 outside alone for a short period of time. All doors and windows to the backyard were noted to be closed. - 7/28/15 at 11:45 a.m., Individual #2 was again noted to be in the backyard of the facility swinging on the swing set with DCS F and Individual #1. DCS F came inside, leaving Individual #2 and Individual #1 alone in the backyard. Doors and windows to the backyard were noted to be closed. - 7/28/15 at 4:00 p.m., Individual #2 engaged in	W 249		

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W 249	Continued From page 66 spitting behavior. DCS D went down the hall, returning with Individual #2's bandana. While DCS D left to obtain the bandana, Individual #2 remained in the common area with Individual #4 and Individual #5. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated if a window or door was open while Individual #2 was in the backyard, staff monitoring may have been sufficient. The City Director stated Individual #2 should not have been left alone or out of the line-of-sight of staff. b. Individual #2's Behavioral Assessment, dated 11/5/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, disruptive behaviors and physical aggression. Individual #2's Behavior Intervention Plan for socially offensive behavior, dated 10/31/14, included interventions during the behavior as follows: - Redirect to communication tools - Step out of the trajectory and block as needed - Hand him a surgical mask Observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to repeatedly spit, resulting in staff intervention inconsistent with his behavior plan, as follows: 7/27/15 from 2:30 - 3:45 p.m.: - 3:35 p.m. Individual #2 began spitting. DCS E verbally cued Individual #2 to stop the behavior. DCS E then obtained a bandana which she provided to Individual #2 and he proceeded to	W 249		

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W 249	Continued From page 67 chew on. 7/28/15 from 6:26 - 7:35 a.m.: - 6:45 a.m. Individual #2 began spitting. DCS F verbally cued Individual #2 to stop the behavior. No further interventions were attempted. - 7:00 a.m. Individual #2 began spitting. DCS F stated to Individual #2 that he needed to stop the behavior or she would have to get his surgical mask. From 3:50 - 4:15 p.m.: - 4:05 p.m. Individual #2 was engaged in spitting behavior. DCS D obtained a bandana which she gave to Individual #2 and he proceeded to chew on. However, the use of a bandana could not be found in Individual #2's behavior plan. Further, at no point during the observations was Individual #2 provided with a surgical mask. Additionally, Individual #2 was not observed to utilize, or be cued to utilize, his communication tool (PECS). During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #2's behavior plan should have been implemented as written. The facility failed to ensure Individual #2 received interventions consistent with his programs. 2. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 68 Individual #3's Behavioral Assessment, dated 8/15/14, documented for a replacement behavior, Individual #3 "will write a shift schedule at the beginning of each shift (AM, PM, DT) stating what he is going to do at specific time frames [sic] to give him more control over his day with a specific verbal cue given at 50% for three consecutive months by 8/31/14." During an observation on 7/28/15 from 11:05 - 11:50 a.m., Individual #3 was observed to utilize a white board for his shift schedule. The white board was noted to have a list of no less than 10 tasks for Individual #3. However, the board was not observed to have specific timeframes for any of the tasks. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #3's white board schedule should have included specific timeframes. The facility failed to ensure Individual #3 received interventions consistent with his programs. 3. Individual #4's IPP, dated 1/15/15, documented a 39 year old male whose diagnoses included severe intellectual disability, autism, stereotypic/repetitive disorder, and seizure disorder. Throughout observations conducted on 7/27/15 and 7/28/15, Individual #4 was not noted to receive continuous active treatment of needed interventions and services as identified in his IPP. Examples included, but were not limited to, the following:	W 249		

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W 249	Continued From page 69 a. Individual #4's IPP included an objective for Individual #4 to "...structure his leisure time by choosing an activity from a choice of three with a nonspecific verbal cue..." Individual #4's 2/2015 leisure choice program plan stated staff were to give Individual #4 a choice of 3 activities during leisure time by showing him a picture of the activity. The plan did not include information related to what activities Individual #4 was to be offered. However, his Sunday through Saturday "P.M. Schedule" stated "Leisure" was scheduled from 2:00 - 3:15 p.m. The schedule included a note which stated "Choice of Leisure:" and listed Wii, army men, train set, game room, reading, computer, etc. Individual #4 was observed on 7/27/15 from 2:30 - 3:40 p.m. During the 50 minute observation period Individual #4 was observed to primarily be sitting on the couch in the living room unengaged in activities. At no time during the observation were staff noted to implement Individual #4's leisure time plan. b. Individual #4's IPP included an objective for Individual #4 to "...chew his food at least 3 times before swallowing when eating with a specific verbal cue..." Individual #4's 2/2015 dining program plan stated staff were to "Be sure [Individual #4] takes a drink every 2-3 bites..." Individual #4 was observed on 7/27/15 from 5:00 - 5:50 p.m. From 5:30 - 5:45 p.m. Individual #4	W 249		

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W 249	Continued From page 70 sat at the dining table and ate the evening meal. At 5:37 p.m., DCS prompted Individual #4 to take a drink, which he did. Individual #4 then continued eating, finished his meal, and took his plate to the kitchen at 5:40 p.m. He returned to the dining table, finished his drink and then went to sit on the living room couch at 5:45 p.m. Staff were not observed to ensure Individual #4 drank or was prompted to drink between every 2 - 3 bites of food. c. Individual #4's IPP included an objective for Individual #4 to "...choose a task from a choice of three during DT time with a nonspecific verbal cue..." The plan stated if Individual #4 refused to participate, staff were to tell him they would give him 5 minutes to think about it and re-cue in 5 minutes. Individual #4's 2/2015 choose task program plan stated staff were to ask Individual #4 to choose a task. The plan did not include information related to how the tasks were to be offered (e.g. actual items, PECS, etc.) or what tasks to offer Individual #4. However, his Monday through Friday "A.M. Schedule" stated "Choice of Task" was scheduled from 10:00 - 11:30 a.m. The schedule included a note which stated "Choice of Task:" and listed coloring, stringing beads, writing, signing name, communication, learning alphabet, vacuuming, laundry, food prep., and community. Individual #4 was observed on 7/28/15 from 11:05 - 11:45 a.m. During the 40 minute observation period, the following was noted:	W 249		

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W 249	Continued From page 71 11:05 - 11:45 a.m.: Individual #4 was standing in the kitchen. At 11:10 a.m., he went to the living room and was sitting on the couch. He was observed intermittently holding a pencil. A DCS prompted him to do laundry. Individual #4 did not respond and remained on the couch. At 11:35 a.m., a DCS prompted Individual #4 to go outside with her for pedestrian safety. Individual #4 did not respond and remained on the couch until 11:44 a.m. At 11:44 a.m., Individual #4 went to the front door. A DCS told him he needed to wait for staff and prompted him to help sweep the floor. Individual #4 did not respond to the request and returned to the couch, remaining seated until the observation ended at 11:45 a.m. At no time during the observation was staff noted to offer Individual #4 a choice of 3 activities, prompt him that they would give him 5 minutes to think, or re-cue after 5 minutes. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #4 should have been offered activities per his programming throughout the observations. The facility failed to ensure Individual #4 received interventions and services consistent with his IPP.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 250		9/23/15

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W 250	Continued From page 72 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop active treatment schedules which were consistent and reflective of individuals' needs for 2 of 4 individuals (Individuals #3 and #4) whose active treatment schedules were reviewed. This had the potential to impede the implementation of individuals' active treatment plans and services. The findings include: 1. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's record included an A.M. Schedule, dated 10/10/12. The schedule included a handwritten note, dated 5/8/15, which indicated the document had been revised. A handwritten change was noted in the 9:15 - 9:30 block for Monday through Friday. The schedule documented "Leave 4 D.T." in each of the boxes, and each had a handwritten strikethrough on "Leave 4" resulting in only "D.T." remaining in the boxes. The schedule blocked out 9:15 a.m. - 2:00 p.m., Monday through Friday for D.T. Individual #3's P.M. Schedule, dated 10/10/12, documented D.T. continued from 2:00 - 2:45 p.m. Individual #3's active treatment schedule for day programming, dated 4/4/14, was reviewed. The schedule included activities Individual #3 was to partake in from 9:30 a.m. - 2:30 p.m. Monday through Friday. Activities included "Deli" from 10:00 a.m. Wednesday until 12:15 p.m., and again on Wednesday from 12:50 - 1:00 p.m. However, per the entrance conference with the City Director on 7/27/15 from 1:40 - 1:55 p.m., the	W 250		

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W 250	Continued From page 73 facility deli was closed during construction that commenced in April or May 2015. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the Day Treatment Program Supervisor stated she was in the process of updating Individual #3's active treatment schedule to reflect the changes to day programming. The Day Treatment Program Supervisor stated even once construction was completed, the facility deli would not be returning and Individual #3's schedule needed revised. The facility failed to ensure Individual #3's active treatment schedules included updated information. 2. Individual #4's IPP, dated 1/15/15, documented a 39 year old male whose diagnoses included severe intellectual disability, autism, stereotypic/repetitive disorder, and seizure disorder. His Active Treatment Schedules, dated 1/15/15, were reviewed and did not contain sufficient information to direct the work of staff. His Schedules did not contain formal and informal objectives and when they were to be implemented, likes and dislikes, what staff were to do if a task was finished before its scheduled time, or if he refused a task. Examples included, but were not limited to, the following: a. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 2:00 - 3:15 p.m.: The schedule stated "Leisure." 3:15 - 3:45 p.m.: The schedule stated "Break."	W 250		

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W 250	Continued From page 74 Individual #4's "P.M. Schedule" included a note which stated "Choice of Leisure:" and listed Wii, army men, train set, game room, reading, computer, etc. Additional information regarding the "Break" time was not indicated. Individual #4 was observed on 7/27/15 from 2:30 - 3:40 p.m. During the 50 minute observation period, the following was noted: 2:30 - 2:55 p.m.: Individual #4 was observed to be sitting on the couch in the living room. At 2:35 p.m., he walked down the hallway, then returned to the couch in the living room, where he remained unengaged until 2:55 p.m. 2:55 - 3:10 p.m.: Individual #4 looked out the front window, walked to the kitchen and then walked to the back of the house to the bathroom. At 3:00 p.m., Individual #4 came out of hall restroom and stood in the hallway buttoning his shorts. Individual #3 verbally directed him to his bedroom. Individual #4 did not respond and went into the living room. At 3:03 p.m., a DCS verbally prompted him twice to go to his room, change his clothes and wash his hands. Individual #4 then went to his bedroom, where he remained until 3:10 p.m. 3:10 - 3:25 p.m.: Individual #4 returned to the living room, sat on the couch, and was noted to be holding a pencil. At 3:20 p.m. a DCS said "hi" to Individual #4 and he walked with the staff and Individual #1 to the staff closet. Individual #4 then went back to his bedroom, where he remained until 3:25 p.m. 3:25 - 3:40 p.m.: At 3:25 p.m. Individual #4 returned to the couch and sat, unengaged in	W 250		

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W 250	Continued From page 75 activites until 3:40 p.m. At 3:40 p.m., he went to the staff closet, obtained a blank sheet of paper then returned to the couch, where he remained when the observation ended. Individual #4's Active Treatment Schedule did not contain sufficient information to direct the work of staff and ensure his active treatment needs were met. Further, Individual #4's IPP included an objective which stated Individual #4 would "...structure his leisure time by choosing an activity from a choice of three with a nonspecific verbal cue..." However, the formal objective was not indicated on Individual #4's Active Treatment Schedule. b. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 4:00 - 4:15 p.m.: The schedule stated "Grooming." Individual #4's IPP included formal objectives for brushing his hair, using a Kleenex, and washing his hands. However, his Active Treatment Schedule did not specify which grooming tasks Individual #4 was to complete or which formal or informal objectives were to be implemented during the grooming time block. c. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 4:15 - 5:00 p.m.: The schedule stated "Leisure." 5:00 - 5:15 p.m.: The schedule stated "ADLs." The schedule did not specify which leisure activities Individual #4 was to be offered or if the	W 250		

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W 250	Continued From page 76 4:15 - 5:00 p.m. leisure time block differed from the 2:00 - 3:15 p.m. leisure time block. Further, the schedule did not specify which ADLs Individual #4 was to complete or which formal or informal objectives were to be implemented during the ADL time block. d. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 5:30 - 6:15 p.m.: The schedule stated "Dinner." 6:15 - 6:30 p.m.: The schedule stated "Clean-up." Individual #4 was observed on 7/27/15 from 5:00 - 5:50 p.m. During the 50 minute observation period, the following was noted: 5:00 - 5:30 p.m.: Individual #4 was sitting on the couch in the living room, intermittently holding a pencil. 5:30 - 5:45 p.m.: Individual #4 sat at the dining table and ate the evening meal. At 5:37 p.m., DCS prompted Individual #4 to take a drink, which he did. Individual #4 then continued eating, finished his meal, and took his plate to the kitchen at 5:40 p.m. He returned to the dining table, finished his drink and then went to sit on the living room couch at 5:45 p.m. 5:45 - 5:50 p.m.: At 5:45 p.m., Individual #4 was sitting on the couch in the living room, intermittently holding a pencil, where he remained when the observation ended. Individual #4's Active Treatment Schedule did not include information regard what staff were to offer Individual #4 if a task was finished before its scheduled time. The Active Treatment Schedule	W 250		

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W 250	Continued From page 77 did not contain sufficient information to direct the work of staff and ensure his active treatment needs were met. e. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 6:30 - 7:00 p.m.: The schedule stated "Chores." 7:00 - 8:00 p.m.: The schedule stated "Activity." The schedule did not specify which chores or activities Individual #4 was to engage in. Additionally, his IPP included formal objectives for transferring his laundry from the washer to the dryer, vacuuming and mopping, and making his bed. His IPP also included formal objectives for exchanging items from a sensory box, participating in sensory activities, and kneading dough. However, his Active Treatment Schedule did not specify which tasks Individual #4 was to complete or which formal or informal objectives were to be implemented during the "Chores" and "Activity" time blocks. f. Individual #4's Monday through Friday "A.M. Schedule" included the following: 10:00 - 11:30 a.m.: The schedule stated "Choice of Task." The "A.M. Schedule" included a note which stated "Choice of Task:" and listed coloring, stringing beads, writing, signing name, communication, learning alphabet, vacuuming, laundry, food prep., and community. However, the "A.M. Schedule" also included a note which stated "Choice of Leisure:" which listed coloring, helping with laundry, walks, etc.	W 250		

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	13G063		08/03/2015

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W 250	Continued From page 78 The schedule did not include which activities were to be completed as tasks or leisure activities. Individual #4 was observed on 7/28/15 from 11:05 - 11:45 a.m. During the 40 minute observation period, the following was noted: 11:05 - 11:45 a.m.: Individual #4 was standing in the kitchen. At 11:10 a.m., he went to the living room and was sitting on the couch. He was observed intermittently holding a pencil. A DCS prompted him to do laundry. Individual #4 did not respond and remained on the couch. At 11:35 a.m., a DCS prompted Individual #4 to go outside with her for pedestrian safety. Individual #4 did not respond and remained on the couch until 11:44 a.m. At 11:44 a.m., Individual #4 went to the front door. A DCS told him he needed to wait for staff and prompted him to help sweep the floor. Individual #4 did not respond to the request and returned to the couch, remaining seated until the observation ended at 11:45 a.m. The schedule did not specify which tasks Individual #4 was to engage in. Additionally, his IPP included formal objectives for sitting in a chair and finishing a task and choosing a task from 3 different tasks. However, his Active Treatment Schedule did not specify which tasks Individual #4 was to complete or which formal or informal objectives were to be implemented during the "Choice of Task" time blocks. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated no other active treatment schedules were present and staff should have been following the schedules that were in place.	W 250		

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W 250	Continued From page 79 The facility failed to ensure Individual #4's Active Treatment Schedules contained sufficient information to direct the work of staff and ensure his active treatment needs were met.	W 250		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 3 of 3 individuals (Individuals #1 - #3) whose program data was reviewed. That failure had the potential to impede the ability of the treatment team in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #3's 8/21/14 IPP stated he was a 30 year old male whose diagnoses included mild mental retardation, bipolar disorder, and IED. Individual #3's raw behavioral data, from 1/1/15 - 7/27/15, was reviewed. The data did not provide sufficient information on which to evaluate the efficacy of behavioral programs. Examples included, but were not limited to, the following: a. Individual #3's record included Positive Behavior Support Intervention Plans, both dated 5/5/14, for socially offensive behavior (defined as arguing or yelling at others, bossing or teasing	W 252		9/23/15

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W 252	Continued From page 80 others, and threatening others), and aggression (defined as hitting others or objects, kicking or scratching others, and attempts to do so). Interventions for socially offensive behavior included: - verbally cue him one time that behavior is not appropriate - verbally redirect him to initiate his coping skills program - use extinction - cue him to stop and take a break Interventions for aggression included: - firmly prompt him to stop and use his coping skills - block as needed - direct him to take a break - do not engage in interaction with him, but maintain visual - give time to calm down - once calm, verbally cue to continue with scheduled task - use supported escort to direct to a quiet area - use one arm support if redirection fails - use body control if he is a threat to self or others - use secure escort if he is a threat to self or others Both programs stated ABC (Behavior Log) data would be used to track each episode of the behavior identified as maladaptive. Individual #3's behavior data from 1/1/15 - 7/27/15 was reviewed. The data did not provide sufficient information related to Individual #3's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following:	W 252		

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W 252	Continued From page 81 - 3/14/15 at 5:40 p.m., a Behavior Log documented Individual #3 "was dishing up his plate for dinner." Under the "Behavior" section, staff documented Individual #3 "was getting his plate of food when he all of a sudden got mad and said he wasn't going to eat his fruit or follow his eating program, take his shower or do chore and T.A.'s. [task analysis/programs]." Staff then documented "Swearing: 5, rude towards staff: 6, refusing programs: 6, arguing: 7, yelling: 5, ignoring: 8, talking to self: 5, noncompliant: 4." At the bottom of the section, staff documented "behavior ended!" Under the "Consequence" section, staff documented "Resident was communicated with and was encouraged to get an alternative. Didn't earn his reinforcement." However, the documentation did not indicate the sequence in which events took place, or at what point in the behavior staff implemented which interventions. Additionally, it was not clear what intervention, if any, caused the behavior to end. - 3/31/15 at 6:00 p.m., a Behavior Log documented Individual #3 was asked to do laundry. Under the "Behavior" section, staff documented "I had asked [Individual #3] to change his laundry. He told me 'No' because has had a bad day and that he was not going to do anything. I had again asked him to at lease [sic] just change it and he got even more rude about it. Rude to staff: 3." Under the "Consequence" section, staff documented "Talked to him about his behavior." However, there as no information indicating how	W 252		

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W 252	Continued From page 82 Individual #3 was "Rude to staff" beyond stating he had a bad day and did not want to do anything. The documentation did not indicate staff had verbally cued him one time that the behavior was not appropriate, that staff redirected him to initiate his coping skills program, or that staff cued him to stop and take a break. - 4/6/15 at 9:00 a.m., a Behavior Log documented Individual #3 "was in the kitchen trying to be staff." Under the "Behavior" section, staff documented Individual #3 "was trying to boss [Individual #5] around and tease him. Staff tried speaking to him but he argued with staff and refused his program to take out the trash." Staff then documented "Rude to others x6, Ignoring x6, Being staff x5, Refusing programs x1, Arguing x5, Bossing x6." Under the "Consequence" section, staff documented "Did not earn reinforcement. Spoke with [Individual #3] about his behavior." However, the documentation did not indicate the sequence in which events took place, or at what point in the behavior staff implemented which interventions. Additionally, it was not clear what intervention, if any, caused the behavior to end. - 5/12/15 at 1:56 p.m., a Behavior Log documented Individual #3 "asked for his 1:45 pm reinforcement." Under the "Behavior" section, staff documented "He had asked for his brake [sic] and staff had explained to him that he had not earned it and he got upset and was very rude to staff and when he removed himself he slammed his door." Staff then documented "rude to staff x2, slamming door x2, yelling x1." Under the "Consequence" section, staff documented "Talked to about behavior, loss of reinforcement."	W 252		

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W 252	Continued From page 83 However, there was no additional documentation that indicated why Individual #3 had not earned his 1:45 reinforcement. Additionally, the documentation did not indicate how Individual #3 was rude to staff, or that staff had implemented the interventions outlined in Individual #3's plan. - 6/11/15 at 9:55 p.m., a Behavior Log documented he asked for his medications. Under the "Behavior" section, staff documented Individual #3 "came out of his bedroom asking for bedtime meds after they had been marked as refused. He then began threatening to harm staff and family, followed by hitting walls and other residents and throwing objects at staff." Under the "Consequence" section, staff documented "talked to about behavior." However, the documentation did not indicate at what point during the incident staff implemented Individual #3's behavioral interventions (such as redirecting him to initiate his coping skills program, cueing him to stop and take a break, blocking physical aggression, etc.). During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the data was not sufficient to demonstrate if or how Individual #3's behavior plan was followed, or if the interventions were effective. b. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for suicidal ideation (defined as making threats to injure himself or stating he was going to kill himself). Interventions for suicidal ideation included: - follow suicide guidelines	W 252		

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W 252	Continued From page 84 - follow suicide protocol including placing 1:1 line-of-sight, notifying Program Supervisor or QIDP, and remaining 1:1 line-of-sight until it is determined he is not at risk The program stated ABC data would be used to track each episode of suicidal ideation. Individual #3's ABC data from 1/1/15 - 7/27/15 was reviewed. The data did not provide sufficient information related to Individual #3's suicidal ideation, or staff's response, to evaluate the efficacy of the programs. Examples included, but were not limited to, the following: - 3/10/15 at 9:25 a.m., a Behavior Log stated Individual #3 arrived at Day Treatment upset. Under the "Behavior" section, staff documented "he came into Day Treatment and started teasing [Individual #5]. He was asked to stop and he said he was going to kill himself and all staff. He also refused to do his work." Staff then documented "Staff tried talking to him and he wouldn't listen so staff extincted him giving him time to calm down." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line-of-sight, notifying the Program Supervisor or QIDP, etc.) was implemented. A Suicide Risk Assessment Sheet, completed by the same staff on 3/10/15 at 9:25 a.m., stated "he came into Day Treatment. He started teasing [Individual #5] and when ask [sic] to stop he said he would just kill himself." The Staff Response section stated "Staff asked him if he wanted to talk about what was bothering him and he said no. Then he said he was going to kill himself	W 252		

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W 252	Continued From page 85 again and kill staff, staff extincted him and put him on suicide watch." The documentation did not explain how Individual #3 could be placed on extinction and suicide watch at the same time. Additionally, the form did not include information related to how the suicide watch was implemented (placed 1:1, dangerous items removed, etc.), or for how long, or when Individual #3 was removed from suicide watch and by whom. - 3/25/15 at 9:50 a.m., a Behavior Log stated Individual #3 was looking at the newspaper. Under the "Behavior" section, staff documented "When he was asked to follow his schedule he refused and said he was going to kill himself and everybody at Day Treatment. He started kicking the board between his desk and [name of other individual] desk. Started acting like staff and tried to tell [Individual #5] what to do. He was swearing." Staff then documented "Swearing x20, Threatened to injure himself x7, threatened to injure others x5, yelling x8." Under the "Consequence" section, staff documented "Staff tried talking to him and he told staff his mom had canceled their time together. Staff tried to explain to him that that is out of our control, but he wouldn't listen. He finally was able to use his coping skills and he calmed down." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line of sight, notifying the Program Supervisor or QIDP, etc.) was implemented. A Suicide Risk Assessment Sheet, completed by	W 252		

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W 252	Continued From page 86 the same staff on 3/25/15 at 9:50 a.m., stated "He said he was going to kill himself and everyone else. Fifth time he said he's going to kill himself tonight." The Staff Response section stated "Staff asked him to follow his schedule and he refused. Staff tried talking to him and he turned his music up so staff extincted him." There was no additional information present to indicate if Individual #3 had been placed on suicide precautions, how those precautions were implemented, or who had made the determination that Individual #3 was not a risk to himself or others. - 4/18/15 at 6:10 p.m., a Behavior Log stated Individual #3 stated he did not want to eat his Mandarin oranges. Under the "Behavior" section, staff documented Individual #3 "had a very rough day and he saw what was for dinner and he said he didn't want to eat his madrian [sic] oranges he dumped them out. I told him that was his choice but he would not earn his reinforcement for the evening cause he was not following his eating program. He then stated he wasn't going to eat his dinner cause we weren't his guardians and he didn't have to listen to anyone other than his mom. He drank his liquids and started walking to his room and he said how about 'I just kill myself' and slammed his door. I went and checked on him and he was just sitting on his bed watching T.V. he said he didn't want to talk to anyone he would go talk to [City Director] on Monday. I did appropriate paperwork and Notified chain of command." Under "Consequence" staff documented "Talked to about behavior."	W 252		

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W 252	Continued From page 87 There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line-of-sight, etc.) was implemented. The documentation did not indicate who had been notified, or what, if any, directions had been given or followed. A Suicide Risk Assessment Sheet, dated 4/18/15 at 6:10 p.m. but unsigned, stated "refused to eat fruit at dinner after seeing cookies on counter. Told staff they could not make him do anything and cannot refuse him treats, staff is not his guardian so they can't boss him around only mom can. When his b-day comes he will get cake and not share w/anyone. I am going to kill myself." There was no additional information regarding implementation of suicide precautions, when Individual #3 was released from precautions or by who. - 6/11/15 at 10:05 p.m., a Behavior Log stated Individual #3 asked if it was too late to take his medications. Under the "Behavior" section, staff documented Individual #3 "came out and asked if it was too late for meds. Staff said yes because of refusing earlier. He began to threaten to kill himself and staff." Under the "Consequence" section, staff documented "Communication about behavior." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line-of-sight, notifying the Program Supervisor or QIDP, etc.) was implemented. A Suicide Risk Assessment Sheet, dated 6/11/15 at 10:00 p.m. and unsigned, stated "He was upset	W 252		

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W 252	Continued From page 88 and wanted his meds after already refusing and proper paperwork had been done and so he stated 'I will just go kill myself.'" The Staff Response section stated "followed Suicide protocol and contacted proper chain of command." However, there was no documentation indicating who was contacted, what direction if any was given, how the suicide protocol was implemented, or when Individual #3 was released from suicide precautions or by whom. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the data was not sufficient to demonstrate Individual #3's suicide protocol had been implemented or followed. c. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for depression (defined as sleeping more or less than usual, losing interest in previously enjoyed activites, refusing ADLs, medications, or day treatment, and being more irritable or agitated). Interventions for depression included: - verbally encourage to attend scheduled activities, day treatment, and programs - assist with choosing another activity or program - visually check on every 10 minutes when isolating in his room The programs stated ABC data would be used to track each episode of depression. However, Individual #3's record included "Depression Tracking Sheet" forms on which staff tracked total time of identified depression symptoms. Staff were to document an "I" for an increase or	W 252		

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W 252	Continued From page 89 decrease in sleep pattern, or an "S" for social withdrawal and loss of interest in typically enjoyed activites or reinforcements. Staff were to document the start and end time of the episode. Additionally, the form included a space for staff to document "Antecedent" and "Intervention" information. The forms documented Individual #3's total depressive symptoms, as follows: January = 43 hours and 15 minutes February = 45 hours and 20 minutes March = 57 hours and 15 minutes April = 25 hours May = 74 hours and 43 minutes June = 64 hours However, the documentation did not provide clear information as to how the symptoms were related to depression, or the frequency and type of intervention provided by staff. For example: - 1/12/15 from 2:00 - 6:30 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "Came home from Day Treatment." Under Intervention, staff documented "let him sleep." - 1/23/15 from 3:00 - 5:30 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "Came home from [Day Treatment] and went to bed." Under Intervention, staff documented "Communication/Encouragement." - 2/11/15 from 3:00 - 6:30 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "Tired, refused programs." Under Intervention, staff documented "let resident sleep."	W 252		

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W 252	Continued From page 90 - 3/31/15 from 2:00 - 10:00 p.m., staff documented "S" on the form. Under "Antecedent" staff documented "Came home from [Day Treatment]." Under Intervention, staff documented "Communication." - 4/5/15 from 8:30 a.m. - 2:00 p.m., staff documented "S" on the form. Under "Antecedent" staff documented "Staying in room playing games or laying in bed." Under Intervention, staff documented "Encouraged to join others in living room." - 5/22/15 from 10:00 a.m. - 2:00 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "talking to staff about programs and pay check." Under Intervention, staff documented "Communication/Encouragement." - 6/30/15 from 7:30 - 9:30 a.m., staff documented "S" on the form. Under "Antecedent" staff documented "Came out and refused [programs]." Under Intervention, staff documented "Encouragement, wait time." The documentation did not demonstrate staff had implemented his program by checking on Individual #3 every 10 minutes, verbally encouraging him to attend scheduled activities or programs, or assisting him to choose activities or programs. Additionally, it was not clear at what point during the identified behavior staff intervened, the frequency of intervention, or at what point the intervention was successful or not. Further, the documentation did not indicate if other issues, such as illness, were addressed as possible causes for sleep.	W 252		

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	13G063		08/03/2015

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W 252	Continued From page 91 During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the tracking sheets was not sufficient to determine if Individual #3's program had been implemented or not. d. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for anxiety (defined as repeating himself or obsessing over an activity or event, restlessness, pacing and being repetitive, being keyed up or overly excited or on edge). Interventions for anxiety included: - cue to attend scheduled activity - encourage to engage in replacement behavior - encourage him to structure his leisure time The programs stated ABC data would be used to track each episode of anxiety. However, Individual #3's record included "Anxiety Tracking Sheet" forms on which staff tracked total time of identified anxiety symptoms. Staff were to document an "R" for repeating himself and/or obsession on a specific activity, a "P" for pacing or restlessness, or an "F" for feeling keyed up or on edge. Staff were to document the start and end time of the episode. Additionally, the form included a space for staff to document "Antecedent" and "Intervention" information. The forms documented Individual #3's total anxiety symptoms, as follows: January = 13 hours and 55 minutes February = 21 hours and 34 minutes March = 52 hours and 25 minutes April = 34 hours May = 30 hours and 4 minutes	W 252		

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W 252	Continued From page 92 June = 53 hours However, the documentation did not provide clear information as to how the symptoms were related to anxiety, or the frequency and type of intervention provided by staff. For example: - 1/12/15 from 6:30 - 7:00 p.m., staff documented an "R" on the form. Under "Antecedent" staff documented "eating dinner." Under Intervention, staff documented "explained he had just stated this statement." - 2/16/15 from 2:30 - 3:30 p.m., staff documented an "R" on the form. Under "Antecedent" staff documented "Home from [Day Treatment]." Under Intervention, staff documented "Repeating about his date and his money." - 3/31/15 from 2:00 - 10:00 p.m., staff documented an "F" on the form. Under "Antecedent" staff documented "Asked to do laundry." Under Intervention, staff documented "Communication." - 4/22/15 from 7:00 - 9:30 a.m., staff documented an "F" on the form. Under "Antecedent" staff documented "Was excited and stressing about going to house 5 for [Day Treatment]." Under Intervention, staff documented "Communication/encouragement." - 5/22/15 from 8:00 - 9:40 a.m., staff documented an "R" and an "F" on the form. Under "Antecedent" staff documented "Stressing about his paycheck." Under intervention, staff documented "Communication/encouragement." - 6/15/15 from 6:00 - 7:00 p.m., staff documented	W 252		

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W 252	Continued From page 93 a "P" on the form. Under "Antecedent" staff documented "Came out of his bedroom." Under Intervention, staff documented "Little restlessness today." The documentation did not demonstrate staff had implemented his program interventions, such as cueing him to attend scheduled activities, encouraging him to engage in his replacement behavior, or encouraging him to structure his leisure time. Additionally, it was not clear at what point during the identified behavior staff intervened, the frequency of intervention, or at what point the intervention was successful or not. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the tracking sheets was not sufficient to determine if Individual #3's program had been implemented or not. The facility failed to ensure Individual #3's behavioral data provided sufficient information to judge the efficacy of his programs. 2. Individual #2's 11/6/14 IPP stated he was a 24 year old male whose diagnoses included profound intellectual disability and autism. Individual #2's raw behavioral data, from 1/1/15 - 7/27/15, was reviewed. The data did not provide sufficient information on which to evaluate the efficacy of behavioral programs. Examples included, but were not limited to, the following: Individual #2's record included 3 Behavior Intervention Plans, as follows: A plan for disruptive behavior, dated 11/7/14,	W 252		

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W 252	Continued From page 94 defined the behavior as yelling and screaming, randomly hitting objects, and throwing objects without targeting anyone. Interventions for disruptive behavior included: - refer to his communication program and attempt to gain his attention - encourage him to go to a quiet area - limit interactions with Individual #2 until no longer exhibiting the behavior - remove others from the area to prevent injury - use a blocking board until the behavior ends A plan for socially offensive behavior, dated 11/7/14, defined the behavior as spitting and rumination in places other than the bathroom sink. Interventions for socially offensive behavior included: - redirect to communication tools - block spit from hitting others - hand him a surgical mask - have him clean up "spit spots" A plan for physically aggressive behavior, dated 11/8/14, defined the behavior as hitting, kicking, and pushing others. Interventions for physically aggressive behavior included: - redirect to picture activities - block hits - redirect with a supportive escort Individual #2's raw behavior data was reviewed. The data did not provide sufficient information related to Individual #2's maladaptive behavior, or staff's response, to evaluate the efficacy of the	W 252		

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W 252	Continued From page 95 program. For example, all 3 programs stated ABC data would be used to track each episode of behavior identified as maladaptive. However, Individual #2's record included a form titled "Behavior Slip [Individual #2] (Socially Offensive)." The form was divided into columns and rows. The far left column was labeled "Time" and documented 15 minute time-blocks for each row on the form. The form covered an entire 8 hour shift. The center columns were labeled spitting, yelling, hitting objects, and pushing. The final column was labeled "Antecedent." Staff were to record a tally-mark for each observed behavior in the appropriate time-block. The bottom row of the form was labeled "Totals" where the total number of each of the 4 identified behaviors (spitting, yelling, hitting objects, and pushing) could be calculated for each shift. However, the form did not include space for staff to document interventions attempted or their outcome. As such, it would not be possible to determine if the interventions outlined in Individual #2's Behavior Intervention Plans were effective or not. Additionally, it would not be possible to determine if staff were implementing interventions correctly. For example, a form dated 2/21/15 documented Individual #2's behavior on the swing shift (2:00 - 10:00 p.m.). The form included tally-marks for each behavior between 5:00 and 6:00 p.m., with totals as follows: spitting 37 times, yelling 10 times, hitting objects 14 times, and pushing 4 times. The Antecedent column was blank. No additional	W 252		

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W 252	Continued From page 96 information was present to indicate how the behavior progressed in the one-hour timeframe, what interventions were attempted and their outcome, or why the behavior finally stopped. Additionally, in March of 2015, the form was modified to include aggression and self-abuse by changing "pushing" to "pushes others" and adding columns for throwing objects, hitting himself and hitting others. However, the form still did not provide information related to the progression of the behavior, interventions attempted, or the response to the intervention. For example, a form dated 3/21/15 documented Individual #2's behavior on the day shift (6:00 a.m. - 1:45 p.m.). The form included tally marks for behaviors, as follows: - 6:00 a.m., spitting 3 times, yelling 2 times. Antecedent - "Just woke up." - 6:15 a.m., spitting 5 times, hit self 2 times, hit others 3 times. Antecedent - "Wanting food." - 6:30 a.m., spitting 2 times. Antecedent - "Time of day." - 7:00 a.m., spitting 3 times, hit others 2 times. Antecedent - "Wanting food." - 7:15 a.m., spitting 5 times, hit others 2 times. Antecedent - repeat marks. - 9:00 a.m., spitting 5 times, yelling 1 time, hit self 1 time. Antecedent - "Time of Day [sic]." - 11:15 a.m., spitting 6 times, yelling 2 times. Antecedent - repeat marks. - 11:30 a.m., spitting 2 times, yelling 1 time. Antecedent - "Wanting food." No additional information was present to indicate how the behavior progressed, what interventions were attempted and their outcome, or why the	W 252		

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W 252	Continued From page 97 behavior finally stopped. Additionally, a Behavior Log, dated 3/21/15 from 6:00 - 6:25 a.m., stated Individual #2 was wanting food. Under the "Behavior" section, staff documented "As soon as staff walked into the house, [Individual #2] was sitting on the kitchen table he was hitting, spitting, yelling staff [sic] could hear him outside. Staff then cued him to use the restroom to get ready for the day he then started to spit and yell more one after another. Another staff cued him to go into the garage to cope. When he was out there he hit staff 3x he then ran inside sat on the Banana Chair and began to cope." Staff then documented "hit - 4, spit - 5, yell - 6." Under the "Consequence" section, staff documented "Staff communicated with him to turn his day around." The data documented on the Behavior Log between 6:00 and 6:25 a.m. was not consistent with the information documented on the Behavior Slip (spitting 5 times vs. spitting 8 times, yelling 6 times vs. yelling 2 times). Neither form documented who Individual #2 hit, or where he hit himself (in the head, leg, arm, etc.). Additionally, neither form indicated interventions as outlined in his program being implemented (i.e., blocking his spit, having him clean up "spit spots," removing others from the area, using blocking boards, using picture activities, etc.). A second Behavior Log, dated 3/21/15 from 11:00 - 11:15 a.m., stated Individual #2 was outside swinging. Under the "Behavior" section, staff documented Individual #2 "came in from outside wanting lunch but was still to [sic] early so we gave him a little bit of apple sause [sic] and he got upset with that and started throwing things	W 252		

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W 252	Continued From page 98 and yelling and bitting [sic] himself, hitting self and staff." Staff then documented "behavior ended!" Under the "Consequence" section, staff documented "Resident was communicated with about his decisions and was encouraged to calm down so he could eat/do his eating program." The Behavior Log did not document the frequency of the behaviors, and the corresponding timeframe on the Behavior Slip did not match the identified behaviors. Additionally, neither form provided clear information indicating Individual #2's behavior interventions had been implemented appropriately, or the outcome to the interventions. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the Behavior Slips and the Behavior Logs was not sufficient to determine if Individual #2's programs had been implemented or not. The facility failed to ensure Individual #2's behavioral data provided sufficient information to judge the efficacy of his programs. 3. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability and Down Syndrome. Individual #1's raw behavioral data, from 1/1/15 - 7/27/15, was reviewed. The data did not provide sufficient information on which to evaluate the efficacy of training and behavioral programs. Examples included, but were not limited to, the following:	W 252		

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W 252	Continued From page 100 - verbally redirect to a common area - explain others' privacy A plan for property destruction defined the behavior as grabbing others' eyeglasses and breaking them, tipping objects over, pulling objects off the wall or windows, and ripping objects. Interventions for property destruction included: - cue one time to stop - cue to initiate coping skills - block and use picture communication - remove the object from Individual #1 - use social stories - assist to clean up A plan for self-injurious behavior defined the behavior as hitting himself with an open hand, sticking objects, fingers, or dirt in his eye, and bending his fingers backwards. Interventions for self-injurious behavior included: - cue one time to stop - cue to initiate coping skills - block - offer saline A plan for aggression defined the behavior as hitting, kicking, and/or pushing others, or attempts. Interventions for aggression included: - cue one time that behavior is unsafe - cue to initiate coping skills - cue to a quiet area - keep distance between him and others - block - use a supportive escort	W 252		

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W 252	Continued From page 101 All four programs stated ABC data would be used to track each episode of the behavior identified as maladaptive. Individual #1's raw behavior data was reviewed. The data did not provide sufficient information related to Individual #1's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following: - 1/19/15 at 1:30 p.m., a Behavior Log documented Individual #1 came out of his bedroom into the hallway. Under the "Behavior" section, staff documented Individual #1 "urinated in his pants and came out naked. Being Naked x3, Urinating in pants x1." The "Consequence" section was blank. There was no documentation indicating how staff responded to Individual #1 urinating in his pants or being naked, what "Being Naked x3" meant, or if Individual #1 responded to interventions offered. - 2/13/15 at 5:21 p.m., a Behavior Log documented Individual #1 wanted food but dinner was not ready. Under the "Behavior" section, staff documented "He began urinating in his pants x2 and walking through the house naked x8." Under the "Consequence" section, staff documented "Talk about behavior did not earn reinforcement." There was no documentation the interventions listed in Individual #1's plans had been implemented, in what sequence, or if they were effective or not.	W 252		

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W 252	Continued From page 102 - 3/30/15 at 11:20 a.m., a Behavior Log documented staff was assisting in lunch preparations. Under the "Behavior" section, staff documented "Urinates in pants x3, walks around naked x4, tips over [Individual #2's] dresser x1, privacy invasion x1, injuring others x6, yells x7." Under the "Consequence" section, staff documented "Cued [Individual #1] to stop, redirect him, extinction with visual checks. Did not earn next reinforcement." Additionally, staff documented a supportive escort was used to remove Individual #1 from another individual's room at 11:40 a.m. However, the documentation did not indicate where Individual #1 was escorted to. Further, the documentation did not indicate at what point during the behavior the interventions listed were implemented (e.g., at what point he was cued to stop, what he was redirected to, how extinction was implemented, etc.). There was no other documentation indicating what other, if any, interventions were attempted (such as having him dress, offering other clothing, blocking him from injuring others, etc.), at what point in the behavior process the intervention attempts were made, and if they were successful or not. In addition, in April 2015, the facility began utilizing a Behavior Slip form to track Individual #1's socially offensive behavior. The form consisted of a series of columns and rows. The far left column was labeled "Time" and there were four columns labeled urinating in clothes/floor, dipping clothes in toilet, throwing wet clothing, walking naked in public, and privacy invasion. The two columns on the right were labeled	W 252		

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W 252	Continued From page 103 "Antecedent" and "Consequence." Staff were to indicate the time in the left-hand column, then place a tally-mark under the appropriate maladaptive behavior. Narrative data could be entered under "Antecedent" and "Consequence." The form did not allow for sufficient information to be documented to determine if Individual #1's behavior program was appropriately implemented, or if the interventions were successful. For example, a Behavior Slip, dated 5/1/15, included an entry at 2:30 p.m. Staff placed a tally-mark under "Urinating in Clothes/Floor" and 5 tally-marks under "Walking Naked in Public." The Antecedent and Consequence columns were blank. No additional information was present on the form to indicate what, if any, interventions were implemented by staff or Individual #1's response to the interventions. A second Behavior Slip, dated 6/8/15, included an entry for 10:45 p.m. Staff placed a tally-mark under "Urinating in Clothes/Floor." Under "Antecedent," staff documented "seeking attention." Under "Consequence," staff documented "communication." A second entry on the form, at 11:00 p.m., included 5 tally-marks under "Walking Naked in Public." The Antecedent and Consequence columns were blank. No additional information was present on the form to indicate what, if any, interventions were implemented by staff or Individual #1's response to the interventions. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the Behavior Slips	W 252		

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W 252	Continued From page 104 and the Behavior Logs was not sufficient to determine if Individual #1's programs had been implemented or not. The facility failed to ensure Individual #1's behavioral data provided sufficient information to judge the efficacy of his programs.	W 252		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure IPPs were revised when individuals failed to progress towards identified objectives for 1 of 3 individuals (Individual #3) whose program summaries were reviewed. Without revisions to program plans when progress had not been demonstrated, individuals would continue experiencing a lack of success. The findings include: 1. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Monthly Program Summaries, dated 1/2015 - 6/2015, documented a lack of progress without revisions. Examples included, but were not limited to, the following:	W 257		9/23/15

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YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 257	Continued From page 105 a. The objective for Self Administration of Medication was set at 95% success for 3 consecutive months. His monthly program summaries documented the following status of the objective: - 1/2015: 35% - 2/2015: 30% - 3/2015: 22% - 4/2015: 47% - 5/2015: 29% - 6/2015: 44% The documentation indicated the program did not meet the 95% success rate once in six months. However, no revisions to the program objective were noted. b. The objective for Exercise was set at 40% success for 3 consecutive months. His monthly program summaries documented the following status of the objective: - 1/2015: 80% - 2/2015: 0% - 3/2015: 33% - 4/2015: 0% - 5/2015: 12% - 6/2015: 13% The documentation indicated the 40% criteria was not met for five consecutive months. However, no revisions to the program objective were noted. c. The objective for Communicating/Paraphrasing was set at 95% success for 3 consecutive months. His monthly program summaries documented the following status of the objective:	W 257		

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W 257	Continued From page 106 - 1/2015: 80% - 2/2015: 70% - 3/2015: 88% - 4/2015: 75% - 5/2015: 40% - 6/2015: 41% The documentation indicated the program did not meet the 95% success rate once in six months. However, no revisions to the program objective were noted. d. The objective for Occupational Therapy was set at 50% success for 3 consecutive months. His monthly program summaries documented the following status of the objective: - 1/2015: 35% - 2/2015: 21% - 3/2015: 28% - 4/2015: 0% - 5/2015: 0% - 6/2015: 0% The documentation indicated the program did not meet the 50% success rate once in six months. However, no revisions to the program objective were noted. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated he revised programs after 3 consecutive months of progress, or a lack thereof. The QIDP stated the identified program objectives should have been revised based on Individual #3's performance percentages. The facility failed to ensure objectives were revised when Individual #3 and failed to make	W 257		

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W 257	Continued From page 107 progress towards them.	W 257		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 3 of 3 individuals (Individuals #1 - #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. Individual #1's MAR documented he received the first dose of the medication on 7/7/15. Individual #1's record contained a Written Informed Consent, dated 7/6/15, for the use of	W 262		9/23/15

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W 262	Continued From page 108 Prozac. The consent documented verbal consent from Individual #1's guardian was obtained on 7/2/15. However, HRC approval for the use of the Prozac was not obtained until 7/13/15. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated HRC approval had not been obtained prior to Individual #1's Prozac being started. The facility failed to ensure the use of Prozac was approved by the HRC prior to being initiated. 2. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's record contained restrictive interventions for which HRC approval could not be located, as follows: a. Individual #2's Physician's Orders, dated 5/6/15, included an order for Valium (an anxiolytic drug) 5 mg by mouth "30 minutes before dental." However, HRC approval for the medication could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated she could not find evidence of HRC approval. b. Individual #2's record contained 1:1 Supervision Guidelines, dated 11/11/14, which documented Individual #2 would require line-of-sight supervision during all waking hours, except when he was in his bedroom alone or in the bathroom. HRC approval for the intervention was obtained on 11/13/14.	W 262		

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W 262	Continued From page 109 Individual #2's record contained a second copy of 1:1 Supervision Guidelines, revised 4/27/15, which documented the addition of line-of-sight supervision when Individual #2 was in the bathroom. However, his record did not contain documentation of HRC approval for line-of-sight supervision while he was in the bathroom. Additionally, observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to enter the restroom with staff no less than three times. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated HRC approval was not re-obtained with the increased restriction. The facility failed to ensure HRC approval was obtained for each of Individual #2's restrictive interventions. 3. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's record contained a Written Informed Consent for his Behavior Management Program, dated 5/2/14, which documented Individual #3's "rights are restricted with the use of a formal behavior management program, including the use of Therapeutic Options supportive restraints which consist of a block, supportive escort, arm control, body control and a secure escort to prevent him from hurting himself, staff, and/or property." The consent documented	W 262		

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W 262	Continued From page 110 "the consent expires on May 2, 2015." The form was signed by two members of the HRC on 5/8/14. However, an updated consent with HRC approval from May 2, 2015 forward could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated renewed approval for Individual #3's behavior plan had not been obtained. The facility failed to ensure HRC approval was obtained for each of Individual #3's restrictive interventions.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure written guardian consent was obtained prior to the implementation of restrictive interventions for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior consent of restrictive interventions. The findings include: 1. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation.	W 263		9/23/15

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W 263	Continued From page 111 Individual #3's record contained a Written Informed Consent for his Behavior Management Program, dated 5/2/14, which documented Individual #3's "rights are restricted with the use of a formal behavior management program, including the use of Therapeutic Options supportive restraints which consist of a block, supportive escort, arm control, body control and a secure escort to prevent him from hurting himself, staff, and/or property." The consent documented "the consent expires on May 2, 2015." The form was signed by Individual #3's guardian on 5/7/14. However, an updated document with guardian consent from May 2, 2015 forward could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated renewed consent for Individual #3's behavior plan had not been obtained. The facility failed to ensure written informed guardian consent was obtained for each of Individual #3's restrictive interventions.	W 263		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	W 266		9/23/15

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W 266	Continued From page 112 ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W276 as it relates to the facility's failure to ensure systematic behavioral interventions were incorporated in the behavioral policy. 2. Refer to W278 as it relates to the facility's failure ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior. 3. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into each individual's program plan. 4. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed. 5. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs. The cumulative effect of these deficient practices significantly impeded the facility's ability to develop, consistently implement and closely	W 266		

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W 266	Continued From page 113 monitor individuals' behavioral interventions.	W 266		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on observation, record review, policy review, and staff interviews it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior, which directly impacted 1 of 3 individuals (Individual #1) whose restrictive interventions were reviewed and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in the implementation of a behavioral intervention that had not been approved by the facility. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 3:15 p.m., Individual #1 was in his bedroom with the door open and his windows uncovered. He was observed to remove his shoes and his pants and was not observed to be wearing underwear. Individual #1 then walked down the hallway and into the garage, without pants on. DCS noticed	W 276		9/23/15

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W 276	Continued From page 114 Individual #1 in the garage and redirected him back to his bedroom. Individual #1 was not able to independently access his clothes without compromising his privacy. Additionally, on 7/27/15 at 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair of clothing..." His assessment and the corresponding Behavior	W 276		

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W 276	Continued From page 115 Intervention Plan for socially offensive behavior, revised 5/1/15, were reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in either the assessment or the plan. Further, the facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 10/9/14, stated "Restriction of personal belongings" was "the removing and denying access to personal belongings in order to protect the individual from harming themselves or others." The policy did not include the removal of personal possessions for reasons other than self harm. During an interview on 8/10/15 from 1:05 - 1:10 p.m., the City Director stated the removal of items was included in policy, however, it was specifically included for instances of self-harm and/or suicidal ideation. The City Director stated the policy did not include any information related to the removal of items as a general behavioral intervention. The facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior.	W 276		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.	W 278		9/23/15

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W 278	Continued From page 116 This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 3 individuals (Individual #1) whose behavior management plans were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's record did not include documentation that less restrictive interventions had been systematically tried and found to be ineffective prior to the initiation of the medication. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no assessment or program plan in place to address Individual #1's depressive symptoms. The QIDP stated staff were reporting Individual #1 was showing loss of interest and was crying, but no tracking of these symptoms had been completed.	W 278		

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W 278	Continued From page 117 Without the implementation of less restrictive systematic interventions and monitoring, it would not be possible for the facility to ensure less restrictive alternatives were ineffective. The facility failed to ensure less restrictive interventions were systematically tried and found to ineffective prior to the initiation of Prozac.	W 278		
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: Based on observation, 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 3 of 3 individuals (Individual #1 - #3) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. a. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for	W 289		9/23/15

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W 289	Continued From page 118 signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's record did not include a program plan, including staff instructions, regarding how to intervene when Individual #1 displayed depressive symptoms. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no program plan in place to address Individual #1's depressive symptoms. The facility failed to ensure techniques used to manage Individual #1's depressive symptoms were incorporated into his program plans. b. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Behavior Intervention Plan for socially offensive behavior, revised 5/1/15, stated he "...displays socially offensive behavior by urinating on the floor/clothing, dipping his clothing	W 289		

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W 289	Continued From page 119 in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." His behavior plan was reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in the plan. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated no additional methods related to Individual #1's restriction to personal possessions had been developed. The facility failed to ensure Individual #1's plans included appropriate information to address his socially offensive behavior. 2. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. Individual #3's Positive Behavior Support Intervention Plans for each assessed behavior were reviewed. The plans did not include comprehensive instructions, as follows: a. Individual #3's Positive Behavior Support Intervention Plan for suicidal ideation, dated 4/1/15, defined the behavior as making threats to injure himself or stating he would kill himself. The plan documented staff were to place Individual #3 on line-of-sight supervision and to follow his suicide guidelines.	W 289		

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W 289	Continued From page 120 However, Individual #3's Suicide Guidelines, dated 4/3/14, were reviewed and documented staff were to place Individual #3 on "arm's length" supervision. It was not clear which level of increased supervision Individual #3 required as a suicidal ideation intervention. b. Individual #3's Suicide Guidelines documented "Remove any potentially dangerous items from Resident and/or his environment." However the plan also documented "If at any time Resident threatens to use an object to harm himself, remove that object as well as any sharp object that Resident can use." It was not clear if staff were expected to immediately remove all potentially dangerous items or if they were to wait until a direct threat to use the item(s) was made. c. The Suicide Guidelines documented if Individual #3 attempted to physically harm himself, staff were to "Encourage Resident to stay with the group and not isolate himself." Staff were also instructed to maintain his increased level of supervision "to ensure intervention if he again attempts to harm himself," encourage the use of coping skills, offer favorite activities and communicate with the Program Supervisor. The instructions did not include any instructions to staff related to physical intervention (e.g. block attempts). d. Individual #3's Suicide Guidelines documented "An emerging precursor of suicidal ideation for Resident occurs is [sic] when he is reporting	W 289		

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W 289	Continued From page 121 feelings that he is mistreated, ignored, or abused by any staff member. Staff MUST report this incident to the Program Manager or supervisor on duty as a sign of suicidal ideation." No additional information was included to clarify why making an allegation was included in the plan as a "sign of suicidal ideation." e. Individual #3's Behavioral Assessment documented he engaged in socially offensive behavior, defined as making rude remarks to others, arguing or yelling at others, bossing or teasing others and threatening others. The Positive Behavior Support Intervention Plan for socially offensive behavior, dated 8/15/14, included interventions as follows: - During meals, provide the option to eat at a later time - Cue Individual #3 one time that his behavior is inappropriate - Redirect Individual #3 to his coping skills program - Extinct the behavior - Cue Individual #3 to stop and take a break - Extinct Individual #3 but maintain visual contact The only intervention steps with direct staff involvement included the use of two verbal cues. No additional instruction to ensure Individual #3 did not continue to tease, threaten, etc. was included in the plan. Additionally, the Behavioral Assessment documented under "Events that typically follow the Maladaptive Behavior," that Individual #3 was "closely monitored" after socially offensive	W 289		

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W 289	Continued From page 122 behavior. No additional information was included in the instructions to clarify when increased monitoring was expected to take place or how the monitoring worked in relation to extinction. f. The Positive Behavior Support Intervention Plan for depression, dated 4/1/15, defined the behavior as isolating in his room, sleeping more or less than usual, losing interest in previously enjoyed activities, refusing ADLs, day treatment or medications and being more irritable or agitated. The plan included interventions as follows: - Encourage Individual #3 to participate in scheduled activities and programs - Assist him with choosing an alternative activity or program - Check on him every 10 - 15 minutes - Cue Individual #3 to his schedule and outings list It was not clear how the instructions were sufficient for staff to address Individual #3's depression symptoms. For example, the plan did not include how many ignored cues meant Individual #3 was refusing a medication and at which point staff would involve nursing. Additionally, the Behavioral Assessment documented under "Events that typically follow the Maladaptive Behavior," that Individual #3 would make "Phone call to mom" after exhibiting depressive symptoms. No information related to a phone call was included in the plan interventions. g. The Positive Behavior Support Intervention Plan for anxiety, dated 4/1/15, defined the behavior as repeating himself, obsessing,	W 289		

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W 289	Continued From page 123 restlessness, pacing and "being keyed up/overly excited or on edge." The plan included interventions as follows: - Encourage Individual #3 to participate in any scheduled activity - Encourage him to choose an alternative coping or sensory activity - Encourage him to structure his leisure time It was not clear how the instructions were sufficient for staff to address Individual #3's anxiety symptoms. For example, the plan did not include how, or if, staff were to address any verbal statements from Individual #3 in situations of repeating himself, obsessing or being excited. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #3's behavior plan needed revised. The City Director, who was also present during the interview, stated they were looking at making revisions to suicidal ideation forms and policy as well. The facility failed to ensure techniques to manage maladaptive behaviors were sufficiently incorporated into Individual #3's behavior plans. 3. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's Behavioral Assessment, dated 11/5/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, disruptive behaviors and physical aggression. Individual #2's Behavior Intervention Plan for socially offensive behavior, dated 10/31/14,	W 289		

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W 289	Continued From page 124 included interventions during the behavior as follows: - Redirect to communication tools - Step out of the trajectory and block as needed - Hand him a surgical mask Observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to repeatedly spit, resulting in staff intervention inconsistent with his behavior plan, as follows: 7/27/15 from 2:30 - 3:45 p.m.: - 3:35 p.m. Individual #2 began spitting. DCS E verbally cued Individual #2 to stop the behavior. DCS E then obtained a bandana which she provided to Individual #2 and he proceeded to chew on. 7/28/15 from 3:50 - 4:15 p.m.: - 4:05 p.m. Individual #2 was engaged in spitting behavior. DCS D obtained a bandana which she gave to Individual #2 and he proceeded to chew on. However, the use of a bandana could not be found in Individual #2's behavior plan. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #2's behavior plan needed revised to include the use of the bandana. The facility failed to ensure techniques to manage socially offensive behavior were sufficiently incorporated into Individual #2's behavior plan.	W 289		

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W 312	483.450(e)(2) DRUG USAGE 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' program plans that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 2 of 3 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 IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. Individual #1's 7/6/15 "Psychotropic Medication Plan" stated Prozac was being used to assist Individual #1 with a loss of interest in activities he	W 312		9/23/15

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W 312	Continued From page 126 previously enjoyed and crying spells. The plan stated "Will consider decreasing Prozac by 5 mg when depression symptoms decrease to 30 hours or less for three consecutive months." However, Individual #1's records, including his 3/28/14 Functional Behavioral Assessment, did not include information related to the depressive symptoms such as when the symptoms started, the frequency, duration and severity of the symptoms, or an analysis of other potential causes for the symptoms beyond depression. Further, his IPP did not include an objective related to the symptoms or a program plan which included non-pharmacological intervention strategies to assist Individual #1 in managing his symptoms. Without such information, it would not be possible for the IDT to establish medication reduction criteria based on Individual #1's assessed status and needs. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated a medication reduction plan for Individual #1's Prozac had not been developed. The facility failed to ensure Individual #1's medication reduction criteria was established based on a data-driven, comprehensive assessment of his depressive symptoms. 2. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's Physician's Orders, dated 5/6/15, included an order for Valium (an anxiolytic drug) 5	W 312		

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W 312	Continued From page 127 mg by mouth "30 minutes before dental." However, a medication reduction plan could not be located in Individual #2's record. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated he had not yet created a medication reduction plan for Individual #2's Valium. The facility failed to ensure Individual #2's medications were sufficiently incorporated into a plan.	W 312		
W 313	483.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. 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 not used until the severity of the behavior was shown to outweigh the potentially harmful risks of the drugs for 1 of 3 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs without the necessary justification. The findings include: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder.	W 313		9/23/15

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W 313	Continued From page 128 Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. Individual #1's record contained a Written Informed Consent, dated 7/6/15, for the use of Prozac which documented potential side effects included, but were not limited to, allergic reaction, anxiety, restlessness, fever, sweating, muscle spasms, nausea, vomiting, diarrhea, seeing or hearing things that are not there, confusion, weakness, muscle twitching, eye pain, trouble seeing, blurry vision, fast, pounding, or uneven heartbeat, dizziness, feeling more excited or energetic than usual, trouble sleeping, seizures, skin rash, blisters, peeling or redness, trouble breathing, unusual behavior, thoughts of hurting one's self, unusual bleeding or bruising, shaking, changes in appetite and weight loss or gain. However, Individual #1's records, including his 3/28/14 Functional Behavioral Assessment, did not include information related to the depressive symptoms such as when the symptoms started, the frequency and duration of the symptoms, less restrictive interventions attempted and found to be ineffective prior to the initiation of the medication, etc. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no assessment or program plan in place to address Individual #1's depressive symptoms. The QIDP stated staff were reporting Individual #1 was showing loss of interest and was crying, but no tracking of these symptoms had been completed.	W 313		

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W 313	Continued From page 129 Without such documentation and monitoring, it would not be possible for the facility to ensure the severity of Individual #1's depressive symptoms outweighed the potential side effects of the Prozac. The facility failed to ensure the severity of Individual #1's depressive symptoms was shown to outweigh the potentially harmful risks of the drug.	W 313		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 3 individuals (Individual #2) whose nursing documentation was reviewed. This resulted in the potential for an individual's medical needs to go unaddressed. The findings include: 1. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability and "Allergy to peanuts." a. Individual #2's record included a Nursing Evaluation, dated 5/18/15, which documented "ALLERGIES: NKDA, MAY HAVE PEANUT BUTTER BUT NO OTHER NUTS OR NUTELLA (PER MOM)."	W 322		9/23/15

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W 322	Continued From page 130 When asked, during an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated she and Individual #2's mother were not sure if Individual #2 had an actual allergy to peanuts. The LPN stated the facility was monitoring Individual #2 to assess his reaction to peanuts. During the same interview, when asked about the physician's involvement, including directions on what to monitor for, the LPN stated she had not been in communication with Individual #2's physician about the issue. b. Individual #2's laboratory records were reviewed. A laboratory report, dated 3/4/15, documented Individual #2's triglycerides were measured on 3/3/15 and were found to be 190 mg/dL. The report documented the normal level for triglycerides was 38 - 150 mg/dL. Individual #2's HDL cholesterol was also measured on 3/3/15 and was found to be 30 mg/dL. The report documented the normal level for HDL cholesterol was 40 - 70 mg/dL. The laboratory report included a handwritten entry, dated 3/6/15, which documented the results were faxed to Individual #2's physician. However, follow-up to Individual #2's laboratory report could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the physician would sign the laboratory report indicating it had been read. The physician's signature could not be located on the report. The LPN stated she would follow-up with the physician to ensure the out-of-range cholesterol levels had been noted.	W 322		

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W 322	Continued From page 131 The facility failed to ensure Individual #2 was provided with general and preventative medical care for his identified needs.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided for 2 of 3 individuals (Individuals #2 and #3) whose routine standing physician's orders were reviewed. This resulted in a lack of clear physician's orders being available to staff. The findings include: 1. Individual #2 and #3's Physician Standing Medication Orders, both dated 1/12/15, were reviewed. The documents included PRN medications which were did not consistently include specific individualized orders, as follows: a. Acetaminophen (an analgesic drug) was ordered "650mg to 1000mg" every four hours PRN. b. Milk of Magnesia (a laxative drug) was ordered for "30-60 cc PRN." c. Loperamide hydrochloride (an antidiarrheal drug) 2 mg was ordered for every "3-4 hours." d. Guaifenesin (an expectorant drug) 10 cc was ordered for every "6-8 hours."	W 331		9/23/15

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W 331	Continued From page 132 e. Benadryl (an antihistamine drug) was ordered "25mg to 50mg [every] 6-8 hours." The orders did not include information regarding how to determine which medication dosage to administer or when a repeat dose could be administered (i.e. 4, 5, 6, etc. hours after the first dose). During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the orders would be clarified. The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were specific.	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure nursing reviews had been completed on a quarterly basis for 1 of 3 individuals (Individual #2) whose nursing documentation was reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: 1. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses	W 336		9/25/15

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W 336	Continued From page 133 included profound intellectual disability. Individual #2's medical record was reviewed. Individual #2's record contained an admission nursing examination, dated 10/8/14. The next quarterly examination was not completed until 3/3/15. Additionally, the record included a quarterly nursing examination, dated 6/30/15, which included the following handwritten note from the LPN, "Had just been running around the house. Refused x2 attempts for assessment." A successful nursing examination after the 3/3/15 quarterly could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the 6/30/15 attempts were the only efforts made to complete a nursing examination during that time period. The facility failed to ensure Individual #2's nursing assessments had been completed on a quarterly basis.	W 336		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 2 individuals (Individual #2)	W 369		9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 134 observed to take medications. This resulted in an individual not receiving medications in the form ordered by the physician. The findings include: 1. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's Physician's Orders, dated 5/6/15, included an order to "Assist with oral medication administration with use of applesauce, pudding, or other food products." The orders also included "Crush medication." An observation was conducted at the facility on 7/28/15 from 6:26 - 7:35 a.m. During that time, Individual #2 was observed to take his morning medications with the assistance of a direct care staff. After Individual #2 pushed all pill-form medications into a small cup, the direct care staff dumped the pills into a bowl of applesauce. The direct care staff portioned out a liquid medication and added that to the bowl as well. Individual #2 was observed to feed himself the applesauce/medication mixture. However, at no time was the direct care staff observed to crush Individual #2's pill-form medications. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the medications should have been crushed prior to administration. The facility failed to ensure Individual #2's medications were administered without error.	W 369		
W 481	483.480(c)(2) MENUS	W 481		9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

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W 481	Continued From page 135 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 2 of 6 individuals (Individuals #1 and #2) residing in the facility and had the potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include: 1. An observation was conducted at the facility on 7/27/15 from 2:30 - 3:45 p.m. At 3:06 p.m., Individual #2 was noted to be seated at the table eating a pureed snack. At 3:30 p.m., Individual #1 was observed to eat a bowl of mixed vegetables for a snack. Individual #2's record was reviewed. His dietary Initial Assessment, dated 10/2014, documented Individual #2 required "6 small meals per day, every 2-3 hours." However, the facility's menus for July 2015 were reviewed and did not include snacks that were planned for the day. When asked about Individual #2's small meals, during an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #2's meals consisted of the three routine meals as well as snacks. The City Director, who was also present, stated that if the snacks were not included on the menu, there would not be documentation of snacks.	W 481		

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W 481	Continued From page 136 The facility failed to ensure accurate documentation of all food actually served was kept.	W 481		

Bureau of Facility Standards

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	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure and complaint survey conducted from 7/27/15 to 8/3/15. The survey was conducted by: Karen Marshall, MS, RD, LD, Team Lead Ashley Henscheid, QIDP Michael Case, LSW, QIDP Common abbreviations used in this report are: 1:1 - One-on-one ABC - Antecedent, Behavior, Consequence ADL - Activity of Daily Living CFA - Comprehensive Functional Assessment DCS - Direct Care Staff DT - Day Treatment HDL - High Density Lipids HRC - Human Rights Committee IED - Intermittent Explosive Disorder IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record mg/dL - milligrams per deciliter NKDA - No Known Drug Allergies PECS - Picture Exchange Communication System PRN - As needed QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	M 000	RECEIVED SEP 21 2015 FACILITY STANDARDS	
MM080	16.03.11100 Governing Body and Management The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e),	MM080		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: QIDP (X6) DATE: 9/18/15

Bureau of Facility Standards

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MM080	Continued From page 1 Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the facility's Governing Body failed to take actions that identified and resolved systematic problems. This failure resulted in inadequate protections, active treatment and behavior interventions being provided to individuals. The findings include: 1. The Governing Body failed to provide sufficient monitoring and oversight to ensure the consistent delivery of services, as follows: a. At 2:25 p.m., the City Director stated the electronic data collection system the facility had been using was discontinued. As a result, the facility had to revert to a paper data collection system. When asked when the system was discontinued, the City Director stated he was not sure. During the paper data review, it was noted that Individual #1's record did not include raw ADL data collection prior to 2/22/15. Individual #2's record did not include raw ADL data collection prior to 2/23/15 and Individual #3's record did not include raw ADL data collection prior to 1/26/15. On 7/28/15 at 1:30 p.m., the City Director provided an email from the corporate office stating the electronic data collection system had been discontinued at the end of February 2015, and that backup files were obtained for data collected prior to 2/28/15. However, the City Director stated he did not have a way to view or	MM080		

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MM080	Continued From page 2 print the backup files. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated when the facility was notified the electronic data collection system was being discontinued, it was discovered no paper data collection system was present to accommodate the loss of the electronic system. As a result, paper data collection sheets had to be created for each of the individuals' training programs. The facility failed to ensure the QIDP had a system was in place to collect program data in the event the electronic data collection system was inoperable. b. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. i. Individual #2's record contained documentation of the following restrictive interventions: - The use of blocking techniques and a supportive escort as interventions for Individual #2's aggression, and - One-on-one line-of-sight supervision during waking hours. However, documentation of guardian consent for the restrictives could not be found. Individual #2's guardian was interviewed on 7/30/15 from 1:58 - 2:12 p.m. She stated things were going well and she had regular contact with the QIDP, including monthly phone calls and additional communication as needed. Individual #2's guardian stated she was not always diligent	MM080		

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MM080	Continued From page 3 in returning items for signatures, and stated she had paperwork that she had approved over the phone she needed to sign and return. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated he was waiting for the guardian to return the signed consents. The QIDP stated verbal consent was obtained and would typically be documented in the record, however, he could not locate such documentation. ii. Individual #2's Physician Standing Medication Orders, dated 1/12/15, included PRN orders, as follows: - Acetaminophen (an analgesic drug) "650mg to 1000mg" every four hours PRN for pain or temperature - Milk of Magnesia (a laxative drug) was ordered for "30-60 cc PRN" for constipation Individual #2's MARs, dated 1/2015 - 6/2015, were reviewed and did not include sufficient information. Examples of incomplete MAR documentation included, but were not limited to, the following: - 1/8/15, 1/10/15, 3/22/15 and 5/20/15: Individual #2's MARs documented he received acetaminophen. None of the documentation included the dose administered. - 3/21/15, 4/24/15, 4/26/15, 5/21/15 and 5/23/15: Individual #2's MARs documented he received acetaminophen. None of the documentation included results of efficacy to evaluate the need for further PRN administration.	MM080		

Bureau of Facility Standards

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MM080	Continued From page 4 - 4/22/15, 4/22/15 (a second time), 4/23/15 and 4/26/15: Individual #2's MARs documented he received 500 mg of acetaminophen. Further, on 4/24/15, Individual #2's MARs documented he received 1000 mg of acetaminophen. None of the documentation included information related to how the doses were determined. - 1/20/15 and 3/22/15: Individual #2's MARs documented he received Milk of Magnesia. None of the documentation included the dose administered. - 1/10/15, 1/26/15, 3/10/15, 3/23/15 and 4/10/15: Individual #2's MARs documented he received Milk of Magnesia. None of the documentation included results of efficacy to evaluate the need for further PRN administration. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated accurate MAR documentation was an ongoing issue and she would address the concerns through staff training. The facility failed to ensure Individual #2's record contained comprehensive information. c. Refer to M134 as it relates to the Governing Body's failure to provide sufficient monitoring and oversight to ensure policies were adequately implemented and monitored necessary to ensure individuals were not subjected to ongoing abuse or neglect. d. Refer to M155 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight. e. Refer to M159 as it relates to the Governing	MM080		

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MM080	Continued From page 5 Body's failure to ensure the facility provided each individual with continuous active treatment designed to meet their individualized needs. f. Refer to M162 as it relates to the Governing Body's failure to ensure the facility ensured techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet the individuals' health, safety, and active treatment needs.	MM080		
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Based on policy review, observation, record review and staff interview, it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals' rights for 3 of 3 individuals (Individuals #1 - #3) residing at the facility. These failures resulted in a lack of effective systems to uphold individuals' rights. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 5/21/13, stated "The Company and/or Administrator will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are thoroughly	MM134		9/23/15

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MM134	Continued From page 6 investigated..." The policy stated the Administrator or designee would document all corrective action taken. a. An Investigation, undated and unsigned, documented, under the Description of Allegation section, "Unauthorized restraints on [Individual #1] to perform Blood [sic] tests." The form documented incidents took place on 1/13/15 and 3/3/15. The form stated the LPN who performed the blood draws was terminated for having authorized restraints without proper consents. Attached to the Investigation was an Incident/Accident Report which stated Individual #1 received a carpet burn to his right arm when staff assisted the nursing staff during a blood draw. The report documented the incident took place on 1/13/15 at 11:45 a.m., and stated the form was completed on 1/14/15 at 10:45 a.m. The QIDP documented on the back of the form, Individual #1 "had to go see the nurse to get his blood drawn. He didn't want to, so he had to be restrained by multiple people. He was laid on a mat, but his arm rubbed against the floor, thus causing the carpet burn." The Corrective Action section of the report stated "If restrain [sic] is necessary, it must be done in a careful manner so that he doesn't hurt himself or others." Also attached to the Investigation were 3 staff statements. One statement from another LPN, dated 5/12/15, stated Individual #1 was assisted by 5 staff to have his blood drawn on 1/13/15, and by 2 staff and the nurse on 3/3/15. The LPN documented she had limited involvement on 1/13/15 and no involvement on 3/3/15 due to her pregnancy. A second statement, dated 5/20/15 and signed by	MM134		

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MM134	Continued From page 7 the staff who completed the Incident/Accident Report, stated 3 staff held Individual #1 on a mat on the floor to accomplish the blood draw on 1/13/15. The statement documented another blood draw was completed 4/29/15. The third statement, dated 5/20/15, stated the staff was not involved but witnessed two staff holding Individual #1 in a restraint on 3/3/15 for a blood draw. It was not clear from the Investigation or the attached staff statements which staff were involved in restraining Individual #1 during which blood draw date, if there were two or three separate incidents, or the specific type of restraint that was completed during each blood draw. Additionally, no information related to lack of timely reporting, why the restraint was not identified as inappropriate following the 1/13/15 incident that resulted in the Incident/Accident Report, information indicating all staff involved had been interviewed including the LPN that was terminated, or how the incident was eventually determined to be an inappropriate restraint was present in the Investigation documentation. Additionally, The Incident/Accident Report and staff statements attached to the Investigation documented up to 5 other staff were involved or present during the use of the unauthorized restraints. However, no corrective action related to failure to protect Individual #1, or failure to report the use of unauthorized restraints, could be found. b. An Investigation, undated and unsigned, stated "Unauthorized restraints on [Individual #2] to perform Blood [sic] tests." The Investigation stated incidents took place 1/13/15, 3/3/15 and	MM134		

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MM134	Continued From page 8 4/29/15. Attached to the Investigation were 3 staff statements. One statement, dated 5/20/15 and signed by a direct care staff, stated she had been present but did not see the blood draw for Individual #2 on 1/13/15. The statement indicated four people were present during the 3/3/15 blood draw, but it was not clear how Individual #2 was restrained, or by how many people. The statement indicated 3 people were involved with the blood draw on 4/29/15. A second statement from an LPN, dated 5/12/15, documented Individual #2 was taken home rather than having his blood drawn on 4/29/15 due to agitation. The statement documented Individual #2 was "assisted by 3 staff and a lab tech" during a blood draw in March 2015, and by 2 staff on 1/13/15. A third statement, dated 5/28/15, documented the staff witnessed two staff holding Individual #2's arms while an LPN attempted to draw his blood on 1/13/15. It was not clear from the Investigation or the attached staff statements which staff were involved in restraining Individual #2 during which blood draw date, or the specific type of restraint that was completed during each blood draw. Additionally, no information related to lack of timely reporting, why there were discrepancies between staff statements, information indicating all staff involved had been interviewed including the LPN that was terminated, or how the incident was eventually determined to be an inappropriate restraint was present in the Investigation documentation.	MM134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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MM134	Continued From page 9 Further, no corrective action related to failure to protect Individual #2, or failure to report the use of unauthorized restraints, could be found During an interview on 7/31/15 from 8:30 a.m. - 11:45 a.m., the QIDP stated the incidents were not initially identified as potential abuse because he assumed the nurse could authorize restraint for medical purposes. The QIDP stated there was no additional information related to the incidents. The RN, who was present during the interview, stated she identified the inappropriate restraints during a chart review in May 2015, which was what initiated the investigations. The City Director, who was also present, confirmed the means of identifying the concerns and stated the investigations were not thorough and that no additional corrective action related to the incidents had been completed. The facility failed to ensure all allegations of potential abuse, neglect and mistreatment were thoroughly investigated, and that appropriate corrective action was completed in accordance with facility policy. 2. The facility's Suicide Policy, revised 6/4/15, was reviewed. The policy stated "It is the goal of the company to prevent individual harm, including self-harm. It is the responsibility of every employee to ensure that individuals are not allowed to harm themselves. As employees we are required to actively strive to prevent and report any incidents of threatening or attempting to harm themselves." The policy was not sufficiently implemented, as follows: a. The policy stated if an individual showed signs of suicidal ideation or threats of suicide (such as stating "I'm going to kill myself"), staff were to	MM134		

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MM134	Continued From page 10 "immediately stop the individual from hurting himself or herself...then place that individual under Arm's Length supervision or follow their suicide guideline if applicable. Remove any potentially dangerous items from the individual and/or their environment." The policy stated to perform a body check if it was a part of the individual's suicide guidelines. The policy defined "Arm's Length" supervision as "The individual is no further away from the staff than a literal arm's length." The policy stated the Administrator or Administrator on Duty was to be notified immediately of all suicidal ideation or threats of suicide. Staff were then to notify everyone on the shift that the individual was on increased supervision and complete an Incident/Accident form. The policy stated the Administrator or Designee would assign an employee trained to complete the suicide assessment, and the Administrator was to also contact the QIDP. The policy stated "The QIDP or the designated person with an equivalent degree will make the decision to either place the individual on Line of Sight supervision, Arm's Length supervision or contact the house to discuss the results of the suicide assessment with the staff member completing the form." The policy stated "Only the QIDP or the designated person with an equivalent degree if the QIDP is not available has the authority to remove supervision and to give the individual their belongings back." Individual #3's 8/21/14 IPP stated he was a 30 year old male whose diagnoses included mild	MM134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

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MM134	Continued From page 11 mental retardation, bipolar disorder, and IED. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for suicidal ideation (defined as making threats to injure himself or stating he was going to kill himself). Interventions for suicidal ideation included: - Follow suicide guidelines - Follow suicide protocol including placing Individual #3 on 1:1 line-of-sight, notifying Program Supervisor or QIDP, and remaining on 1:1 line-of-sight until it is determined he is not at risk His Suicide Guidelines, revised 4/3/14, stated if Individual #3 stated he wanted to die, staff were to ensure he was within arm's length and encourage him to use problem solving. Staff were then to implement the Suicide Policy. Individual #3's suicidal ideation documentation was reviewed. The documentation did not provide sufficient information to demonstrate suicide protocols were implemented according to policy or his plans. Examples included, but were not limited to, the following: - 3/10/15 at 9:25 a.m., a Behavior Log documented Individual #3 arrived at DT upset. Under the "Behavior" section, staff documented "he said he was going to kill himself and all staff." Staff then documented "Staff tried talking to him and he wouldn't listen so staff extincted him giving him time to calm down." The facility utilized a Suicide Risk Assessment Sheet that included a place to document the individual's name, the date, the time of day, and	MM134		

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MM134	Continued From page 12 the person completing the form. A list of options with check boxes was included for sex, age, intellectual disability, psychiatric diagnosis, physical pain, suicide history, and self-injurious behavior history. The person completing the form could then circle one of two options to describe intent, plan, lethal potential, and how it was discovered. There were two sections that allowed narrative data, labeled "Summarize the event of concern" and "Staff Response." A Suicide Risk Assessment Sheet for Individual #3, completed on 3/10/15 at 9:24 a.m. by the same staff completing the Behavior Log, stated "he said he would just kill himself." The Staff Response section stated "Staff asked him if he wanted to talk about what was bothering him and he said no. Then he said he was going to kill himself again and kill staff, staff extincted him and put him on suicide watch." The documentation did not explain how Individual #3 could be placed on extinction and suicide watch at the same time. Additionally, the form did not include information related to how, or if, the suicide policy or suicide protocols for Individual #3 had been implemented, by whom, and how or when Individual #3 was released from the suicide watch. - 3/25/15 at 9:50 a.m., a Behavior Log documented Individual #3 was looking at the newspaper. Under the "Behavior" section, staff documented "When he was asked to follow his schedule he refused and said he was going to kill himself and everybody at Day Treatment....Threatened to injure himself x7..." A Suicide Risk Assessment Sheet, completed by the same staff on 3/25/15 at 9:50 a.m., stated "He	MM134		

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MM134	Continued From page 13 said he was going to kill himself and everyone else. Fifth time he said he's going to kill himself tonight." The Staff Response section stated "Staff asked him to follow his schedule and he refused. Staff tried talking to him and he turned his music up so staff extincted him." There was no indication the suicide policy was implemented. - 4/18/15 at 6:10 p.m., a Behavior Log documented Individual #3 stated he did not want to eat his Mandarin oranges. Under the "Behavior" section, staff documented Individual #3 stated "how about 'I just kill myself' and slammed his door. I went and checked on him and he was just sitting on his bed watching T.V. he said he didn't want to talk to anyone he would go talk to [City Director] on Monday. I did appropriate paperwork and Notified chain of command." A Suicide Risk Assessment Sheet, dated 4/18/15 at 6:10 p.m. but unsigned, stated "refused to eat fruit at dinner after seeing cookies on counter. Told staff they could not make him do anything and cannot refuse him treats, staff is not his guardian so they can't boss him around only mom can. When his b-day comes he will get cake and not share w/anyone. I am going to kill myself." There was no indication the suicide policy was implemented. - 6/11/15 at 10:05 p.m., a Behavior Log stated Individual #3 asked if it was too late to take his medications. Under the "Behavior" section, staff documented Individual #3 "came out and asked if it was too late for meds. Staff said yes because of refusing earlier. He began to threaten to kill	MM134		

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MM134	Continued From page 15 Designee." The policy was not implemented, as follows: Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for depression (defined as sleeping more or less than usual, losing interest in previously enjoyed activites, refusing ADLs, medications, or DT, and being more irritable or agitated). The programs stated ABC data would be used to track each episode of depression. However, Individual #3's record included "Depression Tracking Sheet" forms on which staff tracked total time of identified depression symptoms. Staff were to document an "I" for an increase or decrease in sleep pattern, or an "S" for social withdrawal and loss of interest in typically enjoyed activites or reinforcements. Staff were to document the start and end time of the episode. The forms documented Individual #3's total depressive symptoms, as follows: January = 43 hours and 15 minutes February = 45 hours and 20 minutes March = 57 hours and 15 minutes April = 25 hours May = 74 hours and 43 minutes June = 64 hours The entries documented signs and symptoms of depression lasting anywhere from 25 minutes to 8 hours at a time. However, there was no indication the Suicide Policy had been implemented for those episodes lasting 2 hours or more. Examples included, but were not limited to, the following: - 1/12/15 from 2:00 - 6:30 p.m., staff documented	MM134		

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MM134	Continued From page 16 "I" and "S" on the form, for a total of 4.5 hours. - 1/23/15 from 3:00 - 5:30 p.m., staff documented "I" and "S" on the form, for a total of 2.5 hours. - 2/11/15 from 3:00 - 6:30 p.m., staff documented "I" and "S" on the form, for a total of 3.5 hours. - 3/31/15 from 2:00 - 10:00 p.m., staff documented "S" on the form, for a total of 8 hours. - 4/5/15 from 8:30 a.m. - 2:00 p.m., staff documented "S" on the form, for a total of 5.5 hours. - 5/22/15 from 10:00 a.m. - 2:00 p.m., staff documented "I" and "S" on the form, for a total of 4 hours. - 6/30/15 from 7:30 - 9:30 a.m., staff documented "S" on the form, for a total of 2 hours. However, none of the forms documented suicide assessments had been completed as per the policy. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the City Director stated the policy should have been implemented and suicide assessments should have been completed for Individual #3 if depressive symptoms were being exhibited for 2 or more hours. The QIDP, who was present during the interview, stated the entries on the Depression Tracking Sheets were not triggering the completion of a suicide assessment. The facility failed to ensure the Suicide Policy was implemented for Individual #3.	MM134		

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MM134	Continued From page 17 3. The facility failed to ensure individual rights were upheld and promoted, as follows: a. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. i. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. On 7/27/15 at 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in	MM134		

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MM134	Continued From page 18 the toilet so that he can be given a different pair of clothing..." Individual #1's Functional Behavior Assessment and the corresponding Behavior Intervention Plan for socially offensive behavior, revised 5/1/15, were reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in either the assessment or the plan. Further, Individual #1's Written Informed Consent for socially offensive behavior, signed by Individual #1's guardian on 6/12/15, was reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in either the plan or the consent. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated they tried programming and environmental changes before choosing to store Individual #1's clothing in the garage. The City Director stated they struggled with ensuring Individual #1 had clean clothes available when he was engaging in maladaptive behavior with the clothing. When asked about his other possessions, the City Director stated he was not sure why they were stored in the garage. The QIDP, who was present during the interview, stated he assumed it was also due to Individual #1's maladaptive behaviors. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated information regarding Individual #1's possessions being stored in the garage was not included in Individual #1's consents or plans that were reviewed by the guardian. The facility failed to ensure Individual #1's right to	MM134		

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MM134	Continued From page 19 retain personal possessions and clothing was upheld, and that his guardian was fully informed of the intervention strategies used to manage his socially offensive behavior. ii. During observations conducted on 7/27/15 and 7/28/15, Individual #1's privacy was not observed to be consistently protected. Examples included, but were not limited to, the following: Observations were conducted on 7/27/15, at which time the following was noted: At 2:50 p.m., Individual #1 was in room getting dressed. His bedroom door was open and his windows were not covered in order to protect his privacy. At 3:15 p.m., Individual #1 was in his bedroom with the door open and his windows uncovered. He was observed to remove his shoes and his pants and was not observed to be wearing underwear. Individual #1 then walked down the hallway and into the garage, where his clothes were stored, without pants on. DCS noticed Individual #1 in the garage and redirected him back to his bedroom. The DCS was not observed to offer Individual #1 anything with which to cover himself in order to protect his privacy prior to redirecting him back down the hallway and to his bedroom. Individual #1 was not able to independently access his clothes without compromising his privacy. At 3:20 p.m., Individual #1 was observed to be in his room putting on a pair of pants. His bedroom door was open and his windows were not covered in order to protect his privacy.	MM134		

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MM134	Continued From page 20 At 3:35 p.m., Individual #1 was in the hallway. Individual #1 became incontinent and his pants were observed to be wet. Individual #1 removed his pants while in the hallway and went into his bedroom. Individual #1 then walked out of his room, without pants on, and back into the hallway carrying his soiled pants. A DCS, who was coming out of the laundry room, noticed Individual #1, took the soiled pants from him and redirected Individual #1 back to his bedroom. The DCS was not observed to assist Individual #1 to close his door or cover his windows in order to protect his privacy. At 3:40 p.m., Individual #1 was observed to leave his bedroom, enter the hallway bathroom, wash his hands and return to his bedroom. Individual #1 was not observed to be wearing clothes. Observations were conducted on 7/28/15, at which time the following was noted: At 3:56 p.m., Individual #1 came out of the restroom with soiled pants. He went to his bedroom, sat on his bed, took off his pants and put on clean pants. The DCS was not observed to assist Individual #1 to close his door or cover his windows in order to protect his privacy. It was also noted an electrician, from outside the company, was in the home, repairing an outlet in the hall bathroom at the time. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #1's nudity and need for privacy was an ongoing issue. The City Director stated they made modifications to try to best provide Individual #1 with privacy (e.g. adding Velcro to the bedroom curtains to ensure they could easily be hung	MM134		

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MM134	Continued From page 21 when needed), however, he stated they recognized his dignity and privacy was still a concern. The facility failed to ensure Individual #1's right to privacy was upheld. b. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. Individual #2's record contained 1:1 Supervision Guidelines, dated 11/11/14, which documented Individual #2 would require line-of-sight supervision during all waking hours, except when he was in his bedroom alone or in the bathroom. A Written Informed Consent for 1:1 supervision, dated 11/11/14, was included in Individual #2's record. Individual #2's record contained a second copy of 1:1 Supervision Guidelines, revised 4/27/15, which documented the addition of line-of-sight supervision when Individual #2 was in the bathroom. However, Individual #2's record did not contain documentation of updated consent for line-of-sight supervision while he was in the bathroom. Additionally, observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to enter the restroom with staff no less than three times. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated updated consent to include the new information had not been	MM134		

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MM134	Continued From page 22 obtained. The facility failed to ensure informed guardian consent was obtained for Individual #2's increased supervision level. The facility failed to ensure individual rights were upheld and promoted.	MM134		
MM155	16.03.11300 Facility Staffing The requirements of Sections 300 through 399 of these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 4 of 4 individuals (Individuals #1 - #4), and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include: 1. The QIDP's program review and revision process was reviewed. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated data from the previous month had to be summarized by the 25th of the current month. As implemented, an individual could meet criteria on a training program, but a month would pass prior to revisions to the program being made and implemented.	MM155		9/23/15

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MM155	Continued From page 23 The City Director, who was present during the interview, stated company policy dictated data summation for the previous month was to be completed by the 10th of the month, and program revisions made at that time. The facility failed to ensure the QIDP ensured a process for timely data review and program revision was implemented. 2. Individuals #1 - #3's raw data for ADLs was reviewed. Data sheets for multiple programs included the compilation of total task data. By compiling the score for all steps of the program, the data did not reflect individuals' actual performance in relation to the identified objective. Examples included, but were not limited to, the following: a. Individual #3's 8/21/14 IPP stated he was a 30 year old male whose diagnoses included mild mental retardation, bipolar disorder, and IED. - Eat Slowly: Individual #3's program objective stated he would take a drink after 3 - 4 bites of food with a gesture cue in 40% of trials. Data was collected on six steps which included takes a bite of food, chews the food, swallows the food, sets his utensil down, takes a drink after 3 - 4 bites, and repeats steps 1 - 5. Each step was scored as successful if Individual #3 completed the step with a gesture cue or better. The total task score was then recorded as Individual #3's progress for the month. However, when compared to his score for the identified step that matched the objective (takes a drink after 3 - 4 bites), the total task data was not reflective of his actual progress, as follows:	MM155		

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MM155	Continued From page 24 January: total task = 67%, step identified in objective = 0% February: total task= 95%, step identified in objective = 91% March: total task = 80%, step identified in objective = 0% April: total task = 64%, step identified in objective = 66% May: total task = 96%, step identified in objective = 80% June: total task = 55%, step identified in objective = 0% - Tooth brushing January: total task = 80%, step identified in objective = 80% February: total task = 70%, step identified in objective = 70% March: total task = 89%, step identified in objective = 83% April: total task = 67%, step identified in objective = 82% May: total task = 83%, step identified in objective = 80% June: total task = 59%, step identified in objective = 25% - Budgeting/Money Management January: total task = 0%, step identified in objective = 0% February: total task = 25%, step identified in objective = 0% March: total task = 100%, step identified in objective = 100% April: total task = 100%, step identified in objective = 100% May: total task = 25%, step identified in objective = 0% June: total task = 67%, step identified in objective = 100%	MM155		

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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
	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM155	Continued From page 25 Individual #3's total task data did not accurately indicate his progress, or lack thereof, related to his training objectives. b. Individual #2's 11/6/14 IPP stated he was a 24 year old male whose diagnoses included profound intellectual disability and autism. - Tooth Brushing: Individual #2's program objective stated he would place a tooth brush inside his mouth with light physical assistance in 15% of trials. Data was collected on 5 steps which included placing the tooth brush inside his mouth, moving the tooth brush against his teeth for 3 seconds, brushing his upper teeth, brushing his lower teeth, and rinsing his mouth. Each step was scored as successful if Individual #2 completed the step with a light physical cue or better. The total task score was then recorded as Individual #2's progress for the month. However, when compared to his score for the identified step that matched the objective (places tooth brush inside of mouth), the total task data was not reflective of his actual progress, as follows: January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 46%, step identified in objective = 100% March: total task = 81%, step identified in objective = 100% April: total task = 100%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 85%, step identified in objective	MM155		

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MM155	Continued From page 26 = 92% - Toileting January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 76%, step identified in objective =100% March: total task = 82%, step identified in objective = 96% April: total task = 100%, step identified in objective = 100% May: total task = 34%, step identified in objective = 78% June: total task = 72%, step identified in objective = 100% - Hand Washing January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 29%, step identified in objective = 100% March: total task = 78%, step identified in objective = 100% April: total task = 85%, step identified in objective = 100% May: total task = 45%, step identified in objective = 91% June: total task = 60%, step identified in objective = 100% Individual #2's total task data did not accurately indicate his progress, or lack there of, related to his training objectives. c. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability and Down Syndrome.	MM155		

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MM155	Continued From page 27 - Hand Washing: Individual #1's program objective stated he would place his hands under running water with a light physical cue in 75% of trials. Data was collected on 4 steps which included placing his hands under running water, applying soap, lathering hands, and rinsing hands. Each step was scored as successful if Individual #1 completed the step with a light physical cue or better. The total task score was then recorded as Individual #1's progress for the month. However, when compared to his score for the identified step that matched the objective (places his hands under running water), the total task data was not reflective of his actual progress, as follows: January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 66%, step identified in objective = 66% March: total task = 62%, step identified in objective = 30% April: total task = 100%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 45%, step identified in objective = 90% - Eating January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 100%, step identified in objective = 100% March: total task = 91%, step identified in	MM155		

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MM155	Continued From page 28 objective = 100% April: total task = 84%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 83%, step identified in objective = 100% - Shaving January: Raw data had been collected in the electronic system no longer accessible by the facility. February: total task = 100%, step identified in objective = 100% March: total task = 52%, step identified in objective = 64% April: total task = 25%, step identified in objective = 20% May: total task = 50%, step identified in objective = 66% June: total task = 35%, step identified in objective = 46% Individual #1's total task data did not accurately indicate his progress, or lack there of, related to his training objectives. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the data should match individuals' objectives. The QIDP and City Director both stated the total task data was not reflective of individuals' abilities or progress. The facility failed to ensure Individual #1 - #3's ADL data was analyzed sufficient to demonstrate the individuals' actual performance on objectives. 3. The Behavior Tracking, dated 2/2015 - 6/2015, for Individual #3 was reviewed. The	MM155		

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MM155	Continued From page 29 documentation did not include all maladaptive behaviors, resulting in the potential for inaccurate behavior numbers to be reported to the physician, as follows: Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. a. The assessment defined Individual #3's socially offensive behavior as making rude remarks, arguing, yelling and bossing or teasing others. Individual #3's Behavior Tracking forms included arguing, bossing and teasing others under the socially offensive category. However, the tracking form included "rude gestures" and yelling under the category of "Informal Behaviors." Individual #3's maladaptive behavior numbers were totaled from the tracking sheet and transferred to the QIDP Tracking form. The two tracking forms were compared, and the numbers on the QIDP Tracking form did not include the numbers from the "Informal Behaviors" category. b. Individual #3's assessment defined depressive symptoms as sleeping more or less than usual, losing interest in previously enjoyed activities, refusing ADLs, medications or DT and being more irritable or agitated. The assessment documented the symptoms were tracked by the amount of time they were exhibited.	MM155		

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MM155	Continued From page 30 Individual #3's 2/2015 Behavior Tracking included ignoring under the "Informal Behaviors" category. Further, the Behavior Tracking forms, dated 3/2015 - 6/2015, included "Ignores/Refuses Program" under Informal Behaviors. However, the Informal Behaviors were tracked by number of occurrence, not by time exhibited. c. Individual #3's assessment defined anxiety symptoms as repeating himself, obsessing over an activity or event, restlessness, pacing and "being keyed up/overly excited or on edge." The assessment documented the symptoms were tracked by the amount of time they were exhibited. However, Individual #3's Behavior Tracking forms included obsessing under Informal Behaviors. Further, the "Informal Behaviors" were tracked by number of occurrence, not by time exhibited. When asked, during an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated all of the maladaptive behaviors exhibited should have been added to the total number for the corresponding objective and reflected on Individual #3's QIDP Tracking. The facility failed to ensure the QIDP ensured behavior tracking was completed in such a way to monitor each maladaptive behavior comprehensively. 4. Refer to M134 as it relates to the facility's failure to ensure the QIDP provided sufficient monitoring and oversight to ensure policies were adequately implemented and monitored necessary to ensure individuals were not	MM155		

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MM155	Continued From page 31 subjected to ongoing abuse or neglect. 5. Refer to M159 as it relates to the facility's failure to ensure the QIDP ensured each individual was provided with continuous active treatment designed to meet their individualized needs. 6. Refer to M162 as it relates to the facility's failure to ensure the QIDP ensured techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. 7. Refer to M366 as it relates to the facility's failure to ensure the QIDP ensured menus were maintained for foods actually served.	MM155		
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure individuals were provided with continuous and consistent active treatment services in accordance with their individualized needs for 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed. That failure resulted in individuals' not receiving services and supports necessary to meet their identified needs. The findings include:	MM159		9/23/15

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MM159	Continued From page 32 The Active Treatment programs for Individuals #1 - #4 were reviewed and did not demonstrate comprehensive, consistent services were being provided, as follows: 1. Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. a. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's 4/10/12 psychiatric evaluation did not include a diagnosis of depression and no additional evaluation data such as when the symptoms started, the frequency, severity and duration of the symptoms, etc. was present in Individual #1's records. Additionally, Individual #1's 3/28/14 Functional Behavioral Assessment did not include information related to the depressive symptoms such as when the symptoms started, the frequency and duration of the symptoms, less restrictive interventions attempted and found to be ineffective prior to the initiation of the medication, etc. Further, Individual #1's IPP did not include an objective, and did not include replacement behavior training, related to his depressive symptoms. When asked during an interview on 8/4/15 at 2:50	MM159		

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MM159	Continued From page 33 p.m., the QIDP and LPN stated Individual #1's depressive symptoms had not been assessed and the decision to initiate the medication was based on anecdotal information provided a couple of months prior to the initiation of the medication. The QIDP and LPN both stated there was no objective in place, and replacement behavior training had not been developed to address Individual #1's depression. The facility failed to ensure Individual #1's depressive symptoms were adequately assessed, and that an objective and replacement behavior training were developed. b. Individual #1's MAR documented he received the first dose of Prozac on 7/7/15. Individual #1's record contained a Written Informed Consent, dated 7/6/15, for the use of Prozac. The consent documented verbal consent from Individual #1's guardian was obtained on 7/2/15. However, HRC approval for the use of the Prozac was not obtained until 7/13/15. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated HRC approval had not been obtained prior to Individual #1's Prozac being started. The facility failed to ensure the use of Prozac was approved by the HRC prior to being initiated. c. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles, blocks, etc.) were also stored in the garage.	MM159		

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MM159	Continued From page 34 When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair of clothing..." The assessment did not address the function of Individual #1's other socially offensive behavior, including walking naked through the house, invading others' privacy, turning lights off or throwing his wet clothing on others. The assessment did not include information related to storing Individual #1's clothing and possessions in the garage. Further, when Individual #1 had soiled his clothing and wanted to access his clean clothes independently, he was required to walk naked, from his bedroom, down the hallway and to the garage. The assessment did not address if his attempts to independently	MM159		

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MM159	Continued From page 35 access his clothes would also be counted as socially offensive behavior, defined, in part, as "walking naked through the house." The "Recommended Proactive/Replacement Behavioral Objective" section of the assessment stated "[Individual #1] will be provided with 2 clothing options at the beginning of the day or following an incident of incontinence. This will give him the ability to choose that which he wants to wear and thus the incidents of urinating in his pants and other maladaptive behaviors that follow it will be prevented and/or decreased." The relationship between Individual #1's episodes of incontinence and invading others' privacy and turning lights off was not evident, and no replacement behavior program that was functionally related to the identified behavior could be found. When asked during an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the City Director stated Individual #1's urination issues were believed to be more related to dementia than to maladaptive behavior. However, Individual #1's Functional Behavior Assessment did not include evaluation data to support the diagnosis of dementia, or information related to its impacts on his socially offensive behaviors. When asked, during a follow up interview on 8/4/15 from 9:45 - 9:50 a.m., the City Director stated there was no assessment information or other type of documentation related to Individual #1's dementia. During a telephone interview on 8/12/15 from	MM159		

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MM159	Continued From page 36 2:26 - 2:32 p.m., the QIDP stated there was no functional replacement behavior developed for Individual #1's invading others' privacy or turning off lights. The facility failed to ensure Individual #1's socially offensive behavior was comprehensively assessed, and that functional replacement behavior training was developed. d. Individual #1's raw behavioral data, from 1/1/15 - 7/27/15, was reviewed. The data did not provide sufficient information on which to evaluate the efficacy of training and behavioral programs. Examples included, but were not limited to, the following: i. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's record did not include data to track incidents of loss of pleasure, sleeping more, or crying. During a telephone interview on 8/4/15 at 2:50 p.m., the QIDP and LPN both stated the decision to start Individual #1 on Prozac was made based upon anecdotal data from staff gathered during two separate behavior meetings. However, no data related to the identified signs and symptoms of depression were being tracked. ii. Individual #1's record included 3 Behavior Interventions Plans, all dated 3/28/14, as follows: A plan for socially offensive behavior defined the	MM159		

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MM159	Continued From page 37 behavior as urinating on the floor or clothing, dipping his clothing in the toilet, walking naked through the house, and/or invading others' privacy by going in others' rooms, turning others' lights off, or throwing his wet clothing on others. Interventions for socially offensive behavior included: - verbally cue him to stop - direct him to the bathroom and explain importance of use - assist him to clean up mess made - ask him to change his clothing - have him complete laundry tasks - direct him to his room and explain privacy - use supportive escort to assist to bedroom - verbally redirect to a common area - explain others' privacy A plan for property destruction defined the behavior as grabbing others' eyeglasses and breaking them, tipping objects over, pulling objects off the wall or windows, and ripping objects. Interventions for property destruction included: - cue one time to stop - cue to initiate coping skills - block and use picture communication - remove the object from Individual #1 - use social stories - assist to clean up A plan for self-injurious behavior defined the behavior as hitting himself with an open hand, sticking objects, fingers, or dirt in his eye, and bending his fingers backwards. Interventions for self-injurious behavior included: - cue one time to stop	MM159		

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MM159	Continued From page 38 - cue to initiate coping skills - block - offer saline A plan for aggression defined the behavior as hitting, kicking, and/or pushing others, or attempts. Interventions for aggression included: - cue one time that behavior is unsafe - cue to initiate coping skills - cue to a quiet area - keep distance between him and others - block - use a supportive escort All four programs stated ABC data would be used to track each episode of the behavior identified as maladaptive. Individual #1's raw behavior data was reviewed. The data did not provide sufficient information related to Individual #1's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following: - 1/19/15 at 1:30 p.m., a Behavior Log documented Individual #1 came out of his bedroom into the hallway. Under the "Behavior" section, staff documented Individual #1 "urinated in his pants and came out naked. Being Naked x3, Urinating in pants x1." The "Consequence" section was blank. There was no documentation indicating how staff responded to Individual #1 urinating in his pants or being naked, what "Being Naked x3" meant, or if Individual #1 responded to interventions offered.	MM159		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM159	Continued From page 39 - 2/13/15 at 5:21 p.m., a Behavior Log documented Individual #1 wanted food but dinner was not ready. Under the "Behavior" section, staff documented "He began urinating in his pants x2 and walking through the house naked x8." Under the "Consequence" section, staff documented "Talk about behavior did not earn reinforcement." There was no documentation the interventions listed in Individual #1's plans had been implemented, in what sequence, or if they were effective or not. - 3/30/15 at 11:20 a.m., a Behavior Log documented staff was assisting in lunch preparations. Under the "Behavior" section, staff documented "Urinates in pants x3, walks around naked x4, tips over [Individual #2's] dresser x1, privacy invasion x1, injuring others x6, yells x7." Under the "Consequence" section, staff documented "Cued [Individual #1] to stop, redirect him, extinction with visual checks. Did not earn next reinforcement." Additionally, staff documented a supportive escort was used to remove Individual #1 from another individual's room at 11:40 a.m. However, the documentation did not indicate where Individual #1 was escorted to. Further, the documentation did not indicate at what point during the behavior the interventions listed were implemented (e.g., at what point he was cued to stop, what he was redirected to, how extinction was implemented, etc.). There was no other documentation indicating what other, if any, interventions were attempted (such as having him dress, offering other clothing, blocking him from	MM159		

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MM159	Continued From page 40 injuring others, etc.), at what point in the behavior process the intervention attempts were made, and if they were successful or not. In addition, in April 2015, the facility began utilizing a Behavior Slip form to track Individual #1's socially offensive behavior. The form consisted of a series of columns and rows. The far left column was labeled "Time" and there were four columns labeled urinating in clothes/floor, dipping clothes in toilet, throwing wet clothing, walking naked in public, and privacy invasion. The two columns on the right were labeled "Antecedent" and "Consequence." Staff were to indicate the time in the left-hand column, then place a tally-mark under the appropriate maladaptive behavior. Narrative data could be entered under "Antecedent" and "Consequence." The form did not allow for sufficient information to be documented to determine if Individual #1's behavior program was appropriately implemented, or if the interventions were successful. For example, a Behavior Slip, dated 5/1/15, included an entry at 2:30 p.m. Staff placed a tally-mark under "Urinating in Clothes/Floor" and 5 tally-marks under "Walking Naked in Public." The Antecedent and Consequence columns were blank. No additional information was present on the form to indicate what, if any, interventions were implemented by staff or Individual #1's response to the interventions. A second Behavior Slip, dated 6/8/15, included an entry for 10:45 p.m. Staff placed a tally-mark under "Urinating in Clothes/Floor." Under "Antecedent," staff documented "seeking attention." Under "Consequence," staff	MM159		

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MM159	Continued From page 41 documented "communication." A second entry on the form, at 11:00 p.m., included 5 tally-marks under "Walking Naked in Public." The Antecedent and Consequence columns were blank. No additional information was present on the form to indicate what, if any, interventions were implemented by staff or Individual #1's response to the interventions. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the Behavior Slips and the Behavior Logs was not sufficient to determine if Individual #1's programs had been implemented or not. The facility failed to ensure Individual #1's behavioral data provided sufficient information to judge the efficacy of his programs. 2. Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. a. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. His assessment did not include accurate, comprehensive information, as follows: - Individual #3's Behavioral Assessment documented he could not control his depression. The assessment documented Individual #3 engaged in the other maladaptive behaviors to: - Control the environment - Escape or avoid non-preferred activities and tasks - Get a reaction or attention from staff	MM159		

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MM159	Continued From page 42 Information related to how, or if, the behaviors were different for the various functions could not be found. Individual #3's Positive Behavior Support Intervention Plan for socially offensive behavior, dated 8/15/14, and for suicidal ideation and aggression, both dated 4/1/15, documented under the Positive Intervention(s) section, Individual #3 was to use exercise, relaxation (such as listening to music in his room, playing video games, reading magazines or watching a movie) and positive self-talk as coping skills. The plans each stated when Individual #3 began exhibiting anxiety or depression symptoms, defined as precursor behaviors, staff were to offer Individual #3 materials to utilize as coping skills (such as headphones, video games, etc.) and to assist him to use the materials as necessary. It was not clear how engaging in preferred activities was not reinforcing Individual #3's desire to "control his environment and/or to escape non-preferred activities and tasks." Further, Individual #3's Positive Behavior Support Intervention Plan for depression, dated 4/1/15, documented he "demonstrates the following symptoms: isolating in his room..." The assessment did not specify how to determine when Individual #3's time in his room was task avoidance, a need to cope or isolation from depression. - Individual #3's Positive Behavior Support Intervention Plan for depression documented the definition included "sleeping more or less than	MM159		

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MM159	Continued From page 43 usual." However, Individual #3's Behavioral Assessment did not contain additional information clarifying how to determine when Individual #3's change in sleep was related to environmental changes, medical concerns or being maladaptive. - Individual #3's Positive Behavior Support Intervention Plan for aggression included the following in the interventions: "Please note, staff should not mention [Individual #3's] eyeglasses or try to remove them during a behavior as this escalates the behavior and draws attention to his glasses and they typically end up broken. Staff should verbally praise [Individual #3] for removing them himself and/or handing them to staff." However, information regarding Individual #3's eyeglasses in relation to his maladaptive behavior could not be found in his assessment. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated the assessment needed revised. The facility failed to ensure Individual #3's Behavioral Assessment included comprehensive information. b. Individual #3's replacement behaviors were reviewed and were not appropriate replacements for the maladaptive behavior, as follows: - The assessment stated Individual #3 engaged in socially offensive behavior, defined as making rude remarks to others, arguing or yelling at others, bossing or teasing others and threatening	MM159		

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MM159	Continued From page 44 others. The assessment stated Individual #3 engaged in socially offensive behavior in an "attempt to control his environment and/or to escape non-preferred activities and tasks and/or to gain attention and/or get a reaction from staff." The assessment included a replacement behavior for socially offensive behavior that stated Individual #3 would remove himself from the situation and choose a coping skill, such as listening to music or playing video games. It was not clear how removing himself from the situation and engaging in a leisure activity was not reinforcing Individual #3's desire to "control his environment and/or to escape non-preferred activities and tasks." Further, the replacement behavior was not functionally related to gaining attention from staff. - The assessment stated Individual #3 engaged in aggression, defined as hitting others or objects (walls), pushing others, kicking others, scratching others and attempts. The assessment stated he engaged in aggression to get a reaction or attention from staff, to escape an undesirable task and to control his environment. The assessment included a replacement behavior for aggression which stated Individual #3 would utilize a punching bag. The replacement behavior was not functionally related to gaining a reaction or attention from staff or escaping an undesirable task. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #3's assessment and replacement behavior objectives needed revised.	MM159		

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MM159	Continued From page 45 The facility failed to ensure Individual #3's replacement behaviors were functionally related to his maladaptive behaviors. c. Individual #3's Behavioral Assessment, dated 8/15/14, documented for a replacement behavior, Individual #3 "will write a shift schedule at the beginning of each shift (AM, PM, DT) stating what he is going to do at specific time frames [sic] to give him more control over his day with a specific verbal cue given at 50% for three consecutive months by 8/31/14." During an observation on 7/28/15 from 11:05 - 11:50 a.m., Individual #3 was observed to utilize a white board for his shift schedule. The white board was noted to have a list of no less than 10 tasks for Individual #3. However, the board was not observed to have specific timeframes for any of the tasks. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #3's white board schedule should have included specific timeframes. The facility failed to ensure Individual #3 received interventions consistent with his programs. d. Individual #3's IPP contained 25 priority training objectives. The corresponding training programs were reviewed and 10 were found to contain insufficient instructions for staff. The Teaching Procedure section in each of the 10 programs, including tooth brushing, spelling and paraphrasing, contained blanks where the suggested prompts staff were to use should have been identified. The programs did not specify	MM159		

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MM159	Continued From page 46 how, when, or how often, staff were to prompt Individual #3. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated a staff would not know which cues to use or the steps of the program based on the information written. The facility failed to ensure Individual #3's training programs included sufficient direction to staff. e. Individual #3's record included an A.M. Schedule, dated 10/10/12. The schedule included a handwritten note, dated 5/8/15, which indicated the document had been revised. A handwritten change was noted in the 9:15 - 9:30 block for Monday through Friday. The schedule documented "Leave 4 D.T." in each of the boxes, and each had a handwritten strikethrough on "Leave 4" resulting in only "D.T." remaining in the boxes. The schedule blocked out 9:15 a.m. - 2:00 p.m., Monday through Friday for D.T. Individual #3's P.M. Schedule, dated 10/10/12, documented D.T. continued from 2:00 - 2:45 p.m. Individual #3's active treatment schedule for day programming, dated 4/4/14, was reviewed. The schedule included activities Individual #3 was to partake in from 9:30 a.m. - 2:30 p.m. Monday through Friday. Activities included "Deli" from 10:00 a.m. Wednesday until 12:15 p.m., and again on Wednesday from 12:50 - 1:00 p.m. However, per the entrance conference with the City Director on 7/27/15 from 1:40 - 1:55 p.m., the facility deli was closed during construction that commenced in April or May 2015. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the Day Treatment Program Supervisor	MM159		

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MM159	Continued From page 47 stated she was in the process of updating Individual #3's active treatment schedule to reflect the changes to day programming. The Day Treatment Program Supervisor stated even once construction was completed, the facility deli would not be returning and Individual #3's schedule needed revised. The facility failed to ensure Individual #3's active treatment schedules included updated information. f. Individual #3's raw behavioral data, from 1/1/15 - 7/27/15, was reviewed. The data did not provide sufficient information on which to evaluate the efficacy of behavioral programs. Examples included, but were not limited to, the following: i. Individual #3's record included Positive Behavior Support Intervention Plans, both dated 5/5/14, for socially offensive behavior (defined as arguing or yelling at others, bossing or teasing others, and threatening others), and aggression (defined as hitting others or objects, kicking or scratching others, and attempts to do so). Interventions for socially offensive behavior included: - verbally cue him one time that behavior is not appropriate - verbally redirect him to initiate his coping skills program - use extinction - cue him to stop and take a break Interventions for aggression included: - firmly prompt him to stop and use his coping skills - block as needed	MM159		

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MM159	Continued From page 48 - direct him to take a break - do not engage in interaction with him, but maintain visual - give time to calm down - once calm, verbally cue to continue with scheduled task - use supported escort to direct to a quiet area - use one arm support if redirection fails - use body control if he is a threat to self or others - use secure escort if he is a threat to self or others Both programs stated ABC (Behavior Log) data would be used to track each episode of the behavior identified as maladaptive. Individual #3's behavior data from 1/1/15 - 7/27/15 was reviewed. The data did not provide sufficient information related to Individual #3's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following: - 3/14/15 at 5:40 p.m., a Behavior Log documented Individual #3 "was dishing up his plate for dinner." Under the "Behavior" section, staff documented Individual #3 "was getting his plate of food when he all of a sudden got mad and said he wasn't going to eat his fruit or follow his eating program, take his shower or do chore and T.A.'s. [task analysis/programs]." Staff then documented "Swearing: 5, rude towards staff: 6, refusing programs: 6, arguing: 7, yelling: 5, ignoring: 8, talking to self: 5, noncompliant: 4." At the bottom of the section, staff documented "behavior ended!" Under the "Consequence" section, staff documented "Resident was communicated with and was encouraged to get an alternative. Didn't	MM159		

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MM159	Continued From page 49 earn his reinforcement." However, the documentation did not indicate the sequence in which events took place, or at what point in the behavior staff implemented which interventions. Additionally, it was not clear what intervention, if any, caused the behavior to end. - 3/31/15 at 6:00 p.m., a Behavior Log documented Individual #3 was asked to do laundry. Under the "Behavior" section, staff documented "I had asked [Individual #3] to change his laundry. He told me 'No' because has had a bad day and that he was not going to do anything. I had again asked him to at lease [sic] just change it and he got even more rude about it. Rude to staff: 3." Under the "Consequence" section, staff documented "Talked to him about his behavior." However, there as no information indicating how Individual #3 was "Rude to staff" beyond stating he had a bad day and did not want to do anything. The documentation did not indicate staff had verbally cued him one time that the behavior was not appropriate, that staff redirected him to initiate his coping skills program, or that staff cued him to stop and take a break. - 4/6/15 at 9:00 a.m., a Behavior Log documented Individual #3 "was in the kitchen trying to be staff." Under the "Behavior" section, staff documented Individual #3 "was trying to boss [Individual #5] around and tease him. Staff tried speaking to him but he argued with staff and refused his program to take out the trash." Staff then documented "Rude to others x6, Ignoring x6, Being staff x5, Refusing programs x1, Arguing x5, Bossing x6." Under the "Consequence" section, staff documented "Did not earn reinforcement.	MM159		

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MM159	Continued From page 50 Spoke with [Individual #3] about his behavior." However, the documentation did not indicate the sequence in which events took place, or at what point in the behavior staff implemented which interventions. Additionally, it was not clear what intervention, if any, caused the behavior to end. - 5/12/15 at 1:56 p.m., a Behavior Log documented Individual #3 "asked for his 1:45 pm reinforcement." Under the "Behavior" section, staff documented "He had asked for his brake [sic] and staff had explained to him that he had not earned it and he got upset and was very rude to staff and when he removed himself he slammed his door." Staff then documented "rude to staff x2, slamming door x2, yelling x1." Under the "Consequence" section, staff documented "Talked to about behavior, loss of reinforcement." However, there was no additional documentation that indicated why Individual #3 had not earned his 1:45 reinforcement. Additionally, the documentation did not indicate how Individual #3 was rude to staff, or that staff had implemented the interventions outlined in Individual #3's plan. - 6/11/15 at 9:55 p.m., a Behavior Log documented he asked for his medications. Under the "Behavior" section, staff documented Individual #3 "came out of his bedroom asking for bedtime meds after they had been marked as refused. He then began threatening to harm staff and family, followed by hitting walls and other residents and throwing objects at staff." Under the "Consequence" section, staff documented "talked to about behavior." However, the documentation did not indicate at what point during the incident staff implemented	MM159		

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MM159	Continued From page 51 Individual #3's behavioral interventions (such as redirecting him to initiate his coping skills program, cueing him to stop and take a break, blocking physical aggression, etc.). During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the data was not sufficient to demonstrate if or how Individual #3's behavior plan was followed, or if the interventions were effective. ii. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for suicidal ideation (defined as making threats to injure himself or stating he was going to kill himself). Interventions for suicidal ideation included: - follow suicide guidelines - follow suicide protocol including placing 1:1 line-of-sight, notifying Program Supervisor or QIDP, and remaining 1:1 line-of-sight until it is determined he is not at risk The program stated ABC data would be used to track each episode of suicidal ideation. Individual #3's ABC data from 1/1/15 - 7/27/15 was reviewed. The data did not provide sufficient information related to Individual #3's suicidal ideation, or staff's response, to evaluate the efficacy of the programs. Examples included, but were not limited to, the following: - 3/10/15 at 9:25 a.m., a Behavior Log stated Individual #3 arrived at Day Treatment upset. Under the "Behavior" section, staff documented "he came into Day Treatment and started teasing [Individual #5]. He was asked to stop and he said he was going to kill himself and all staff. He also	MM159		

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MM159	Continued From page 52 refused to do his work." Staff then documented "Staff tried talking to him and he wouldn't listen so staff extincted him giving him time to calm down." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line-of-sight, notifying the Program Supervisor or QIDP, etc.) was implemented. A Suicide Risk Assessment Sheet, completed by the same staff on 3/10/15 at 9:25 a.m., stated "he came into Day Treatment. He started teasing [Individual #5] and when ask [sic] to stop he said he would just kill himself." The Staff Response section stated "Staff asked him if he wanted to talk about what was bothering him and he said no. Then he said he was going to kill himself again and kill staff, staff extincted him and put him on suicide watch." The documentation did not explain how Individual #3 could be placed on extinction and suicide watch at the same time. Additionally, the form did not include information related to how the suicide watch was implemented (placed 1:1, dangerous items removed, etc.), or for how long, or when Individual #3 was removed from suicide watch and by whom. - 3/25/15 at 9:50 a.m., a Behavior Log stated Individual #3 was looking at the newspaper. Under the "Behavior" section, staff documented "When he was asked to follow his schedule he refused and said he was going to kill himself and everybody at Day Treatment. He started kicking the board between his desk and [name of other individual] desk. Started acting like staff and tried to tell [Individual #5] what to do. He was swearing." Staff then documented "Swearing	MM159		

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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
	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM159	Continued From page 53 x20, Threatened to injure himself x7, threatened to injure others x5, yelling x8." Under the "Consequence" section, staff documented "Staff tried talking to him and he told staff his mom had canceled their time together. Staff tried to explain to him that that is out of our control, but he wouldn't listen. He finally was able to use his coping skills and he calmed down." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line of sight, notifying the Program Supervisor or QIDP, etc.) was implemented. A Suicide Risk Assessment Sheet, completed by the same staff on 3/25/15 at 9:50 a.m., stated "He said he was going to kill himself and everyone else. Fifth time he said he's going to kill himself tonight." The Staff Response section stated "Staff asked him to follow his schedule and he refused. Staff tried talking to him and he turned his music up so staff extincted him." There was no additional information present to indicate if Individual #3 had been placed on suicide precautions, how those precautions were implemented, or who had made the determination that Individual #3 was not a risk to himself or others. - 4/18/15 at 6:10 p.m., a Behavior Log stated Individual #3 stated he did not want to eat his Mandarin oranges. Under the "Behavior" section, staff documented Individual #3 "had a very rough day and he saw what was for dinner and he said he didn't want to eat his madrian [sic] oranges he dumped them out. I told him that was his choice but he would not earn his reinforcement for the	MM159		

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MM159	Continued From page 54 evening cause he was not following his eating program. He then stated he wasn't going to eat his dinner cause we weren't his guardians and he didn't have to listen to anyone other than his mom. He drank his liquids and started walking to his room and he said how about 'I just kill myself' and slammed his door. I went and checked on him and he was just sitting on his bed watching T.V. he said he didn't want to talk to anyone he would go talk to [City Director] on Monday. I did appropriate paperwork and Notified chain of command." Under "Consequence" staff documented "Talked to about behavior." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line-of-sight, etc.) was implemented. The documentation did not indicate who had been notified, or what, if any, directions had been given or followed. A Suicide Risk Assessment Sheet, dated 4/18/15 at 6:10 p.m. but unsigned, stated "refused to eat fruit at dinner after seeing cookies on counter. Told staff they could not make him do anything and cannot refuse him treats, staff is not his guardian so they can't boss him around only mom can. When his b-day comes he will get cake and not share w/anyone. I am going to kill myself." There was no additional information regarding implementation of suicide precautions, when Individual #3 was released from precautions or by who. - 6/11/15 at 10:05 p.m., a Behavior Log stated Individual #3 asked if it was too late to take his medications. Under the "Behavior" section, staff	MM159		

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MM159	Continued From page 55 documented Individual #3 "came out and asked if it was too late for meds. Staff said yes because of refusing earlier. He began to threaten to kill himself and staff." Under the "Consequence" section, staff documented "Communication about behavior." There was no indication that Individual #3's plan (suicide guidelines, suicide protocol including placing him on 1:1 line-of-sight, notifying the Program Supervisor or QIDP, etc.) was implemented. A Suicide Risk Assessment Sheet, dated 6/11/15 at 10:00 p.m. and unsigned, stated "He was upset and wanted his meds after already refusing and proper paperwork had been done and so he stated 'I will just go kill myself.'" The Staff Response section stated "followed Suicide protocol and contacted proper chain of command." However, there was no documentation indicating who was contacted, what direction if any was given, how the suicide protocol was implemented, or when Individual #3 was released from suicide precautions or by whom. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the data was not sufficient to demonstrate Individual #3's suicide protocol had been implemented or followed. iii. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for depression (defined as sleeping more or less than usual, losing interest in previously enjoyed activites, refusing ADLs, medications, or day treatment, and being more irritable or agitated).	MM159		

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MM159	Continued From page 56 Interventions for depression included: - verbally encourage to attend scheduled activities, day treatment, and programs - assist with choosing another activity or program - visually check on every 10 minutes when isolating in his room The programs stated ABC data would be used to track each episode of depression. However, Individual #3's record included "Depression Tracking Sheet" forms on which staff tracked total time of identified depression symptoms. Staff were to document an "I" for an increase or decrease in sleep pattern, or an "S" for social withdrawal and loss of interest in typically enjoyed activites or reinforcements. Staff were to document the start and end time of the episode. Additionally, the form included a space for staff to document "Antecedent" and "Intervention" information. The forms documented Individual #3's total depressive symptoms, as follows: January = 43 hours and 15 minutes February = 45 hours and 20 minutes March = 57 hours and 15 minutes April = 25 hours May = 74 hours and 43 minutes June = 64 hours However, the documentation did not provide clear information as to how the symptoms were related to depression, or the frequency and type of intervention provided by staff. For example: - 1/12/15 from 2:00 - 6:30 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "Came home from Day Treatment." Under Intervention, staff documented "let him	MM159		

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MM159	Continued From page 57 sleep." - 1/23/15 from 3:00 - 5:30 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "Came home from [Day Treatment] and went to bed." Under Intervention, staff documented "Communication/Encouragement." - 2/11/15 from 3:00 - 6:30 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "Tired, refused programs." Under Intervention, staff documented "let resident sleep." - 3/31/15 from 2:00 - 10:00 p.m., staff documented "S" on the form. Under "Antecedent" staff documented "Came home from [Day Treatment]." Under Intervention, staff documented "Communication." - 4/5/15 from 8:30 a.m. - 2:00 p.m., staff documented "S" on the form. Under "Antecedent" staff documented "Staying in room playing games or laying in bed." Under Intervention, staff documented "Encouraged to join others in living room." - 5/22/15 from 10:00 a.m. - 2:00 p.m., staff documented "I" and "S" on the form. Under "Antecedent" staff documented "talking to staff about programs and pay check." Under Intervention, staff documented "Communication/Encouragement." - 6/30/15 from 7:30 - 9:30 a.m., staff documented "S" on the form. Under "Antecedent" staff documented "Came out and refused [programs]." Under Intervention, staff documented "Encouragement, wait time."	MM159		

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MM159	Continued From page 58 The documentation did not demonstrate staff had implemented his program by checking on Individual #3 every 10 minutes, verbally encouraging him to attend scheduled activities or programs, or assisting him to choose activities or programs. Additionally, it was not clear at what point during the identified behavior staff intervened, the frequency of intervention, or at what point the intervention was successful or not. Further, the documentation did not indicate if other issues, such as illness, were addressed as possible causes for sleep. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the tracking sheets was not sufficient to determine if Individual #3's program had been implemented or not. iv. Individual #3's record included a Positive Behavior Support Intervention Plan, dated 5/5/14, for anxiety (defined as repeating himself or obsessing over an activity or event, restlessness, pacing and being repetitive, being keyed up or overly excited or on edge). Interventions for anxiety included: - cue to attend scheduled activity - encourage to engage in replacement behavior - encourage him to structure his leisure time The programs stated ABC data would be used to track each episode of anxiety. However, Individual #3's record included "Anxiety Tracking Sheet" forms on which staff tracked total time of identified anxiety symptoms. Staff were to document an "R" for repeating himself and/or obsession on a specific activity, a "P" for pacing or restlessness, or an "F" for feeling keyed up or on edge. Staff were to document the start and	MM159		

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MM159	Continued From page 59 end time of the episode. Additionally, the form included a space for staff to document "Antecedent" and "Intervention" information. The forms documented Individual #3's total anxiety symptoms, as follows: January = 13 hours and 55 minutes February = 21 hours and 34 minutes March = 52 hours and 25 minutes April = 34 hours May = 30 hours and 4 minutes June = 53 hours However, the documentation did not provide clear information as to how the symptoms were related to anxiety, or the frequency and type of intervention provided by staff. For example: - 1/12/15 from 6:30 - 7:00 p.m., staff documented an "R" on the form. Under "Antecedent" staff documented "eating dinner." Under Intervention, staff documented "explained he had just stated this statement." - 2/16/15 from 2:30 - 3:30 p.m., staff documented an "R" on the form. Under "Antecedent" staff documented "Home from [Day Treatment]." Under Intervention, staff documented "Repeating about his date and his money." - 3/31/15 from 2:00 - 10:00 p.m., staff documented an "F" on the form. Under "Antecedent" staff documented "Asked to do laundry." Under Intervention, staff documented "Communication." - 4/22/15 from 7:00 - 9:30 a.m., staff documented an "F" on the form. Under "Antecedent" staff documented "Was excited and stressing about going to house 5 for [Day Treatment]." Under	MM159		

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MM159	Continued From page 60 Intervention, staff documented "Communication/encouragement." - 5/22/15 from 8:00 - 9:40 a.m., staff documented an "R" and an "F" on the form. Under "Antecedent" staff documented "Stressing about his paycheck." Under intervention, staff documented "Communication/encouragement." - 6/15/15 from 6:00 - 7:00 p.m., staff documented a "P" on the form. Under "Antecedent" staff documented "Came out of his bedroom." Under Intervention, staff documented "Little restlessness today." The documentation did not demonstrate staff had implemented his program interventions, such as cueing him to attend scheduled activities, encouraging him to engage in his replacement behavior, or encouraging him to structure his leisure time. Additionally, it was not clear at what point during the identified behavior staff intervened, the frequency of intervention, or at what point the intervention was successful or not. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the tracking sheets was not sufficient to determine if Individual #3's program had been implemented or not. The facility failed to ensure Individual #3's behavioral data provided sufficient information to judge the efficacy of his programs. g. Individual #3's Monthly Program Summaries, dated 1/2015 - 6/2015, documented a lack of progress without revisions. Examples included, but were not limited to, the following:	MM159		

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MM159	Continued From page 61 i. The objective for Self Administration of Medication was set at 95% success for 3 consecutive months. His monthly program summaries documented the following status of the objective: - 1/2015: 35% - 2/2015: 30% - 3/2015: 22% - 4/2015: 47% - 5/2015: 29% - 6/2015: 44% The documentation indicated the program did not meet the 95% success rate once in six months. However, no revisions to the program objective were noted. ii. The objective for Exercise was set at 40% success for 3 consecutive months. His monthly program summaries documented the following status of the objective: - 1/2015: 80% - 2/2015: 0% - 3/2015: 33% - 4/2015: 0% - 5/2015: 12% - 6/2015: 13% The documentation indicated the 40% criteria was not met for five consecutive months. However, no revisions to the program objective were noted. iii. The objective for Communicating/Paraphrasing was set at 95% success for 3 consecutive months. His monthly program summaries documented the following status of the objective:	MM159		

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MM159	Continued From page 62 - 1/2015: 80% - 2/2015: 70% - 3/2015: 88% - 4/2015: 75% - 5/2015: 40% - 6/2015: 41% The documentation indicated the program did not meet the 95% success rate once in six months. However, no revisions to the program objective were noted. iv. The objective for Occupational Therapy was set at 50% success for 3 consecutive months. His monthly program summaries documented the following status of the objective: - 1/2015: 35% - 2/2015: 21% - 3/2015: 28% - 4/2015: 0% - 5/2015: 0% - 6/2015: 0% The documentation indicated the program did not meet the 50% success rate once in six months. However, no revisions to the program objective were noted. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated he revised programs after 3 consecutive months of progress, or a lack thereof. The QIDP stated the identified program objectives should have been revised based on Individual #3's performance percentages. The facility failed to ensure objectives were revised when Individual #3 and failed to make progress towards them.	MM159		

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MM159	Continued From page 63 h. Individual #3's record contained a Written Informed Consent for his Behavior Management Program, dated 5/2/14, which documented Individual #3's "rights are restricted with the use of a formal behavior management program, including the use of Therapeutic Options supportive restraints which consist of a block, supportive escort, arm control, body control and a secure escort to prevent him from hurting himself, staff, and/or property." The consent documented "the consent expires on May 2, 2015." The form was signed by Individual #3's guardian on 5/7/14, and by two members of the HRC on 5/8/14. However, an updated document with guardian consent or HRC approval from May 2, 2015 forward could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated renewed guardian consent and HRC approval for Individual #3's behavior plan had not been obtained. The facility failed to ensure guardian consent and HRC approval was obtained for each of Individual #3's restrictive interventions. 3. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. a. Individual #2's Behavioral Assessment, dated 11/5/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, disruptive behaviors and physical aggression. - Individual #2's Behavior Tracking, dated 3/2015 - 6/2015, documented Individual #2 engaged in self-abuse defined as biting or hitting himself, as	MM159		

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MM159	Continued From page 64 follows: March: 16 times April: 67 times May: 36 times June: 5 times However, no information related to self-abuse could be found in Individual #2's Behavioral Assessment. Additionally, the IPP did not include an objective related to self-abuse. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated the Behavioral Assessment needed revised and an objective for self-abuse needed to be developed. Additionally, Individual #2's Behavior Intervention Plan for socially offensive behavior, dated 10/31/14, included interventions during the behavior as follows: - Redirect to communication tools - Step out of the trajectory and block as needed - Hand him a surgical mask Observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to repeatedly spit, resulting in staff intervention inconsistent with his behavior plan, as follows: 7/27/15 from 2:30 - 3:45 p.m.: - 3:35 p.m. Individual #2 began spitting. DCS E verbally cued Individual #2 to stop the behavior. DCS E then obtained a bandana which she provided to Individual #2 and he proceeded to chew on.	MM159		

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MM159	Continued From page 65 7/28/15 from 6:26 - 7:35 a.m.: - 6:45 a.m. Individual #2 began spitting. DCS F verbally cued Individual #2 to stop the behavior. No further interventions were attempted. - 7:00 a.m. Individual #2 began spitting. DCS F stated to Individual #2 that he needed to stop the behavior or she would have to get his surgical mask. From 3:50 - 4:15 p.m.: - 4:05 p.m. Individual #2 was engaged in spitting behavior. DCS D obtained a bandana which she gave to Individual #2 and he proceeded to chew on. However, the use of a bandana could not be found in Individual #2's behavior plan. Further, at no point during the observations was Individual #2 provided with a surgical mask. Additionally, Individual #2 was not observed to utilize, or be cued to utilize, his communication tool (PECS). During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #2's behavior plan should have been implemented as written. The facility failed to ensure Individual #2 received interventions consistent with his programs. b. The Behavioral Assessment documented following disruptive behavior, Individual #2 typically had "Time to himself, outside." However, Individual #2's record contained 1:1 Supervision Guidelines, dated 4/27/15, which	MM159		

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	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM159	Continued From page 66 documented Individual #2 required line-of-sight supervision during all waking hours, except when he was in his bedroom alone. The guidelines included "This means that staff should be able to see any part of [Individual #2's] body. Staff must also maintain closer proximity to [Individual #2] than any other resident." The assessment did not include additional information regarding how time alone affected his 1:1 supervision needs. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated the Behavioral Assessment needed revised. Additionally, during observations completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes, Individual #2 was noted to be away from staff. Examples included, but were not limited to, the following: - 7/27/15 at 3:15 p.m., Individual #2 was noted to exit the facility to the back and began swinging on the swing set. No door or window to the backyard was open. Individual #2's staff, DCS G, was in the dining area monitoring Individual #5 on the computer. DCS G joined Individual #2 in the backyard briefly at approximately 3:23 p.m. before coming back inside the facility, again closing the door, and offering Individual #1 assistance. Individual #2 came inside and joined DCS G at approximately 3:27 p.m. - 7/28/15 at 9:35 a.m., Individual #2 was noted to be in the backyard of the facility swinging on the swing set with DCS F. DCS F was observed to come inside the facility to get a beverage, closing the door behind her. No window was noted to remain open. DCS F took the beverage to	MM159		

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MM159	Continued From page 67 Individual #2, who remained outside during this time. - 7/28/15 at 11:35 a.m., Individual #2 was noted to be in the backyard of the facility swinging on the swing set with DCS F and Individual #1. At 11:38 a.m., DCS F and Individual #1 were noted to come into the facility, leaving Individual #2 outside alone for a short period of time. All doors and windows to the backyard were noted to be closed. - 7/28/15 at 11:45 a.m., Individual #2 was again noted to be in the backyard of the facility swinging on the swing set with DCS F and Individual #1. DCS F came inside, leaving Individual #2 and Individual #1 alone in the backyard. Doors and windows to the backyard were noted to be closed. - 7/28/15 at 4:00 p.m., Individual #2 engaged in spitting behavior. DCS D went down the hall, returning with Individual #2's bandana. While DCS D left to obtain the bandana, Individual #2 remained in the common area with Individual #4 and Individual #5. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated if a window or door was open while Individual #2 was in the backyard, staff monitoring may have been sufficient. The City Director stated Individual #2 should not have been left alone or out of the line-of-sight of staff. The facility failed to ensure Individual #2 received interventions consistent with his programs. c. Individual #2's CFA, dated 11/1/14, was reviewed and contained multiple sections of tasks that were deemed "not applicable" and were subsequently not assessed. Examples of areas	MM159		

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	13G063		08/03/2015

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MM159	Continued From page 68 marked as "N/A" included, but were not limited to, the following: - Money Management: All 18 tasks - Money Management and Shopping: All 37 tasks - Writing Skills: 14 tasks - Time Management: 18 tasks - Phone Skills: 13 tasks During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated the assessment did not get completed. The facility failed to ensure Individual #2's assessments included comprehensive information, and that his IPP included specific objectives necessary to meet his identified behavioral needs. d. Individual #2's raw behavioral data, from 1/1/15 - 7/27/15, was reviewed. The data did not provide sufficient information on which to evaluate the efficacy of behavioral programs. Examples included, but were not limited to, the following: Individual #2's record included 3 Behavior Intervention Plans, as follows: A plan for disruptive behavior, dated 11/7/14, defined the behavior as yelling and screaming, randomly hitting objects, and throwing objects without targeting anyone. Interventions for disruptive behavior included: - refer to his communication program and attempt to gain his attention - encourage him to go to a quiet area - limit interactions with Individual #2 until no longer exhibiting the behavior	MM159		

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MM159	Continued From page 69 - remove others from the area to prevent injury - use a blocking board until the behavior ends A plan for socially offensive behavior, dated 11/7/14, defined the behavior as spitting and rumination in places other than the bathroom sink. Interventions for socially offensive behavior included: - redirect to communication tools - block spit from hitting others - hand him a surgical mask - have him clean up "spit spots" A plan for physically aggressive behavior, dated 11/8/14, defined the behavior as hitting, kicking, and pushing others. Interventions for physically aggressive behavior included: - redirect to picture activities - block hits - redirect with a supportive escort Individual #2's raw behavior data was reviewed. The data did not provide sufficient information related to Individual #2's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. For example, all 3 programs stated ABC data would be used to track each episode of behavior identified as maladaptive. However, Individual #2's record included a form titled "Behavior Slip [Individual #2] (Socially Offensive)." The form was divided into columns and rows. The far left column was labeled "Time" and documented 15 minute time-blocks for each row on the form. The form covered an entire 8 hour shift. The	MM159		

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MM159	Continued From page 70 center columns were labeled spitting, yelling, hitting objects, and pushing. The final column was labeled "Antecedent." Staff were to record a tally-mark for each observed behavior in the appropriate time-block. The bottom row of the form was labeled "Totals" where the total number of each of the 4 identified behaviors (spitting, yelling, hitting objects, and pushing) could be calculated for each shift. However, the form did not include space for staff to document interventions attempted or their outcome. As such, it would not be possible to determine if the interventions outlined in Individual #2's Behavior Intervention Plans were effective or not. Additionally, it would not be possible to determine if staff were implementing interventions correctly. For example, a form dated 2/21/15 documented Individual #2's behavior on the swing shift (2:00 - 10:00 p.m.). The form included tally-marks for each behavior between 5:00 and 6:00 p.m., with totals as follows: spitting 37 times, yelling 10 times, hitting objects 14 times, and pushing 4 times. The Antecedent column was blank. No additional information was present to indicate how the behavior progressed in the one-hour timeframe, what interventions were attempted and their outcome, or why the behavior finally stopped. Additionally, in March of 2015, the form was modified to include aggression and self-abuse by changing "pushing" to "pushes others" and adding columns for throwing objects, hitting himself and hitting others. However, the form still did not provide information related to the progression of the behavior, interventions	MM159		

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MM159	Continued From page 71 attempted, or the response to the intervention. For example, a form dated 3/21/15 documented Individual #2's behavior on the day shift (6:00 a.m. - 1:45 p.m.). The form included tally marks for behaviors, as follows: - 6:00 a.m., spitting 3 times, yelling 2 times. Antecedent - "Just woke up." - 6:15 a.m., spitting 5 times, hit self 2 times, hit others 3 times. Antecedent - "Wanting food." - 6:30 a.m., spitting 2 times. Antecedent - "Time of day." - 7:00 a.m., spitting 3 times, hit others 2 times. Antecedent - "Wanting food." - 7:15 a.m., spitting 5 times, hit others 2 times. Antecedent - repeat marks. - 9:00 a.m., spitting 5 times, yelling 1 time, hit self 1 time. Antecedent - "Time of Day [sic]." - 11:15 a.m., spitting 6 times, yelling 2 times. Antecedent - repeat marks. - 11:30 a.m., spitting 2 times, yelling 1 time. Antecedent - "Wanting food." No additional information was present to indicate how the behavior progressed, what interventions were attempted and their outcome, or why the behavior finally stopped. Additionally, a Behavior Log, dated 3/21/15 from 6:00 - 6:25 a.m., stated Individual #2 was wanting food. Under the "Behavior" section, staff documented "As soon as staff walked into the house, [Individual #2] was sitting on the kitchen table he was hitting, spitting, yelling staff [sic] could hear him outside. Staff then cued him to use the restroom to get ready for the day he then started to spit and yell more one after another. Another staff cued him to go into the garage to cope. When he was out there he hit staff 3x he	MM159		

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MM159	Continued From page 72 then ran inside sat on the Banana Chair and began to cope." Staff then documented "hit - 4, spit - 5, yell - 6." Under the "Consequence" section, staff documented "Staff communicated with him to turn his day around." The data documented on the Behavior Log between 6:00 and 6:25 a.m. was not consistent with the information documented on the Behavior Slip (spitting 5 times vs. spitting 8 times, yelling 6 times vs. yelling 2 times). Neither form documented who Individual #2 hit, or where he hit himself (in the head, leg, arm, etc.). Additionally, neither form indicated interventions as outlined in his program being implemented (i.e., blocking his spit, having him clean up "spit spots," removing others from the area, using blocking boards, using picture activities, etc.). A second Behavior Log, dated 3/21/15 from 11:00 - 11:15 a.m., stated Individual #2 was outside swinging. Under the "Behavior" section, staff documented Individual #2 "came in from outside wanting lunch but was still to [sic] early so we gave him a little bit of apple sause [sic] and he got upset with that and started throwing things and yelling and bitting [sic] himself, hitting self and staff." Staff then documented "behavior ended!" Under the "Consequence" section, staff documented "Resident was communicated with about his decisions and was encouraged to calm down so he could eat/do his eating program." The Behavior Log did not document the frequency of the behaviors, and the corresponding timeframe on the Behavior Slip did not match the identified behaviors. Additionally, neither form provided clear information indicating Individual #2's behavior interventions had been implemented appropriately, or the outcome to the	MM159		

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MM159	Continued From page 73 interventions. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated the documentation on the Behavior Slips and the Behavior Logs was not sufficient to determine if Individual #2's programs had been implemented or not. The facility failed to ensure Individual #2's behavioral data provided sufficient information to judge the efficacy of his programs. e. Individual #2's record contained restrictive interventions for which HRC approval could not be located, as follows: i. Individual #2's Physician's Orders, dated 5/6/15, included an order for Valium (an anxiolytic drug) 5 mg by mouth "30 minutes before dental." However, HRC approval for the medication could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated she could not find evidence of HRC approval. ii. Individual #2's record contained 1:1 Supervision Guidelines, dated 11/11/14, which documented Individual #2 would require line-of-sight supervision during all waking hours, except when he was in his bedroom alone or in the bathroom. HRC approval for the intervention was obtained on 11/13/14. Individual #2's record contained a second copy of 1:1 Supervision Guidelines, revised 4/27/15, which documented the addition of line-of-sight supervision when Individual #2 was in the	MM159		

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MM159	Continued From page 74 bathroom. However, his record did not contain documentation of HRC approval for line-of-sight supervision while he was in the bathroom. Additionally, observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to enter the restroom with staff no less than three times. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated HRC approval was not re-obtained with the increased restriction. The facility failed to ensure HRC approval was obtained for each of Individual #2's restrictive interventions. 4. Individual #4's IPP, dated 1/15/15, documented a 39 year old male whose diagnoses included severe intellectual disability, autism, stereotypic/repetitive disorder, and seizure disorder a. Individual #4's IPP included an objective for Individual #4 to "...structure his leisure time by choosing an activity from a choice of three with a nonspecific verbal cue..." Individual #4's 2/2015 leisure choice program plan stated staff were to give Individual #4 a choice of 3 activities during leisure time by showing him a picture of the activity. The plan did not include information related to what activities Individual #4 was to be offered. However, his Sunday through Saturday "P.M.	MM159		

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MM159	Continued From page 75 Schedule" stated "Leisure" was scheduled from 2:00 - 3:15 p.m., and "Break" was scheduled from 3:15 - 3:45 p.m. The schedule included a note which stated "Choice of Leisure:" and listed Wii, army men, train set, game room, reading, computer, etc. Additional information regarding the "Break" time was not indicated. Individual #4 was observed on 7/27/15 from 2:30 - 3:40 p.m. During the 50 minute observation period, the following was noted: 2:30 - 2:55 p.m.: Individual #4 was observed to be sitting on the couch in the living room. At 2:35 p.m., he walked down the hallway, then returned to the couch in the living room, where he remained unengaged in activities until 2:55 p.m. 2:55 - 3:10 p.m.: Individual #4 looked out the front window, walked to the kitchen and then walked to the back of the house to the bathroom. At 3:00 p.m., Individual #4 came out of hall restroom and stood in the hallway buttoning his shorts. Individual #3 verbally directed him to his bedroom. Individual #4 did not respond and went into the living room. At 3:03 p.m., a DCS verbally prompted him twice to go to his room, change his clothes and wash his hands. Individual #4 then went to his bedroom, where he remained until 3:10 p.m. 3:10 - 3:25 p.m.: Individual #4 returned to the living room, sat on the couch, and was noted to be holding a pencil. At 3:20 p.m. a DCS said "hi" to Individual #4 and he walked with the staff and Individual #1 to the staff closet. Individual #4 then went back to his bedroom, where he remained until 3:25 p.m. 3:25 - 3:40 p.m.: At 3:25 p.m. Individual #4	MM159		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
3335 SPRINGFIELD
IDAHO FALLS, ID 83404

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MM159	Continued From page 76 returned to the couch and sat, unengaged in activities until 3:40 p.m. At 3:40 p.m., he went to the staff closet, obtained a blank sheet of paper then returned to the couch, where he remained when the observation ended. Other than using the restroom, Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 50 minute observation period. Additionally, at no time during the observation were staff noted to implement Individual #4's leisure time plan. Individual #4's Active Treatment Schedule did not contain sufficient information to direct the work of staff and ensure his active treatment needs were met. Further, Individual #4's IPP included an objective which stated Individual #4 would "...structure his leisure time by choosing an activity from a choice of three with a nonspecific verbal cue..." However, the formal objective was not indicated on Individual #4's Active Treatment Schedule. - Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 4:00 - 4:15 p.m.: The schedule stated "Grooming." Individual #4's IPP included formal objectives for brushing his hair, using a Kleenex, and washing his hands. However, his Active Treatment Schedule did not specify which grooming tasks Individual #4 was to complete or which formal or informal objectives were to be implemented during the grooming time block.	MM159		

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MM159	Continued From page 77 b. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 4:15 - 5:00 p.m.: The schedule stated "Leisure." 5:00 - 5:15 p.m.: The schedule stated "ADLs." The schedule did not specify which leisure activities Individual #4 was to be offered or if the 4:15 - 5:00 p.m. leisure time block differed from the 2:00 - 3:15 p.m. leisure time block. Further, the schedule did not specify which ADLs Individual #4 was to complete or which formal or informal objectives were to be implemented during the ADL time block. - Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 5:30 - 6:15 p.m.: The schedule stated "Dinner." 6:15 - 6:30 p.m.: The schedule stated "Clean-up." Additionally, Individual #4's IPP included an objective for Individual #4 to "...chew his food at least 3 times before swallowing when eating with a specific verbal cue..." Individual #4's 2/2015 dining program plan stated staff were to "Be sure [Individual #4] takes a drink every 2-3 bites..." Individual #4 was observed on 7/27/15 from 5:00 - 5:50 p.m. During the 50 minute observation period, the following was noted: 5:00 - 5:30 p.m.: Individual #4 was sitting on the couch in the living room, intermittently holding a pencil. 5:30 - 5:45 p.m.: Individual #4 sat at the dining table and ate the evening meal. At 5:37 p.m.,	MM159		

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MM159	Continued From page 78 DCS prompted Individual #4 to take a drink, which he did. Individual #4 then continued eating, finished his meal, and took his plate to the kitchen at 5:40 p.m. He returned to the dining table, finished his drink and then went to sit on the living room couch at 5:45 p.m. 5:45 - 5:50 p.m.: At 5:45 p.m., Individual #4 was sitting on the couch in the living room, intermittently holding a pencil, where he remained when the observation ended. Other than eating dinner and taking his plate to the kitchen, Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 50 minute observation period. Additionally, staff were not observed to ensure Individual #4 drank or was prompted to drink between every 2 - 3 bites of food. Further, Individual #4's Active Treatment Schedule did not include information regard what staff were to offer Individual #4 if a task was finished before its scheduled time. The Active Treatment Schedule did not contain sufficient information to direct the work of staff and ensure his active treatment needs were met. c. Individual #4's Sunday through Saturday "P.M. Schedule" included the following: 6:30 - 7:00 p.m.: The schedule stated "Chores." 7:00 - 8:00 p.m.: The schedule stated "Activity." The schedule did not specify which chores or activities Individual #4 was to engage in. Additionally, his IPP included formal objectives for transferring his laundry from the washer to the dryer, vacuuming and mopping, and making his	MM159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM159	Continued From page 79 bed. His IPP also included formal objectives for exchanging items from a sensory box, participating in sensory activities, and kneading dough. However, his Active Treatment Schedule did not specify which tasks Individual #4 was to complete or which formal or informal objectives were to be implemented during the "Chores" and "Activity" time blocks. Additionally, Individual #4 was observed on 7/28/15 from 6:26 - 7:35 a.m. During the 1 hour and 9 minute observation period, the following was noted: 6:26 - 7:00 a.m.: Individual #4 came out of his bedroom and sat on the couch in the living room, where he remained until 6:30 a.m. Individual #4 stood up, then sat back down until 6:54 a.m. At that time, Individual #4 walked to the refrigerator, and then returned to the couch. At 6:58 a.m., he walked down the hallway with a DCS, then returned to the living room couch at 7:00 a.m. 7:00 - 7:10 a.m.: Individual #4 was sitting on the living room couch. A DCS offered him the remote control for the television. Individual #4 did not respond. He was then prompted to take his morning medications and he went down the hall and into the bathroom, where he remained until 7:10 a.m. 7:10 - 7:30 a.m.: Individual #4 came out of the bathroom and returned to the couch, where he remained intermittently holding a pencil and smelling his fingers until the observation ended at 7:30 a.m. Other than taking his medications, Individual #4 was not observed to be consistently encouraged or prompted to participate in functional,	MM159		

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MM159	Continued From page 80 meaningful activities during the 1 hour and 9 minute observation period. d. Individual #4's Monday through Friday "A.M. Schedule" included the following: 10:00 - 11:30 a.m.: The schedule stated "Choice of Task." The "A.M. Schedule" included a note which stated "Choice of Task:" and listed coloring, stringing beads, writing, signing name, communication, learning alphabet, vacuuming, laundry, food prep., and community. However, the "A.M. Schedule" also included a note which stated "Choice of Leisure:" which listed coloring, helping with laundry, walks, etc. The schedule did not include which activities were to be completed as tasks or leisure activities. Additionally, Individual #4's IPP included an objective for Individual #4 to "...choose a task from a choice of three during DT time with a nonspecific verbal cue..." The plan stated if Individual #4 refused to participate, staff were to tell him they would give him 5 minutes to think about it and re-cue in 5 minutes. Individual #4's 2/2015 choose task program plan stated staff were to ask Individual #4 to choose a task. The plan did not include information related to how the tasks were to be offered (e.g. actual items, PECS, etc.) or what tasks to offer Individual #4. However, his Monday through Friday "A.M. Schedule" stated "Choice of Task" was scheduled from 10:00 - 11:30 a.m. The schedule included a note which stated "Choice of Task:" and listed	MM159		

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MM159	Continued From page 81 coloring, stringing beads, writing, signing name, communication, learning alphabet, vacuuming, laundry, food prep., and community. Individual #4 was observed on 7/28/15 from 11:05 - 11:45 a.m. During the 40 minute observation period, the following was noted: 11:05 - 11:45 a.m.: Individual #4 was standing in the kitchen. At 11:10 a.m., he went to the living room and was sitting on the couch. He was observed intermittently holding a pencil. A DCS prompted him to do laundry. Individual #4 did not respond and remained on the couch. At 11:35 a.m., a DCS prompted Individual #4 to go outside with her for pedestrian safety. Individual #4 did not respond and remained on the couch until 11:44 a.m. At 11:44 a.m., Individual #4 went to the front door. A DCS told him he needed to wait for staff and prompted him to help sweep the floor. Individual #4 did not respond to the request and returned to the couch, remaining seated until the observation ended at 11:45 a.m. Individual #4 was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives during the 40 minute observation period. At no time during the observation was staff noted to offer Individual #4 a choice of 3 activities, prompt him that they would give him 5 minutes to think, or re-cue after 5 minutes. The schedule did not specify which tasks Individual #4 was to engage in. Additionally, his IPP included formal objectives for sitting in a chair and finishing a task and choosing a task from 3 different tasks. However, his Active Treatment Schedule did not specify which tasks Individual #4 was to complete or which formal or informal	MM159		

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MM159	Continued From page 82 objectives were to be implemented during the "Choice of Task" time blocks. Further, Individual #4's IPP stated he required 1:1 line-of-sight supervision between the hours of 6:00 a.m. and 2:00 p.m. However, during the observations conducted on 7/28/15 from 6:26 - 7:35 a.m. and from 11:05 - 11:45 a.m., Individual #4 was not observed to be consistently provided with a 1:1 staff. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the City Director stated Individual #4 should have been offered activities per his programming throughout the observations. The City Director stated his 1:1 staff should not have left him alone during his hours of increased supervision and the staff should have been continuously attempting to engage Individual #4. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated no other active treatment schedules were present and staff should have been following the schedules that were in place. The facility failed to ensure Individual #4 was consistently encouraged or prompted to participate in functional, meaningful activities, and received interventions and services consistent with his IPP.	MM159		
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4)(iii), Condition of Participation: Client Behavior	MM162		9/23/15

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MM162	Continued From page 83 and Facility Practices incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1.The facility's behavior policy as well as Individual #1's behavioral documentation was reviewed. Concerns were identified, as follows: Individual #1's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound intellectual disability, Down Syndrome, and Disruptive Behavior Disorder. a. During observations conducted on 7/27/15 at 2:55 p.m., it was noted Individual #1's clothes were stored in the garage. At 3:15 p.m., Individual #1 was in his bedroom with the door open and his windows uncovered. He was observed to remove his shoes and his pants and was not observed to be wearing underwear. Individual #1 then walked down the hallway and into the garage, without pants on. DCS noticed Individual #1 in the garage and redirected him back to his bedroom. Individual #1 was not able to independently access his clothes without compromising his privacy. Additionally, on 7/27/15 at 5:10 p.m., it was noted Individual #1's other belongings (e.g. puzzles,	MM162		

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MM162	Continued From page 84 blocks, etc.) were also stored in the garage. When asked on 7/28/15 at 7:37 a.m., DCS A stated Individual #1's clothes were stored in the garage because he would dip them in the toilet and throw them. When asked on 7/28/15 at 8:17 a.m., the Program Supervisor stated Individual #1's personal possessions were stored in the garage because he would tip things over, pull items out, urinate on them and dip them in the toilet. Individual #1's Functional Behavior Assessment, dated 3/28/14, included a section for socially offensive behavior, defined as "urinating on the floor/clothing, dipping his clothes in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." The assessment stated Individual #1's socially offensive behavior "...tends to occur when [Individual #1] wants a different pair of clothing. If he does not like what he is wearing, he will urinate in his pants and at times dip clothing in the toilet so that he can be given a different pair of clothing..." His assessment and the corresponding Behavior Intervention Plan for socially offensive behavior, revised 5/1/15, were reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in either the assessment or the plan. Further, the facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 10/9/14, stated "Restriction of personal belongings" was "the removing and denying access to personal	MM162		

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MM162	Continued From page 85 belongings in order to protect the individual from harming themselves or others." The policy did not include the removal of personal possessions for reasons other than self harm. During an interview on 8/10/15 from 1:05 - 1:10 p.m., the City Director stated the removal of items was included in policy, however, it was specifically included for instances of self-harm and/or suicidal ideation. The City Director stated the policy did not include any information related to the removal of items as a general behavioral intervention. The facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior. b. Individual #1's 7/1/15 psychiatric notes documented he was prescribed Prozac (an antidepressant drug) 10 mg each morning for signs and symptoms of depression which included a loss of pleasure, sleeping more, and crying. However, Individual #1's record did not include documentation that less restrictive interventions had been systematically tried and found to be ineffective prior to the initiation of the medication. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no assessment or program plan in place to address Individual #1's depressive symptoms. The QIDP stated staff were reporting Individual #1 was showing loss of interest and was crying, but no tracking of these symptoms had been completed. Without the implementation of less restrictive systematic interventions and monitoring, it would	MM162		

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MM162	Continued From page 86 not be possible for the facility to ensure less restrictive alternatives were ineffective. The facility failed to ensure less restrictive interventions were systematically tried and found to ineffective prior to the initiation of Prozac. c. Individual #1's record did not include a program plan, including staff instructions, regarding how to intervene when Individual #1 displayed depressive symptoms. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no program plan in place to address Individual #1's depressive symptoms. The facility failed to ensure techniques used to manage Individual #1's depressive symptoms were incorporated into his program plans. d. Individual #1's Behavior Intervention Plan for socially offensive behavior, revised 5/1/15, stated he "...displays socially offensive behavior by urinating on the floor/clothing, dipping his clothing in the toilet, walking naked through the house, and/or invading others' privacy by going in others [sic] rooms/turning others [sic] lights off/throwing his wet clothing on others." His behavior plan was reviewed. Information related to storing Individual #1's clothes and other personal possessions in the garage was not included in the plan. During a telephone interview on 8/12/15 from 2:26 - 2:32 p.m., the QIDP stated no additional methods related to Individual #1's restriction to personal possessions had been developed. The facility failed to ensure Individual #1's plans	MM162		

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MM162	Continued From page 87 included appropriate information to address his socially offensive behavior. e. Individual #1's 7/6/15 "Psychotropic Medication Plan" stated Prozac was being used to assist Individual #1 with a loss of interest in activities he previously enjoyed and crying spells. The plan stated "Will consider decreasing Prozac by 5 mg when depression symptoms decrease to 30 hours or less for three consecutive months." However, Individual #1's records, including his 3/28/14 Functional Behavioral Assessment, did not include information related to the depressive symptoms such as when the symptoms started, the frequency, duration and severity of the symptoms, or an analysis of other potential causes for the symptoms beyond depression. Further, his IPP did not include an objective related to the symptoms or a program plan which included non-pharmacological intervention strategies to assist Individual #1 in managing his symptoms. Without such information, it would not be possible for the IDT to establish medication reduction criteria based on Individual #1's assessed status and needs. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated a medication reduction plan for Individual #1's Prozac had not been developed. The facility failed to ensure Individual #1's medication reduction criteria was established based on a data-driven, comprehensive assessment of his depressive symptoms. f. Individual #1's record contained a Written	MM162		

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MM162	Continued From page 88 Informed Consent, dated 7/6/15, for the use of Prozac which documented potential side effects included, but were not limited to, allergic reaction, anxiety, restlessness, fever, sweating, muscle spasms, nausea, vomiting, diarrhea, seeing or hearing things that are not there, confusion, weakness, muscle twitching, eye pain, trouble seeing, blurry vision, fast, pounding, or uneven heartbeat, dizziness, feeling more excited or energetic than usual, trouble sleeping, seizures, skin rash, blisters, peeling or redness, trouble breathing, unusual behavior, thoughts of hurting one's self, unusual bleeding or bruising, shaking, changes in appetite and weight loss or gain. However, Individual #1's records, including his 3/28/14 Functional Behavioral Assessment, did not include information related to the depressive symptoms such as when the symptoms started, the frequency and duration of the symptoms, less restrictive interventions attempted and found to be ineffective prior to the initiation of the medication, etc. When asked during an interview on 8/4/15 at 2:50 p.m., the QIDP and LPN stated there was no assessment or program plan in place to address Individual #1's depressive symptoms. The QIDP stated staff were reporting Individual #1 was showing loss of interest and was crying, but no tracking of these symptoms had been completed. Without such documentation and monitoring, it would not be possible for the facility to ensure the severity of Individual #1's depressive symptoms outweighed the potential side effects of the Prozac. The facility failed to ensure the severity of Individual #1's depressive symptoms was shown	MM162		

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MM162	Continued From page 89 to outweigh the potentially harmful risks of the drug. 2. Individual #3's behavioral documentation was reviewed. Concerns were identified, as follows: Individual #3's IPP, dated 8/21/14, documented a 30 year old male whose diagnoses included mild mental retardation. Individual #3's Behavioral Assessment, dated 8/15/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, suicidal ideation, depression, anxiety and aggression. Individual #3's Positive Behavior Support Intervention Plans for each assessed behavior were reviewed. The plans did not include comprehensive instructions, as follows: a. Individual #3's Positive Behavior Support Intervention Plan for suicidal ideation, dated 4/1/15, defined the behavior as making threats to injure himself or stating he would kill himself. The plan documented staff were to place Individual #3 on line-of-sight supervision and to follow his suicide guidelines. However, Individual #3's Suicide Guidelines, dated 4/3/14, were reviewed and documented staff were to place Individual #3 on "arm's length" supervision. It was not clear which level of increased supervision Individual #3 required as a suicidal ideation intervention. b. Individual #3's Suicide Guidelines documented "Remove any potentially dangerous items from Resident and/or his environment." However the plan also documented "If at any time Resident	MM162		

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MM162	Continued From page 90 threatens to use an object to harm himself, remove that object as well as any sharp object that Resident can use." It was not clear if staff were expected to immediately remove all potentially dangerous items or if they were to wait until a direct threat to use the item(s) was made. c. The Suicide Guidelines documented if Individual #3 attempted to physically harm himself, staff were to "Encourage Resident to stay with the group and not isolate himself." Staff were also instructed to maintain his increased level of supervision "to ensure intervention if he again attempts to harm himself," encourage the use of coping skills, offer favorite activities and communicate with the Program Supervisor. The instructions did not include any instructions to staff related to physical intervention (e.g. block attempts). d. Individual #3's Suicide Guidelines documented "An emerging precursor of suicidal ideation for Resident occurs is [sic] when he is reporting feelings that he is mistreated, ignored, or abused by any staff member. Staff MUST report this incident to the Program Manager or supervisor on duty as a sign of suicidal ideation." No additional information was included to clarify why making an allegation was included in the plan as a "sign of suicidal ideation." e. Individual #3's Behavioral Assessment documented he engaged in socially offensive behavior, defined as making rude remarks to others, arguing or yelling at others, bossing or teasing others and threatening others.	MM162		

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MM162	Continued From page 91 The Positive Behavior Support Intervention Plan for socially offensive behavior, dated 8/15/14, included interventions as follows: - During meals, provide the option to eat at a later time - Cue Individual #3 one time that his behavior is inappropriate - Redirect Individual #3 to his coping skills program - Extinct the behavior - Cue Individual #3 to stop and take a break - Extinct Individual #3 but maintain visual contact The only intervention steps with direct staff involvement included the use of two verbal cues. No additional instruction to ensure Individual #3 did not continue to tease, threaten, etc. was included in the plan. Additionally, the Behavioral Assessment documented under "Events that typically follow the Maladaptive Behavior," that Individual #3 was "closely monitored" after socially offensive behavior. No additional information was included in the instructions to clarify when increased monitoring was expected to take place or how the monitoring worked in relation to extinction. f. The Positive Behavior Support Intervention Plan for depression, dated 4/1/15, defined the behavior as isolating in his room, sleeping more or less than usual, losing interest in previously enjoyed activities, refusing ADLs, day treatment or medications and being more irritable or agitated. The plan included interventions as follows: - Encourage Individual #3 to participate in scheduled activities and programs	MM162		

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	13G063		08/03/2015

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE

STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD, IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM162	Continued From page 92 - Assist him with choosing an alternative activity or program - Check on him every 10 - 15 minutes - Cue Individual #3 to his schedule and outings list It was not clear how the instructions were sufficient for staff to address Individual #3's depression symptoms. For example, the plan did not include how many ignored cues meant Individual #3 was refusing a medication and at which point staff would involve nursing. Additionally, the Behavioral Assessment documented under "Events that typically follow the Maladaptive Behavior," that Individual #3 would make "Phone call to mom" after exhibiting depressive symptoms. No information related to a phone call was included in the plan interventions. g. The Positive Behavior Support Intervention Plan for anxiety, dated 4/1/15, defined the behavior as repeating himself, obsessing, restlessness, pacing and "being keyed up/overly excited or on edge." The plan included interventions as follows: - Encourage Individual #3 to participate in any scheduled activity - Encourage him to choose an alternative coping or sensory activity - Encourage him to structure his leisure time It was not clear how the instructions were sufficient for staff to address Individual #3's anxiety symptoms. For example, the plan did not include how, or if, staff were to address any verbal statements from Individual #3 in situations of repeating himself, obsessing or being excited.	MM162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G063		08/03/2015

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MM162	Continued From page 93 During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #3's behavior plan needed revised. The City Director, who was also present during the interview, stated they were looking at making revisions to suicidal ideation forms and policy as well. The facility failed to ensure techniques to manage maladaptive behaviors were sufficiently incorporated into Individual #3's behavior plans. 3. Individual #2's behavioral documentation was reviewed. Concerns were identified, as follows: Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability. a. Individual #2's Behavioral Assessment, dated 11/5/14, documented he engaged in maladaptive behaviors including socially offensive behaviors, disruptive behaviors and physical aggression. Individual #2's Behavior Intervention Plan for socially offensive behavior, dated 10/31/14, included interventions during the behavior as follows: - Redirect to communication tools - Step out of the trajectory and block as needed - Hand him a surgical mask Observations were completed on 7/27/15 and 7/28/15 for a cumulative 5 hours 15 minutes. During that time, Individual #2 was observed to repeatedly spit, resulting in staff intervention inconsistent with his behavior plan, as follows: 7/27/15 from 2:30 - 3:45 p.m.:	MM162		

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MM162	Continued From page 94 - 3:35 p.m. Individual #2 began spitting. DCS E verbally cued Individual #2 to stop the behavior. DCS E then obtained a bandana which she provided to Individual #2 and he proceeded to chew on. 7/28/15 from 3:50 - 4:15 p.m.: - 4:05 p.m. Individual #2 was engaged in spitting behavior. DCS D obtained a bandana which she gave to Individual #2 and he proceeded to chew on. However, the use of a bandana could not be found in Individual #2's behavior plan. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #2's behavior plan needed revised to include the use of the bandana. The facility failed to ensure techniques to manage socially offensive behavior were sufficiently incorporated into Individual #2's behavior plan. b. Individual #2's Physician's Orders, dated 5/6/15, included an order for Valium (an anxiolytic drug) 5 mg by mouth "30 minutes before dental." However, a medication reduction plan could not be located in Individual #2's record. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated he had not yet created a medication reduction plan for Individual #2's Valium. The facility failed to ensure Individual #2's medications were sufficiently incorporated into a	MM162		

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MM162	Continued From page 95 plan. The cumulative effect of these deficient practices significantly impeded the facility's ability to develop, consistently implement and closely monitor individuals' behavioral interventions.	MM162		
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n)(2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals were provided with adequate general and preventative medical care for 2 of 4 individuals (Individuals #2 and #3) whose medical records were reviewed. This resulted in the potential for medication administration errors and individuals' medical needs to go unidentified and unaddressed. The findings include: 1. Medical records for Individual #2 and Individual #3 were reviewed. Medical concerns were identified, as follows: a. Individual #2's IPP, dated 11/6/14, documented he was a 24 year old male whose diagnoses included profound intellectual disability and "Allergy to peanuts." Individual #2's record included a Nursing Evaluation, dated 5/18/15, which documented "ALLERGIES: NKDA, MAY HAVE PEANUT	MM166		9/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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MM166	Continued From page 96 BUTTER BUT NO OTHER NUTS OR NUTELLA (PER MOM)." When asked, during an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated she and Individual #2's mother were not sure if Individual #2 had an actual allergy to peanuts. The LPN stated the facility was monitoring Individual #2 to assess his reaction to peanuts. During the same interview, when asked about the physician's involvement, including directions on what to monitor for, the LPN stated she had not been in communication with Individual #2's physician about the issue. b. Individual #2's laboratory records were reviewed. A laboratory report, dated 3/4/15, documented Individual #2's triglycerides were measured on 3/3/15 and were found to be 190 mg/dL. The report documented the normal level for triglycerides was 38 - 150 mg/dL. Individual #2's HDL cholesterol was also measured on 3/3/15 and was found to be 30 mg/dL. The report documented the normal level for HDL cholesterol was 40 - 70 mg/dL. The laboratory report included a handwritten entry, dated 3/6/15, which documented the results were faxed to Individual #2's physician. However, follow-up to Individual #2's laboratory report could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the physician would sign the laboratory report indicating it had been read. The physician's signature could not be located on the report. The LPN stated she would follow-up with the physician to ensure the out-of-range	MM166		

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MM166	Continued From page 97 cholesterol levels had been noted. The facility failed to ensure Individual #2 was provided with general and preventative medical care for his identified needs. c. Individual #2's medical record was reviewed for quarterly nursing examinations. Individual #2's record contained an admission nursing examination, dated 10/8/14. The next quarterly examination was not completed until 3/3/15. Additionally, the record included a quarterly nursing examination, dated 6/30/15, which included the following handwritten note from the LPN, "Had just been running around the house. Refused x2 attempts for assessment." A successful nursing examination after the 3/3/15 quarterly could not be found. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the 6/30/15 attempts were the only efforts made to complete a nursing examination during that time period. The facility failed to ensure Individual #2's nursing assessments had been completed on a quarterly basis. d. Individual #2's Physician's Orders, dated 5/6/15, included an order to "Assist with oral medication administration with use of applesauce, pudding, or other food products." The orders also included "Crush medication." An observation was conducted at the facility on 7/28/15 from 6:26 - 7:35 a.m. During that time,	MM166		

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MM166	Continued From page 98 Individual #2 was observed to take his morning medications with the assistance of a direct care staff. After Individual #2 pushed all pill-form medications into a small cup, the direct care staff dumped the pills into a bowl of applesauce. The direct care staff portioned out a liquid medication and added that to the bowl as well. Individual #2 was observed to feed himself the applesauce/medication mixture. However, at no time was the direct care staff observed to crush Individual #2's pill-form medications. During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the medications should have been crushed prior to administration. The facility failed to ensure Individual #2's medications were administered without error. e. Individual #2 and #3's Physician Standing Medication Orders, both dated 1/12/15, were reviewed. The documents included PRN medications which were did not consistently include specific individualized orders, as follows: - Acetaminophen (an analgesic drug) was ordered "650mg to 1000mg" every four hours PRN. - Milk of Magnesia (a laxative drug) was ordered for "30-60 cc PRN." - Loperamide hydrochloride (an antidiarrheal drug) 2 mg was ordered for every "3-4 hours." - Guaifenesin (an expectorant drug) 10 cc was ordered for every "6-8 hours."	MM166		

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MM166	Continued From page 99 - Benadryl (an antihistamine drug) was ordered "25mg to 50mg [every] 6-8 hours." The orders did not include information regarding how to determine which medication dosage to administer or when a repeat dose could be administered (i.e. 4, 5, 6, etc. hours after the first dose). During an interview on 7/31/15 from 8:25 - 10:35 a.m., the LPN stated the orders would be clarified. The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were specific.	MM166		
MM215	16.03.11711.01 Good Repair Each building used by the ICF/ID and its equipment must be in good repair. This Rule is not met as evidenced by: 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 in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 7/29/15 from 2:48 - 3:50 p.m. The Program Supervisor and facility maintenance person were both present. During that time, the following was noted: - The light cover was missing from the ceiling light in the bedroom shared by Individual #1 and Individual #4.	MM215		9/23/15

Bureau of Facility Standards

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MM215	Continued From page 100 - Both of the 2 dining room tables were bubbled and peeling on the surface. - There was no screen on the window in the bedroom shared by Individuals #1 and #4. - One of the 9 kitchen drawers was missing a knob. Two of the drawers were broken from the tracks. - There was an approximate one inch height difference between the cement of the driveway and the cement of the front walkway, resulting in uneven surface where the structures met. - There was a banana chair in the living room with ripped upholstery fabric. During an interview on 7/29/15 from 4:00 - 4:20 p.m., the City Director stated the banana chair belonged to Individual #1 and he would speak to the guardian about repair options. The City Director stated he was aware of the uneven pavement and that bids had been obtained. The facility failed to ensure the environment was kept clean and repairs were completed and maintained.	MM215		
MM366	16.03.11800 Dietetic Services The requirements of Sections 800 through 899 of these rules are modifications and additions to the requirements of 42 CFR 483.480 - 483.480(d)(5), Condition of Participation: Dietetic Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by:	MM366		9/23/15

Bureau of Facility Standards

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MM366	Continued From page 101 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 2 of 6 individuals (Individuals #1 and #2) residing in the facility and had the potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include: 1. An observation was conducted at the facility on 7/27/15 from 2:30 - 3:45 p.m. At 3:06 p.m., Individual #2 was noted to be seated at the table eating a pureed snack. At 3:30 p.m., Individual #1 was observed to eat a bowl of mixed vegetables for a snack. Individual #2's record was reviewed. His dietary Initial Assessment, dated 10/2014, documented Individual #2 required "6 small meals per day, every 2-3 hours." However, the facility's menus for July 2015 were reviewed and did not include snacks that were planned for the day. When asked about Individual #2's small meals, during an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated Individual #2's meals consisted of the three routine meals as well as snacks. The City Director, who was also present, stated that if the snacks were not included on the menu, there would not be documentation of snacks. The facility failed to ensure accurate documentation of all food actually served was kept.	MM366		

ASPIRE
HUMAN SERVICES, LLC

RECEIVED
SEP 18 2015
FACILITY STANDARDS

9/17/15

Karen Marshall
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RE: Springfield, Provider #13G063

Dear Karen Marshall:

Thank you for your considerate observations during your recent visit at the Springfield home on August 3, 2015. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

W102
Please see the response given under W104.

W104
Currently Aspire Human Services has a policy and procedure in place which outlines the governing body of the facility. The Program Manager is listed in the policy as one part of the governing body.

Please see the responses given under W111, W122, W149, W154, W157, W159, W195 and W266.

W111

1. Currently there is paper data in place for individuals #1, #2 and #3 and all ADL data is being collected as specified in each program. The QIDP for the home is currently in the process of obtaining a Written Informed Consent for Individual #2 in relation blocking and supporting escorting interventions. Individual #2's MAR sheets are in the process of being revised to include comprehensive information.
2. All individuals residing in the home currently have accurate data collection in place for all ADL Programs. The IDT is in the process of reviewing all restrictive interventions in the home and verifying that Written Informed Consents are in place for all restrictive interventions. The IDT is also currently in the process of reviewing the MAR sheets for each individual residing in the home to ensure they contain the comprehensive information required.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that client records are maintained.

4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W122

Please see the responses given under W124, W129, W137 and W149.

W124

1. The consents for individuals #1 and #2 are being revised to ensure each guardian is aware of all restrictive interventions being utilized.
2. The IDT is in the process of reviewing all of the written informed consents to ensure that the guardians are fully informed of all restrictive interventions. Corrections are being made to each consent that does not contain comprehensive information.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that the written informed consents are comprehensive.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W129

1. Individual #1's treatment team is in the process of revising his behavior assessment and programming to better address his privacy and dignity issues. Part of the revisions include staff instructions for clothing to protect his right to privacy.
2. The IDT at the Springfield facility is currently reviewing all of the program plans and making revisions as necessary to protect the right to privacy of each individual residing at the in the facility.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that privacy issues are thoroughly addressed in each program plan.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W137

1. Individual #1's IDT is in the process of revising his behavior assessment and programming to better address his right to have access to his personal possessions. Parts of the revisions include staff instructions for ensuring he has access to his personal possessions.
2. The IDT at the Springfield facility is currently reviewing all of the program plans and making revisions as necessary to protect the right to personal possessions of each individual residing the in the facility.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that the right to personal possessions is thoroughly addressed in each program plan.

4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W149

1. Aspire Human Services is currently in the process of revising the company policy as it relates to suicide ideation.
2. All Employees that work in the Springfield home are being re-trained on the revised Suicide Policy. Specifically, all employees are being trained on identifying when an individual is displaying suicidal ideation, supervision definitions and needs, suicide risk assessment, the importance of documentation.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that suicide ideation is addressed in the Individual Program Plan when appropriate.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

Please see the responses given under W154 and W157.

W154

1. All employees that work in the Springfield home are currently being re-trained on the company policy for Abuse/Neglect and Mistreatment. The training is focusing on the definitions of abuse, who to notify, when to make notifications, the investigation process and the importance of documentation.
2. All incident reports for the Springfield home are being reviewed to ensure that the Abuse/Neglect and Mistreatment policy has been implemented for each incident.
3. Aspire Human Services is currently utilizing a standardized investigation format. The goal of the standardized format is to ensure investigations are completed thoroughly.
4. The Idaho Falls facilities are coordinating a weekly meeting with the Program Supervisors. At the meeting each incident/accident report is reviewed for accuracy. The Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W157

1. All Program Supervisors are currently being re-trained on the company policy for Abuse/Neglect and Mistreatment. The training is focusing on taking appropriate correction action when conducting an investigation.
2. All incident reports for the Springfield home are being reviewed to ensure that the Abuse/Neglect and Mistreatment policy has been implemented for each incident and appropriate correction action has been taken.
3. Aspire Human Services is currently utilizing a standardized investigation format. The goal of the standardized format is to ensure investigations are completed thoroughly.

The last section of the standardized format is to list the correction action taken to protect individuals.

4. The Idaho Falls facilities are coordinating a weekly meeting with the Program Supervisors. At the meeting each incident/accident report and investigation is reviewed for accuracy. The Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W159

1. The ADL data for individuals 1-4 is currently being collected by paper data. The behavior assessments for individuals 2 and 3 are being revised to contain accurate definitions of maladaptive behaviors in order to ensure that data is being collected accurately.
2. All the individuals' ADL data in the home is being collected by paper data. All the behavioral assessments are being reviewed to ensure the data is being collected accurately.
3. We are currently doing chart reviews in order to verify that the ADL data is being collected accurately. In addition, we will verify that the behavioral assessments contain accurate definitions of maladaptive behaviors, so the data can be summarized accordingly.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

Please see the responses given under W124, W129, W137, W196, W278, W289, W312, W313 and W481.

W195

Please see the response given under W196.

W196

1. Individual 4's active treatment schedule is being revised to provide guidance to staff on how to provide active treatment for his needs. All staff in the home are being trained on individual 4's active treatment needs.
2. All individuals' active treatment in the home will be reviewed and revised if necessary in order to provide guidance to staff that they may be able to provide active treatment for their needs.
3. QIDP's are currently conducting active treatment observations to ensure that services are being provided accurately.
4. The Program Manager is creating a schedule to ensure each QIDP is conducting weekly observations at the home.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

Please see the responses given under W212, W214, W227, W234, W239, W249, W250, W252, W257, W262 and W263.

W212

1. Individual 1 is scheduled to have a psychological assessment on Monday, 8/24/15 to obtain an accurate diagnosis. The behavioral assessment will then be revised in order to ensure that the behavioral assessment accurately reflects current diagnosis and medication needs.
2. All of the psychological assessments are being reviewed to verify an accurate diagnosis. Corrections will be made if inaccurate diagnoses are found.
3. Currently the facility is doing chart reviews to verify accuracy of diagnoses.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W214

1. Individuals 1, 2, and 3's behavioral assessments are being revised to include comprehensive and accurate information. Individual 2's CFA is being revised and all areas are being assessed.
2. All individuals' behavioral assessments are being reviewed and revised if necessary to ensure that they include comprehensive and accurate information. All CFA's are being reviewed and revised if necessary to ensure all areas are assessed accurately.
3. Aspire Human Services is currently doing chart reviews in order to verify the accuracy of the behavioral assessments. In addition, we will verify that all areas in the CFA's have been assessed for each individual.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W227

1. Individual 1's behavioral assessment is being revised to include depressive symptoms. In addition, corresponding objectives have been developed to address his assessed needs for depression. Individual 2's behavioral assessment is being revised to include his self-injurious behaviors. In addition, corresponding objectives have developed to address his assessed needs for self-injurious behavior.
2. Aspire Human Services will review all behavioral assessments to ensure that all needs are being addressed properly. Objectives are being developed for all needs identified in the revised behavioral assessments.
3. The facility is doing chart reviews, part of which is verifying that behavioral assessments are comprehensive and that all needs are addressed.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W234

1. Individuals #1- #3's training programs will be revised to include adequate directions to staff.
2. All individuals' training programs will be revised to include adequate directions to staff.

3. The facility is doing chart reviews, part of which is verifying that adequate directions are present in each training program.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

Please see the response given under W289

W239

1. Individual 1 and 3's replacement behavior will be revised so that they are functionally related to their maladaptive behaviors.
2. All individuals' replacement behaviors will be revised so that they are functionally related to their maladaptive behaviors.
3. The facility is doing chart reviews, part of which is verifying that the replacement behaviors are reflective of the individuals maladaptive behaviors.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W249

1. Individual 2 and 4's 1:1 guidelines will be reviewed and revised so that they adequately reflect interventions consistent with their programs. Training will be provided to ensure staff knows all guidelines and how to appropriately implement them. Individual 2, 3 and 4's programs will be revised to reflect the needs addressed in the IPP.
2. All individuals' 1:1 guidelines will be reviewed and revised if necessary, so that they adequately reflect interventions consistent with their programs. All individuals' programs will be reviewed and revised if necessary to reflect the needs addressed in the IPP.
3. The facility is doing chart reviews, part of which is verifying that the 1:1 guidelines are reflective of the individuals' needs.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W250

1. Active treatment schedules for individuals 3 and 4 will be revised to contain sufficient information to direct the work of staff and ensure their active treatment needs are met.
2. All of the active treatment schedules for individuals will be revised to contain sufficient information to direct the work of staff and ensure their active treatment needs are met.
3. The facility is doing chart reviews, part of which is verifying that the active treatment schedules are reflective of the individuals' needs.

4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W252

1. Revised ABC forms have been implemented for individuals 1, 2, and 3 in the home in order for staff to accurately document sufficient information to judge the efficacy of programming. Incidents of depression and anxiety are being documented on the ABC data form. On 8/18/15 all staff were trained on how to properly complete the ABC forms. In addition, all staff will receive training on recording incidents of suicide ideation – including the risk assessment.
2. The revised ABC form is being used to collect data for all individuals in the home.
3. The facility is doing chart reviews, part of which is verifying that the ABC data provides sufficient information to judge the efficacy of their programs.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W257

1. Individual 3's IDT took place on 8/20/15 where the QIDP discussed his programming and made revisions based on his current needs.
2. All individuals' objectives will be reviewed and revised if necessary to reflect current functioning levels. 9/11/15
3. The facility is doing chart reviews, part of which is verifying that the programs have been revised when needed to assist the individuals to make progress towards their goals.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W262

1. The QIDP is currently obtaining guardian and HRC consent for individuals 1, 2, and 3's restrictive programming.
2. All individuals' records will be reviewed as necessary for obtaining guardian and HRC consent for restrictive programming.
3. The facility is doing chart reviews, part of which is verifying that consents have been obtained from guardians and HRC.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.

5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W263

1. The QIDP is currently obtaining guardian consent for individual 3's restrictive programming.
2. All individuals' records will be reviewed as necessary for obtaining guardian consent for restrictive programming.
3. The facility is doing chart reviews, part of which is verifying that consents have been obtained from guardians.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W266

Please see the responses given under W276, W278, W289, W312 and W313.

W276

1. The behavior policy is being reviewed and revised to include the strategies utilized to manage individual 1's maladaptive behavior.
2. The behavior management policy is being reviewed and revised as necessary to include all strategies utilized to address maladaptive behavior.
3. The facility is doing chart reviews, part of which is verifying that all intervention strategies are consistent with the behavior management policy.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W278

1. The facility has created a document to capture the lesser restrictive interventions implemented prior to initiating restrictive interventions.
2. This document will be utilized for all restrictive interventions for all individuals.
3. The facility is doing chart reviews, part of which is verifying that lesser restrictive interventions are documented prior to implementation of restrictive interventions.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W289

1. The interventions strategies are being written for individuals 1-3, to address their behavior management needs. Once the strategies have been written, all staff will receive training.

2. All behavior management plans are being reviewed and revised as necessary to ensure appropriate techniques are present to manage their needs.
3. The facility is doing chart reviews, part of which is verifying that program plans contain techniques to address individuals' needs.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W312

1. The medication plans for individuals 1 and 2 are being revised and medications are being incorporated into the reduction plans.
2. All medication plans are being reviewed and revised as necessary to ensure medications are incorporated into the reduction plans.
3. The facility is doing chart reviews, part of which is verifying that medications have been incorporated into the med reduction plans.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W313

1. Individual 1 is scheduled for a psych meeting on 9/2/15 to discuss whether the benefits outweigh the risks of his Prozac.
2. All individuals taking medications to manage maladaptive behavior will be discussed and reviewed with the psychiatrist at the psych meeting 9/2/15 to discuss whether the benefits outweigh the risks of their medications.
3. The facility is doing chart reviews, part of which is verifying that the medications utilized by the individuals outweigh the risks.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

W322

1. Individual 2's labs are being forwarded to his physician to address his out-of-range labs. Documentation will be kept in the nursing book. Individual 2 has an appointment with his allergist on 8/27/15 to address his peanut allergies.
2. The Doctors have been notified of any labs that are out-of-range. Any updated Doctor's notes will be kept in the nursing books. Currently there is a nurse available to the facility 24 hours per day so staff members can solicit assistance with any nursing issue including potential allergic reactions. All potential allergic reactions are documented on a Health Status form so they can be tracked and reported to the physician if needed.

3. The facility is doing chart reviews, part of which is verifying that labs that are out-of-range have been addressed by their Doctor and that orders from doctors are followed such as orders to address potential allergies.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & Facility Nurse
6. Completion Date: 9/23/15

W331

1. The routine standing orders for individuals 2 and 3 have be revised and currently do not have or contain ranges.
2. All of the routine standing orders have been revised and currently do not have or contain ranges.
3. The facility is doing chart reviews, part of which is verifying that the facility is providing sufficient nursing oversight necessary to ensure individuals' medication orders were specific.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & Facility Nurse
6. Completion Date: 9/23/15

W336

1. The IDT has discussed strategies to obtain individual 2's quarterly nursing assessments. Currently Individual#2 has an objective incorporated into his IPP to help him desensitize to his participation in medical needs such as quarterly assessments and has a current nursing assessment completed.
2. Individuals 1, 2, 3, 4, 5, and 6 currently have up-to-date quarterly nursing assessments in their charts.
3. The facility is doing chart reviews, part of which is verifying that quarterly assessments are completed in a timely manner.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & Facility Nurse
6. Completion Date: 9/25/15

W369

1. Individual 2's MAR will be individualized to include instruction that medications are to be crushed. Nursing to hold an in-service and provide additional training for the staff in relation to individual 2's medications needing to be crushed.
2. All MAR's are being reviewed and revised as necessary to ensure medications are administered without error.
3. The facility is doing chart reviews, part of which is verifying that MAR's have necessary instructions.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, Facility Nurses' are currently conducting medication observations two times per month to ensure that services are being provided accurately.

5. Person Responsible: Program Manager & Facility Nurse
6. Completion Date: 9/23/15

W481

1. Staff are currently documenting all food consumed for individuals 1 and 2.
2. All food consumed by all individuals is currently being recorded.
3. QIDP's are reviewing food charts monthly to ensure all food consumed is being documented.
4. QIDP's to complete data checks, including menu tracking twice a month. Documentation will be provided to the program manager for review. In addition, QIDP's are currently conducting meal observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager, QIDP & Facility Nurse
6. Completion Date: 9/23/15

Javon Collins
Program Supervisor / QIDP

ASPIRE
HUMAN SERVICES, LLC

9/18/15

Karen Marshall
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RE: Springfield, Provider #13G063
Dear Karen Marshall:

Thank you for your considerate observations during your recent visit at the Springfield home on August 3, 2015. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

MM080

1.

1. Currently there is paper data in place for individuals #1, #2 and #3 and all ADL data is being collected as specified in each program. The QIDP for the home is currently in the process of obtaining a Written Informed Consent for Individual #2 in relation blocking and supporting escorting interventions. Individual #2's MAR sheets are in the process of being revised to include comprehensive information.
2. All individuals residing in the home currently have accurate data collection in place for all ADL Programs. The IDT is in the process of reviewing all restrictive interventions in the home and verifying that Written Informed Consents are in place for all restrictive interventions. The IDT is also currently in the process of reviewing the MAR sheets for each individual residing in the home to Ensure they contain comprehensive information.
3. Aspire Human Services has recently implemented chart reviews for all homes. One part of the chart reviews includes verifying that client records are maintained.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

- Refer to M134 as it relates to the Governing Body's failure to provide sufficient monitoring and oversight to ensure policies were adequately implemented and monitored if necessary to ensure individuals were not subjected to ongoing abuse or neglect.
- Refer to M155 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight.
- Refer to M159 as it relates to the Governing Body's failure to ensure the facility provided each individual with continuous active treatment designed to meet their individualized needs.

- Refer to M162 as it relates to the Governing Body's failure to ensure the facility ensured techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored.

MM134

Currently Aspire Human Services has a policy and procedure in place which outlines the governing body of the facility. The Program Manager is listed in the policy as one part of the governing body.

1.

1. All employees that work in the Springfield home are currently being re-trained on the company policy for Abuse/Neglect and Mistreatment. The training is focusing on the definitions of abuse, who to notify, when to make notifications, the investigation process and the importance of documentation.
2. All incident reports for the Springfield home are being reviewed to ensure that the abuse/neglect and mistreatment policy has been implemented for each incident.
3. Aspire Human Services is currently utilizing a standardized investigation format. The goal of the standardized format is to Ensure investigations are completed thoroughly.
4. The Idaho Falls facilities are coordinating a weekly meeting with the Program Supervisors. At the meeting each incident/accident report is reviewed for accuracy. The Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

2.

1. Aspire Human Services is currently in the process of revising the company policy as it relates to suicide ideation.
2. All Employees that work in the Springfield home are being re-trained on the revised policy. Specifically, the employees are being trained on identifying when an individual is displaying suicidal ideation, supervision definitions and needs, suicide risk assessment, the importance of documentation.
3. Aspire Human Services has recently implemented chart reviews for all homes. One part of the chart reviews includes verifying that suicide ideation is addressed in the Individual Program Plan when appropriate.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

3.

1. The consents for individuals #1 and #2 are being revised to ensure each guardian is aware of all restrictive interventions being utilized. Currently individual #1 has access to all of this clothing and none of his clothing his kept in the garage area. In addition, individual has a one to one staff in place to assist him in protecting his privacy by being available to intervene when he requires assistance.
2. The IDT is in the process of reviewing all of the written informed consents to ensure that the guardians are fully informed of all restrictive interventions. Corrections are being made to each consent that does not contain comprehensive information.

3. Aspire Human Services has recently implemented chart reviews for all homes. One part of the chart reviews includes verifying that the written informed consents are comprehensive.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

MM155

1. The policy and procedure for active treatment currently clarifies that program summaries are to be completed by the 10th of each month which affects each individual living in the facility. Currently there is paper data in place for individuals #1, #2 and #3 and all ADL data is being collected as specified in each program. Individual #3's behavior tracking has been revised and is currently being recorded in such a way to monitor each of his maladaptive behaviors comprehensively.
2. All individuals living in the facility are affected by the current policy for active treatment which clarifies that program summaries are to be completed by the 10th of each month. Currently all individuals in the home have paper data in place which captures specific program data for each program on the IPP's. Currently all individuals in the home have a behavior tracking system in place which records data recorded in such a way to monitor each of his maladaptive behaviors comprehensively.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that summaries are completed as outlined in the policy and that data collected is comprehensive.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

Please refer to the response given under M134, M159, M162 and M 366.

MM159

1. Individual #1's depressive symptoms are currently addressed in his assessments and programing, his Prozac has been approved by the HRC, his Socially Offensive behavior is being comprehensively address and his behavior data is being collected in a way that the efficacy of his programs can be assessed In addition, corresponding objectives have been developed to address his assessed needs for depression. Individual #3's behavior assessment has been revised to include comprehensive information, his replacement behaviors have been revised so they are functionally related, he is currently receiving interventions consistent with is programs, his training programs have sufficient direction for staff, his active treatment schedules have been revised to include updated information, his behavioral data is being collected to provide sufficient information, his programming has been revised to match his current abilities and he currently has guardian and HRC consent is in place for all restrictive interventions. Individual #2' is currently receiving interventions consistent with interventions and programs, his assessments have been revised to include comprehensive information, his objectives have been revised to match his assessments including a revised objective to address his assessed need of Self-Injurious Behavior, his behavioral data is being collected in such a way to provide sufficient information to judge the efficacy of his programs and HRC

consent has been obtained for all restrictive programming. Individual #4 is currently encouraged to participate in functional, meaningful activities and receiving interventions as outlined on is IPP.

2. All individual files have been reviewed and revised as necessary to include comprehensive information, up to date consents, adequate data collection systems and current assessments. All individuals in the home are currently receiving active treatment as outlined in their IPP's.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that summaries are completed as outlined in the policy, that data collected is comprehensive, assessments are current and comprehensive and that guardian and HRC consents are current. In addition, the QIDP is currently doing weekly documented observations in the home to verify active treatment is being provided for each individual.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

MM162

1. Currently all of Individual #1's restrictive components of his programming is addressed in the company's policy and procedure manual. Individual #1's behavior assessment and behavior programming has been revised to include to include comprehensive information on his less restrictive interventions and how his symptoms outweigh the potential harmful risks of his medications. Individual #3's behavior assessment and corresponding behavior plans have been revised to include techniques to manage his maladaptive behaviors. Individual #2 currently has a revised behavior assessment with information on how his medications effect his behavior.
2. All of the behavior assessments in the home have been revised to include comprehensive information.
3. Aspire Human Services has recently implemented chart reviews for all homes. Part of the chart review includes verifying that behavior assessments are comprehensive. In addition, the QIDP is doing weekly documented observations in the home to assure Active treatment is being provided for each individual.
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, QIDP's are currently conducting active treatment observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

MM166

1. Individual 2's labs are being forwarded to his physician to address his out-of-range labs. Documentation will be kept in the nursing book. Individual 2 has an appointment with his allergist on 8/27/15 to address his peanut allergies. The IDT has discussed strategies to obtain individual 2's quarterly nursing assessments and now has one completed. Currently Individual#2 has an objective incorporated into his IPP to help him desensitize to his participation in medical needs such as quarterly assessments. Individual 2's MAR will be individualized to include instruction that medications are to be crushed. Nursing to

hold an in-service and provide additional training for the staff in relation to individual 2's medications needing to be crushed.

2. The doctors have been notified of any labs that are out-of-range. Any updated doctor's notes will be kept in the nursing books. Individuals 1, 2, 3, 4, 5, and 6 currently have up-to-date quarterly nursing assessments in their charts. All MAR's are being reviewed and revised as necessary to ensure medications are administered without error. Currently there is a nurse available to the facility 24 hours per day so staff members can solicit assistance with any nursing issue including potential allergic reactions. All potential allergic reactions are documented on a Health Status form so they can be tracked and reported to the physician if needed.
3. The facility is doing chart reviews, part of which is verifying that labs that are out-of-range have been addressed by their doctor, verifying that quarterly assessments are completed in a timely manner and verifying that MAR's have necessary instructions
4. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. In addition, Facility Nurses' are currently conducting medication observations two times per month to ensure that services are being provided accurately.
5. Person Responsible: Program Manager & Facility Nurse
6. Completion Date: 9/23/15

MM215

1. The light cover will be replaced.
2. Dining tables (2) will be replaced or resurfaced.
3. The screen was replaced in window shared by individual numbers 1 &4.
4. The kitchen drawers will be inspected and repaired.
5. The driveway is scheduled to be replaced September 15, 2015.
6. The banana chair in the living room will be re-upholstered or replaced with guardian's permission.
7. The QIDP will train the Program Supervisor to complete the universal home checklist more thoroughly.
8. The QIDP will make observations in the home at least twice monthly to inspect for repairs needed.
9. Person Responsible: Program Manager & QIDP
10. Completion Date:9/23/15

M366

1. Staff are currently documenting all food consumed for individuals 1 and 2.
2. All food consumed by all individuals is currently being recorded.
3. QIDP's are reviewing food charts monthly to ensure all food consumed is being documented.
4. QIDP's to complete data checks, including menu tracking twice a month. Documentation will be provided to the program manager for review. In addition, QIDP's are currently conducting meal observations weekly to ensure that services are being provided accurately.
5. Person Responsible: Person Responsible: Program Manager & QIDP
6. Completion Date: 9/23/15

Javon Collins
Program Supervisor / QIDP

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 19, 2015

Steve Young, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83402

Provider #13G063

Dear Mr. Young:

An unannounced on-site complaint investigation was conducted from July 27, 2015 to August 3, 2015 at Yellowstone Group Home #1 Springfield. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007064

Allegation #1: The Qualified Intellectual Disabilities Professional (QIDP) is not providing sufficient oversight and monitoring of individuals' needs.

Findings #1: During the survey, observations were completed, the facility's investigations, incident/accident forms, behavior and activity of daily living (ADL) data, and individual records were reviewed, and staff and individual interviews were conducted.

On 7/27/15 at 2:25 p.m., behavior and ADL data from 1/1/15 - 7/27/15 was requested. The City Director stated the electronic data collection system the facility had been using for ADL data had been discontinued. As a result, the facility had to revert to a paper data collection system.

Three individuals were selected for review. One individual's record did not include raw ADL data prior to 1/26/15, the second individual's record did not include raw ADL data prior to 2/22/15, and the third individual's record did not include raw ADL data prior to 2/23/15.

During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated no paper data system was in place for ADLs when they were notified the electronic system would be discontinued. As a result, paper ADL data collection sheets had to be created for the individuals' programs. The QIDP stated the electronic system was still in place through February. The QIDP stated summary data for January and February 2015 was a combination of information from the electronic system and paper system. However, the information from the electronic system related to implementation rates, refusals, etc., was not present or accessible.

The City Director provided an email from the corporate office, dated 7/28/15 at 1:30 p.m., stating the electronic data collection system for ADLs had been discontinued at the end of February 2015, and that backup files were obtained for the data collected prior to 2/28/15. However, the City Director stated he did not have a way to view or print the backup files.

The facility failed to ensure a system was in place to collect data in the event the electronic data collection system was inoperable.

The 3 individuals' raw behavior data was reviewed. The facility utilized a Behavior Log form to collect data related to individuals' identified maladaptive behaviors, as well as new and emerging maladaptive behaviors. The form included a check-mark section with a list of antecedent setting events and triggers, but also included a narrative section where staff could describe the antecedent, behavior, and consequence. Additionally, the form included a place to document if restraint had been utilized.

Instructions on the Behavior Log form directed staff to complete an Incident/Accident Report form if a restraint was utilized that resulted in injury to the individual or was outside of the approved restraints in the individual's behavior plan (e.g., emergency restraint).

Seven direct care staff were interviewed from 7/28/15 - 7/29/15. All 7 staff stated they had received initial training and that continued training took place on a regular basis. All 7 staff stated training meetings were held once a month for a couple of hours, and information reviewed included training on medical issues, behavioral issues, and ADL issues. All staff stated they felt appropriately trained to complete their job duties and knew where to get information if questions arose. Further, all of the direct care staff were able to describe the facility's process for documenting restraints that resulted in injury or were outside individuals' authorized restraints. All staff stated new or emerging behaviors were to be documented on a Behavior Log, along with identified maladaptive behaviors and restraint.

During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated new and emerging behaviors were tracked as non-target behaviors on the monthly Behavior Tracking forms, and would be assessed and added as targeted behaviors if they were seen on a continual basis.

The raw behavior data, from 1/1/15 - 7/27/15, was reviewed for the three individuals selected for review. None of the restraints documented on the Behavior Log forms resulted in injury.

The facility's investigations and Incident/Accident Report forms, from 8/26/14 - 7/27/15, were reviewed. An investigation, undated and completed by the QIDP, documented staff utilized an unauthorized restraint to complete two individuals' blood draws on 1/13/15, 3/3/15 and 4/29/15. The Incident/Accident Report attached was completed on 1/14/15, and documented one of the individuals received a rug burn while being restrained for a blood draw on 1/13/15.

The investigation stated a Licensed Practical Nurse (LPN) instructed staff to restrain the individuals in order to complete blood draws. However, the restraints utilized were not in the individuals' plans and not authorized for use.

During an interview on 7/31/15 from 8:30 - 11:45 a.m., the QIDP and Registered Nurse (RN) both stated the RN discovered the unauthorized restraints during a chart review. The investigation was initiated at that time. The investigation was reviewed and did not address the delay in reporting for the incident, and corrective action related to timely reporting was not evident.

No other incidents of unauthorized restraint use, or of injury received during restraint, were documented. Additionally, no other concerns regarding investigations were identified.

The 3 individuals' monthly Behavior Tracking forms were reviewed. The forms documented summation of identified maladaptive behaviors, as well as new and emerging behaviors that had been identified on the Behavior Log forms.

One individual's record included documentation he engaged in suicidal ideation and would make threats to kill himself. The record included a suicide protocol and referenced the facility's suicide policy. The protocol and policy both stated staff were to place an individual on arm's length or line-of-sight supervision if a threat of suicide was made, the Administrator was to be notified, and a suicide assessment was to be completed.

The individual's record included documentation of multiple statements that he wanted to kill himself, including attached suicide assessment forms. However, the suicide assessment forms did not consistently document who had completed the form. Additionally, none of the documentation supported if the individual's suicide protocol or the policy had been implemented, including placing the individual on arm's length or line-of-sight supervision, clearing dangerous items, when he was released from increased supervision, etc.

Additionally, the facility's suicide policy, revised 6/4/15, stated a suicide assessment would be completed for any individual demonstrating signs and symptoms of depression for more than 2 consecutive hours.

The facility began using a Depression Tracking Sheet, in January 2015, for the individual that exhibited suicidal ideation. The tracking sheets included a "Total Time" column and documented multiple instances where the individual exhibited signs and symptoms of depression for up to 8 hours. However, corresponding suicide assessments could not be found.

The facility failed to ensure the individual's suicide protocol, or the facility's suicide policy, were implemented appropriately.

Additionally, all 3 individuals' records included the use of "tally" sheets for behavior data collection. The sheets did not provide sufficient information to evaluate the efficacy of interventions, or to determine what happened before, during and after the maladaptive behavior.

For example, one individual's record included a tally sheet titled "Behavior Slip {Individual's name} (Socially Offensive)." The form was divided into columns and rows. The far left column was labeled "Time" and documented 15 minute time-blocks for each row on the form. The form covered an entire 8 hour shift. The center columns were labeled spitting, yelling, hitting objects, and pushing. The final column was labeled "Antecedent." Staff were to record a tally-mark for each observed behavior in the appropriate time-block.

The bottom row of the form was labeled "Totals" where the total number of each of the 4 identified behaviors (spitting, yelling, hitting objects, and pushing) could be calculated for each shift. However, the form did not include space for staff to document interventions attempted or their outcome. As such, it would not be possible to determine if the interventions outlined in the individual's Behavior Intervention Plans were effective or not, or if staff were implementing interventions correctly.

Seven direct care staff were interviewed about the facility's data collection process, between 7/28/15 and 7/29/15. All direct care staff stated they collected program data on their shift. All direct care staff state once the data was collected, the QIDPs were the ones responsible for totaling data and making program changes.

Each individual's record included a QIDP Tracking Form, which included summary data for each program. The paper data documented multiple programs for the 3 individuals were being collected as "total task" data, where data was being collected on multiple steps of the program in addition to the identified step as stated in the program objective. The data was then compiled based on the individual's progress on all steps, not just the identified step of the objective. This resulted in individuals' data not being reflective of the individual's actual ability.

For example, one individual's dining program stated he would take a drink after 3 - 4 bites of food with a gesture cue in 40% of trials. However, data was being collected on 6 steps, one of which was taking a drink. Total task data for 3/2015 documented a success rate of 80%, but the success rate for the identified step (taking a drink) was 0%.

During an interview on 7/30/15 from 9:30- a.m. - 12:30 p.m., the QIDP and the City Director both stated total task data did not give an accurate reflection of individuals' progress.

Deficient practice related to restraint use was not identified. However, deficient practice was identified related to behavior and ADL data collection and analysis, the facility's failure to ensure behavior and ADL data was collected at a form specified in the individuals' plans, and that summary data accurately reflected individuals' progress toward their objectives.

Further, the QIDP Tracking Forms for the 3 individuals selected for review documented revisions were made to ADL programs based upon progress, or a lack thereof. During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated he gathered the previous month's data by the 10th of the current month. The QIDP stated he then had 2 weeks in which to review and analyze the data. At that time, he would make revisions to individuals' programs based upon their progress or lack of progress. The program revisions would be implemented the following month.

As described, the QIDP's process for summarizing and reviewing data would prevent revisions from being completed and implemented until a month after the data indicated a change was required (i.e., the individual met criteria on the objective, or was failing to progress).

The City Director, who was present during the interview, stated company policy dictated data summation for the previous month was to be completed by the 10th of the current month, and program revisions made at that time.

The facility failed to ensure the QIDP's process for data review resulted in timely program revisions and implementation.

It was determined that the QIDP failed to provide sufficient monitoring and oversight to ensure individuals' needs were being met. Additionally, it was determined the Governing Body failed to ensure investigations were thorough and appropriate corrective action was taken. Therefore, the allegation was substantiated and deficient practice was cited at W102, W122, W195, and W266 and related standard level deficiencies.

Conclusion #1: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: The facility does not address guardian concerns or provide timely notification of events.

Findings #2: During the survey, the facility's investigations, incident/accident forms, and guardian notification request forms were reviewed, and staff and guardian interviews were conducted.

During the entrance conference on 7/27/15 at 1:40 p.m., the City Director stated grievances would be documented on the facility's Incident/Accident Report form and investigated.

The facility's Investigations and Incident/Accident Report forms were reviewed, from 3/26/15 - 7/27/15. The guardian notification documentation was compared with the guardian notification request forms. The documentation indicated notification was taking place as requested. Additionally, no guardian grievances were documented.

One individual's guardian was interviewed on 7/30/15. The guardian stated he had no concerns about notification and felt he was notified of events as they happened. The guardian stated he could reach the QIDP by phone, text, or email, and stated he received contact from the QIDP in the same manner. When asked about specific events, the guardian stated he was aware of the events and had been notified when they happened.

During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and City Director both stated notification was to take place as quickly as possible following an event, and that all attempts were made to complete notification within 24 hours.

It could not be determined the facility was not addressing guardian concerns or providing timely notification of events. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals are not being provided with vocational programming in accordance with their assessed needs.

Findings #3: During the survey, observations, record review, and staff interviews were conducted.

During the entrance conference on 7/27/15 at 1:40 p.m., the City Director stated the main office was in process of being remodeled. As a result, the Day Treatment Program had been moved into the facility until the remodel was completed. Day Treatment was conducted from 9:30 a.m. - 2:30 p.m.

An observation was conducted at the facility, on 7/27/15 and 7/28/15 for a cumulative 5 hours and 15 minutes. During that time, one individual was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives, including vocational activities.

Additionally, a second individual's Comprehensive Functional Assessment did not include sufficient information related to his vocational skills, but documented "N/A" (not applicable) next to many vocational tasks without additional information as to why the tasks did not apply.

A third individual's record did not contain a current active treatment schedule for vocational activities. For example, the active treatment schedule documented his program revolved around an activity that was no longer available through the facility.

Seven direct care staff were interviewed between 7/28/15 and 7/29/15. All 7 staff stated the main office, were vocational training usually took place, was being remodeled. As a result, vocational training took place primarily at the facility.

During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated no additional information was present in relation to individuals' active treatment schedules and they needed to be revised. The City Director, who was present during the interview, stated individuals' should have been actively engaged in programs related to their vocational needs.

The facility was not providing sufficient assessment, direction to staff, and implementation of active treatment programing to meet individuals' vocational needs. Therefore, the allegation was substantiated and deficient practice was cited at W195 and related standard level deficiencies.

Conclusion #3: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #4: The facility fails to follow dietary recommendations, including specialized diets.

Findings #4: During the investigation, observations, record review, and staff interviews were conducted.

Observations were conducted at the facility on 7/27/15 and 7/28/15 for a cumulative 5 hours and 15 minutes. During those times, all individuals residing at the facility were observed to participate in meals and snacks. No issues were identified related to individuals' diets.

Three individuals' records were selected for review. One of the individual's records documented he was to receive a pureed diet. A second individual's record documented he had lost weight. As a result, the individual's diet had been changed to a high calorie diet.

The facility's menus were reviewed and were consistent with the recommendations found in individuals' records and the observations with the exception of snacks. The facility's menus did not include snacks. However, snacks were observed to be offered and consumed by the individuals, in accordance with their diets.

Seven direct care staff were interviewed on 7/28/15 and 7/29/15. All seven staff were able to describe individuals' dietary needs, including specialized diets. All staff stated the menus were to be followed.

During an interview on 7/31/15 from 8:25 - 10:35 a.m., the QIDP stated diets were to be followed. The City Director, who was present during the interview, stated if the facility's menus did not include snacks there would be no documentation of all food served.

The facility was following individuals' dietary recommendations, including specialized diets. However, the facility's menus did not document snacks provided. Therefore, the allegation was unsubstantiated, but the facility was cited at W481 in relation to documentation of food served.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Nicole Wisenor for

KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care

Nicole Wisenor

NICOLE WISENOR
Co-Supervisor
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KM/pmt