



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

August 17, 2015

Steve Young, Administrator
Yellowstone Group Home #2 Sunnybrook
560 West Sunnyside Lane
Idaho Falls, ID 83402

RE: Yellowstone Group Home #2 Sunnybrook, Provider #13G064

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #2 Sunnybrook, which was conducted on August 3, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **August 28, 2015**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by August 28, 2015. If a request for informal dispute resolution is received after August 28, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2015
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification and complaint survey conducted from 7/27/15 to 8/3/15.</p> <p>The surveyors conducting your survey were:</p> <p>Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Trish O'Hara, RN</p> <p>Common abbreviations used in this report are:</p> <p>ADL - Activities of Daily Living HDL - High Density Lipoprotein IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record mg - milligram ODD - Oppositional Defiant Disorder PA - Physician Assistant PAP - Papanicolaou (test for cervical cancer) QIDP - Qualified Intellectual Disability Professional RN - Registered Nurse USPSTF - United States Preventive Services Task Force</p>	W 000	<p>RECEIVED AUG 31 2015 FACILITY STANDARDS</p>	
* W 111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a</p>	W 111	<p>Please refer to Attached Plan of Corrections -</p> 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



QIDP / PS

8/25/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	<p>Continued From page 1</p> <p>record keeping system that contained comprehensive information for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in a lack of information being available regarding the individuals' experiences at the facility. The findings include:</p> <p>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 system. When asked when the system was discontinued, the City Director stated he was not sure.</p> <p>During the paper data review, no raw data for ADLs was provided for Individuals #1 - #3 for the months of January or February 2015.</p> <p>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 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.</p> <p>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.</p> <p>The QIDP stated summary data reflected on the</p>	W 111			

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W 111	Continued From page 2 QIDP Tracking Form prior to 2/28/15 had been transcribed from the electronic system. However, information related to implementation rates, refusals, etc., was not present or accessible.	W 111			
* W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility failed to ensure a system was in place to collect program data in the event the electronic data collection system was inoperable. 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 abuse policy, record review and staff interview, it was determined the facility failed to ensure thorough investigations were conducted. That failure directly impacted 1 of 1 individuals (Individual #1) 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 Administrator will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are thoroughly investigated..." An Investigation, undated and completed by the QIDP, stated "Unauthorized use of restraint on [Individual #1] on attempted blood draw." The	W 154			

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W 154	<p>Continued From page 3</p> <p>Investigation stated incidents took place on 1/13/15 and 4/8/15, but were not reported until 5/11/15. The investigation stated the LPN who performed the blood draws was terminated for having authorized the restraints without proper consent.</p> <p>An Incident/Accident Report, completed 5/11/15 at 10:30 a.m. by the QIDP, stated "Nursing attempted to perform blood draw. [Individual #1] became uncooperative so nursing instructed staff present to use unauthorized restraint to attempt blood draw." The report documented the incident took place 4/8/15 at 2:00 p.m.</p> <p>Also attached to the investigation were 3 staff statements. One statement from another LPN, dated 5/12/15, stated she was not involved in either incident.</p> <p>A direct care staff statement, undated, stated he assisted in a restraint with two other direct care staff. The direct care staff documented he held Individual #1 seated between his legs while two additional staff held her arms.</p> <p>A second direct care staff statement, dated 5/12/15, stated she assisted in a restraint with Individual #1 during a blood draw "about a month ago." The direct care staff documented she held one of Individual #1's arms during the restraint.</p> <p>No information related to lack of timely reporting, why direct care staff involved failed to identify the restraint as inappropriate, information indicating all potential witnesses, including the LPN that was terminated, had been interviewed, or how the incident was eventually determined to be an inappropriate restraint was present in the</p>	W 154		

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W 154	Continued From page 4 Investigation documentation. During an interview on 7/31/15 from 8:30 - 11:45 a.m., 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 restraint during a chart review in May 2015, which was what initiated the investigation. The City Director, who was also present, confirmed the means of identifying the concern and stated the investigation was not thorough.	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 in response to all investigations. That failure directly impacted 1 of 1 individuals (Individual #1) 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	W 157			

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W 157	Continued From page 5 would document all corrective action taken. An Investigation, undated and completed by the QIDP, stated an unauthorized restraint had been used for Individual #1 during a blood draw. The form documented incidents took place on 1/13/15 and 4/8/15. The Investigation stated the LPN who performed the blood draws was terminated for having authorized the restraints without proper consent. The "Recommendations" section of the Investigation stated Individual #1 would have a desensitization program developed for medical procedures, the LPN would seek approval for Emla Cream (a topical antiarrhythmic drug) prior to blood draws, and the RN would instruct the LPN on how to respond to refusals for medical treatment. However, no corrective action related to failure to protect Individual #1, to identify unauthorized restraint at the time they are implemented, or failure to report the use of unauthorized restraints could be found. During an interview on 7/31/15 from 8:30 - 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's investigation.	W 157		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

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W 159	<p>Continued From page 6</p> <p>integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which impacted 3 of 3 individuals (Individuals #1 - #3) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:</p> <p>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 gathered 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, revisions would be made and implemented the following month.</p> <p>As described, an individual could meet criteria on a training program, but a month would pass prior to revisions to the program being made and implemented.</p> <p>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.</p> <p>The facility failed to ensure the QIDP reviewed data and revised programs in a timely manner.</p> <p>2. Individuals #2 and #3's raw data for ADLs, from 3/1/15 - 5/31/15, was reviewed. Data sheets for</p>	W 159			

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W 159	<p>Continued From page 7</p> <p>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:</p> <p>a. Individual #2's IPP, dated 9/18/14, documented a 32 year old female whose diagnoses included moderate intellectual disability and depression.</p> <p>- Eating: Individual #2's program objective stated she would chew with her mouth closed with a nonspecific verbal cue in 65% of trials. Data was collected on 3 steps which included takes a bite of food, chews with mouth closed, and takes a drink. Each step was scored successful if Individual #2 completed the step with a nonspecific verbal cue or better. The total task score was then recorded as Individual #2's progress for the month.</p> <p>However, when compared to her score for the identified step that matched the objective (chews with mouth closed), the total task data was not reflective of her actual progress, as follows:</p> <p>March: total task = 45%, step identified in objective = 18% April: total task = 13%, step identified in objective = 24% May: total task = 51%, step identified in objective = 22%</p> <p>- Wash hands March: total task = 38%, step identified in objective = 0% April: total task = 63%, step identified in objective = 28%</p>	W 159			

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W 159	<p>Continued From page 8</p> <p>May: total task = 14%, step identified in objective = 0%</p> <p>- Pedestrian Safety March: total task = 75%, step identified in objective = 75% April: total task = 53%, step identified in objective = 37% May: total task = 57%, step identified in objective = 0%</p> <p>b. Individual #3's IPP, dated 4/6/15, documented a 18 year old female whose diagnoses included mild intellectual disability, ODD, and bipolar.</p> <p>- Eating: Individual #3's program objective stated she would take three bites and a drink in order to slow down when eating with a nonspecific verbal cue in 95% of trials. Data was collected on 2 steps which included putting her utensil down after 2 bites and taking a drink. Each step was scored successful if Individual #3 completed the step with a nonspecific verbal cue or better. The total task score was then record as Individual #3's progress for the month.</p> <p>It was not clear why data would be collected on setting her utensil down after 2 bites. Additionally, when compared to her score for the identified step that matched the objective (taking a drink), the total task data was not reflective of her actual progress, as follows:</p> <p>March: total task = 90%, step identified in objective = 93% April: total task = 100%, step identified in objective = 100% May: total task = 68%, step identified in objective = 66%</p>	W 159			

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W 159	<p>Continued From page 9</p> <p>- Laundry March: total task = 33%, step identified in objective = 0% April: total task = 100%, step identified in objective = 100% May: total task = 50%, step identified in objective = 0%</p> <p>- Individual #3's Pedestrian Safety program stated she would look to the left and right before crossing the street with a gesture cue in 100% of trials. Data was collected on 4 steps including stopping at the curb, looking left, looking right, and safely crossing the street. Each step was scored 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.</p> <p>However, in order to find an accurate score for the objective, two steps (looking left and looking right) would have to be looked at holistically (i.e., if he was successful looking left but not right, the trial would reflect the objective not being met).</p> <p>For example, for the 5/2015, data was collected on 7 separate occasions for a total of 28 data points (4 steps for each of the 7 occasions). Individual #3's total task data was scored at 96%. However, she independently looked both ways during each trial. Therefore, Individual #3 actually successfully completed the objective 100% of trials.</p> <p>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 the objective. The QIDP and City Director both stated the total task</p>	W 159		

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W 159	Continued From page 10 data was not reflective of individuals' abilities. The facility failed to ensure Individual #2 and #3's data provided sufficient information to evaluate the efficacy of their programs. 3. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' assessments contained accurate and comprehensive information. 4. Refer to W257 as it relates to the facility's failure to ensure the QIDP ensured an individual's programs were revised when failure to progress was identified. 5. Refer to W488 as it relates to the facility's failure to ensure the QIDP ensured individuals ate in a manner consistent with their developmental levels.	W 159			
* W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments contained comprehensive information for 2 of 3 individuals (Individuals #2 and #3) whose assessments were reviewed. This resulted in a lack of behavioral information on which to base program intervention decisions. The findings include: 1. Individual #3's IPP, dated 4/6/15, documented	W 214			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2015
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	<p>Continued From page 11</p> <p>an 18 year old female whose diagnoses included mild intellectual disability, ODD, and bipolar disorder.</p> <p>Individual #3's record included a Physician's Recap Order, dated 5/6/15, that documented she received Abilify (an antipsychotic drug) 10 mg once a day and Depakote (an anticonvulsant drug) 500 mg twice a day.</p> <p>Individual #3's record contained a Functional Behavior Assessment, revised 6/16/15, which documented she received Depakote for ODD and bipolar disorder. However, the assessment did not include information related to her Abilify (e.g., how it impacted her maladaptive behaviors, if it was tied to a psychiatric diagnosis, etc.).</p> <p>When asked on 7/31/15 from 10:55 - 11:45 a.m., the QIDP stated the assessment should have included Abilify.</p> <p>2. Individual #2's IPP, dated 9/18/14, documented a 32 year old female whose diagnoses included moderate intellectual disability and depression.</p> <p>Individual #2's record included a Behavior Assessment, dated 4/3/14. The "Events that typically precede the Maladaptive Behavior" section for each identified maladaptive behavior (aggression, property destruction, socially offensive behavior, disruptive behavior, and arguing/leaving) documented being over cued was an event that typically preceded a maladaptive behavior.</p> <p>However, the assessment did not contain information on what being over cued meant.</p>	W 214		

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W 214	Continued From page 12 When asked on 7/31/15 from 10:55 - 11:45 a.m., the QIDP stated the staff were to wait 5 - 10 minutes between cues and that the assessment needed to be updated.	W 214			
* W 257	The facility failed to ensure Individuals #2 and #3's behavior assessments included comprehensive information. 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 3 of 3 individuals (Individuals #1 - #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 #2's IPP, dated 9/18/14, documented a 32 year old female whose diagnoses included moderate intellectual disability and depression. Individual #2's QIDP Tracking Form, dated 1/2015 - 6/2015, documented a lack of progress. Examples included, but were not limited to, the following:	W 257			

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W 257	<p>Continued From page 13</p> <p>a. The objective for eating was set at 65% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 58% - 2/2015: 67% - 3/2015: 50% - 4/2015: 46% - 5/2015: 50% - 6/2015: 51% <p>The documentation indicated the program met the 65% success rate one time in six months.</p> <p>b. The objective for Purchase was set at 85% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 50% - 2/2015: 33% - 3/2015: 34% - 4/2015: 100% - 5/2015: 0% - 6/2015: 0% <p>The documentation indicated the program met the 85% success rate one time in six months.</p> <p>c. The objective for toothbrushing was set at 65% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 8% - 2/2015: 37% - 3/2015: 0% 	W 257			

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W 257	<p>Continued From page 14</p> <ul style="list-style-type: none"> - 4/2015: 20% - 5/2015: 37% - 6/2015: 0% <p>The documentation indicated the program did not meet the 65% success rate once in six months.</p> <p>d. The objective for Self Administration of medication was set at 60% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 17% - 2/2015: 0% - 3/2015: 0% - 4/2015: 0% - 5/2015: 23% - 6/2015: 0% <p>The documentation indicated the program did not meet the 60% success rate once in six months.</p> <p>e. The objective for Choose Activity was set at 75% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 60% - 2/2015: 67% - 3/2015: 63% - 4/2015: 65% - 5/2015: 66% - 6/2015: 0% <p>The documentation indicated the program did not meet the 75% success rate once in six months.</p> <p>During an interview on 7/31/15 from from 10:55 - 11:45 a.m., the QIDP stated the programs should</p>	W 257			

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W 257	<p>Continued From page 15 have been revised.</p> <p>The facility failed to ensure objectives were revised when Individual #2 failed progress.</p> <p>2. Individual #3's IPP, dated 4/6/15, documented an 18 year old female whose diagnoses included mild intellectual disability, ODD, and bipolar.</p> <p>Individual #3's QIDP Tracking Form, dated 1/2015 - 6/2015, documented a lack of progress. Examples included, but were not limited to, the following:</p> <p>a. The objective for Self Administration of Medication was set at 75% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 58% - 2/2015: 0% - 3/2015: 0% - 4/2015: 0% - 5/2015: 50% - 6/2015: 88 <p>The documentation indicated the program met the 75% success rate one time in six months.</p> <p>b. The objective for Sorting Laundry was set at 70% success for 3 consecutive months. Her QIDP Tracking Form showed the following status of the objective:</p> <ul style="list-style-type: none"> - 1/2015: 50% - 2/2015: 54% - 3/2015: 50% - 4/2015: 100% - 5/2015: 33% 	W 257			

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W 257	<p>Continued From page 16 - 6/2015: no entry</p> <p>The documentation indicated the program met the 70% success rate one time in six months.</p> <p>During an interview on 7/31/15 from from 10:55 - 11:45 a.m., the QIDP stated the programs should have been revised.</p> <p>The facility failed to ensure objectives were revised when Individual #3 failed to progress.</p> <p>3. Individual #1's IPP, dated 11/6/14, documented a 23 year old female whose diagnoses included profound intellectual disability, hydrocephalus, and blindness.</p> <p>Individual #1's QIDP Tracking From, dated 11/2014 - 6/2015, documented a lack of progress with no change in programming.</p> <p>a. The objective for dental desensitization was set at 25% success for 5 consecutive months. Her QIDP Tracking From showed a 6 month failure to progress without a change in the program being made as follows:</p> <ul style="list-style-type: none"> - 11/2014: 0% - 12/2014: 13% - 1/2015: 0% - 2/2015: 17% - 3/2015: 0% - 4/2015: Refused <p>The documentation indicated the program did not meet the 25% success rate one time in six months.</p> <p>b. The objective for face washing was set at 75%</p>	W 257		

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W 257	<p>Continued From page 17</p> <p>success for 4 months. Her QIDP Tracking From showed a 7 month failure to progress without a change in the program being made as follows:</p> <ul style="list-style-type: none"> - 12/2014: 48% - 1/2015: 17% - 2/2015: 38% - 3/2015: 37% - 4/2015: 50% - 5/2015: 36% - 6/2015: 0% <p>The documentation indicated the program did not meet the 75% success rate one time in seven months.</p> <p>c. The objective for hair care was set at 75% success for 4 months. Her QIDP Tracking From showed an 8 month failure to progress in spite of a change in the program goal being changed to 30% for 5 months in January, 2015 as follows:</p> <ul style="list-style-type: none"> - 11/2014: 20% - 12/2014: 20% - 1/2015: 0% - 2/2015: 17% - 3/2015: 33% - 4/2015: 0% - 5/2015: 15% - 6/2015: 0% <p>The documentation indicated the program did not meet the 75% success rate one time in eight months.</p> <p>d. The objective for money management was set at 50% success for 4 months. Her QIDP Tracking From showed an 8 month failure to progress before a change in the program was</p>	W 257			

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W 257	Continued From page 18 made as follows: 11/2014: 12% 12/2014: 25% 1/2015: 0% 2/2015: 15% 3/2015: 0% 4/2015: 0% 5/2015: 0% 6/2015: 0% During an interview on 7/31/15 from from 10:55 - 11:45 a.m., the QIDP stated the programs should have been revised. The facility failed to ensure objectives were revised when Individual #1 failed to progress.	W 257			
* 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 adequate general and preventative medical care was provided for 2 of 3 individuals (Individuals #1 and #2) whose medical records were reviewed. This resulted in a lack of follow-thorough with dietary recommendations, and PAP testing not being performed. The findings include: 1. Individual #2's IPP, dated 9/18/14, documented a 32 year old female whose diagnoses included moderate intellectual disability and depression.	W 322			

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W 322	<p>Continued From page 19</p> <p>Individual #2's record contained an Annual Nutritional Assessment, dated 9/2014, which recommended a fish oil supplement related to high triglycerides and low HDL. However, the record did not include documentation the recommendation had been addressed.</p> <p>Individual #2's most recent lipid profile, dated 6/19/15, documented continued high triglycerides and low HDL.</p> <p>When asked on 7/31/15 from 10:55 - 11:45 a.m., the LPN stated she was not sure why Individual #2 had not received the fish oil supplement.</p> <p>The facility failed to ensure there was follow up to a dietary recommendation for Individual #2.</p> <p>2. Individual #1's IPP, dated 11/6/14, documented a 23 year old female with diagnoses including profound intellectual disability, hydrocephalus, blindness, and heavy and painful menses.</p> <p>Individual #1's Physician Standing Orders, dated 1/13/15, included directions for a "yearly Gyn [gynecological] exam for females unless otherwise specified by physician."</p> <p>However, Individual #1's record did not include documentation a complete gynecological exam, include a PAP smear, had been completed.</p> <p>Individual #1 was seen by a physician on 11/26/14 for complaints of menstrual cramping and breakthrough bleeding. Her birth control prescription was changed, but there was no documentation a PAP smear was performed and no documentation of conversation with the physician concerning scheduling or need for the</p>	W 322			

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W 322	Continued From page 20 test. The USPSTF guidelines, 2012, recommended a PAP smear every one to three years for all females between the ages of 21 - 65. In an interview on 7/31/15 from 10:45 - 11:55 a.m., the LPN confirmed Individual #1 had not had a PAP smear as recommended and no discussion with her physician had taken place. The facility failed to provide Individual #1 with medical care ordered by the physician.	W 322			
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to provide laboratory testing for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This failure allowed the potential for an individual to experience abnormal serum cholesterol levels without appropriate treatment. The findings include: 1. Individual #1's IPP documented a 23 year old female with diagnoses including profound intellectual disability, hydrocephalus, and hypercholesterolemia. Individual #1's medical record showed physician's	W 325			

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W 325	Continued From page 21 orders, dated 11/4/14, that included a Lipid Profile to be drawn yearly. Her record also included physician's orders for Lipitor, 40 mg daily, and Zetia, 10 mg daily. According to the 2016 Nursing Drug Handbook, both of the medications were used to control elevated cholesterol. Individual #1's record included laboratory results of a blood tests completed on 1/13/15 and 4/8/15. Neither of the laboratory reports included a Lipid Profile for serum cholesterol levels. During an interview on 7/31/15 from 10:45 - 11:55 a.m., the LPN stated the blood specimen drawn from Individual #1 on 1/13/15 was of poor quality and could not be used by the testing laboratory, and a Lipid Profile was not drawn on 4/8/15. The facility failed to ensure laboratory testing, as ordered by the physician, was completed for Individual #1.	W 325			
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure dental care for the relief of pain and infection was provided for 1 of 3 individuals (Individual #1) whose records were reviewed. This failure allowed an individual to experience untreated	W 356			

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W 356	<p>Continued From page 22 pain for several days. The findings include:</p> <p>1. Individual #1's IPP, dated 11/6/14, documented a 23 year old female with diagnoses including profound intellectual disability and hydrocephalus. Individual #1 was non-verbal.</p> <p>Individual #1's record documented she was seen by a dentist on 5/26/15. An exam was not performed because Individual #1 was not cooperative. Treatment notes for the visit stated "It would be in her best interest to be fully sedated in a surgical setting to receive a full exam, x-rays, and cleaning." The dental assistant also noted "He [the dentist] said at this point if she is not exhibiting signs of pain or change in eating habits he does not think it is worth putting her through the trauma of sedation."</p> <p>On 6/24/15, a Physician Order Request was faxed to Individual #1's primary physician by the LPN. The request stated "[Individual #1] has been refusing to eat going on day 3 - she is barely taking in enough fluids to be barely wet (uses depends). Her left cheek has been swollen since Monday. She usually will be very vocal but has been very quiet. She has been drooling a foul odorous yellowish saliva but refuses visulization [sic] of oral cavity or any oral care. She has a rash now along her collar bone on left side she kept [sic] rubbing at. She has not been running a fever. I do not believe she would allow any sort of swabbing. What can we do?"</p> <p>Individual #1 was seen at the primary physician's office, on 6/26/15. The PA's note for the visit stated "Patient was uncooperative and was unable to examine mouth etc ...Instructed them to take pt (patient) for full dental exam under</p>	W 356			

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W 356	Continued From page 23 sedation. However, no documentation indicating the dental work had been completed was present in the record. During an interview on 7/31/15 from 10:45 - 11:55 a.m., the LPN stated Individual #1 had not yet received a dental exam or care under sedation. The RN, who was present during the interview, stated the facility was having a difficult time finding a practitioner willing to use full sedation for individuals who had a certain type of insurance, such as Individual #1.	W 356			
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual ate in a manner consistent with their developmental level which directly impacted 6 of 6 individuals (Individuals #1 - #6) who were observed during mealtime. This failure impacted individuals' ability to learn appropriate dining skills and master the social skills involved in dining. The findings include: 1. An observation was conducted at the facility, on 7/27/15 from 4:35 - 6:25 p.m. During that time, Individuals #1 - #6 were observed to	W 488			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

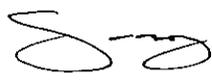
PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/03/2015
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 488	<p>Continued From page 24</p> <p>participate in the evening meal, as follows:</p> <ul style="list-style-type: none"> - At 6:04 p.m., Individual #2 was observed to pour three glasses of milk and take them to the table. - At 6:08 p.m., a direct care staff was observed to scoop casserole from a casserole dish located on the stove to paper plates. Individual #2 and Individual #3 then carried the paper plates to the table. <p>Individuals were not observed to be offered an opportunity to participate in dining activities, such as serving and passing food. No condiments, such as salt or pepper, were noted to be on the table. Additionally, there was no extra food or fluids observed on the table and available for individuals to serve themselves.</p> <p>When asked on 7/31/15 from 10:55 - 11:45 a.m., the QIDP stated the dinner should not have been served as observed, and paper plates should not have been used for meals. The QIDP stated the observed meal did not demonstrate family style dining as expected.</p> <p>The facility failed to ensure individuals were provided an opportunity to participate in appropriate dining skills.</p>	W 488			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBRC	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Trish O'Hara, RN	M 000		
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), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W111.	MM080	<i>Please see attached Plan of Corrections -</i> 	
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: Refer to W154 and W157.	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),	MM155		

RECEIVED

AUG 31 2015

FACILITY STANDARDS

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

[Handwritten Signature]

TITLE

QIDP/PS

(X6) DATE

8/25/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBRC	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM155	Continued From page 1 Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Refer to W159.	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: Refer to W214 and W257.	MM159		
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: Refer to W322, W325 and W356.	MM166		
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.	MM366		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBRC	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM366	Continued From page 2 This Rule is not met as evidenced by: Refer to W488.	MM366		



August 31, 2015

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

RECEIVED
AUG 31 2015
FACILITY STANDARDS

RE: Sunnybrook, Provider #13G064

Dear Michael Case:

Thank you for your considerateness during the recent annual certification at the Sunnybrook home. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

W111

1. Currently there is paper data in place for individuals #1-3 all ADL data is being collected as specified in each program.
2. All individuals residing in the home currently have accurate data collection in place for all ADL Programs.
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.
5. Person Responsible: Program Supervisor-QIDP, Program Manager
6. Completion Date: October 3, 2015.

W154

1. All employees that work in the Sunnybrook 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 Sunnybrook 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 Supervisor-QIDPs. 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 Supervisor-QIDP, Program Manager
6. Completion Date: October 3, 2015.

W157

1. All Program Supervisor-QIDPs 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 Sunnybrook 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 Supervisor-QIDPs. 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 Supervisor-QIDP, Program Manager
6. Completion date: October 3, 2015.

W159

1. The ADL data for individuals 1-3 is currently being collected by paper data. The ADL program data sheets are being revised to ensure that data is collected accurately and is reflective of individuals 2 and 3 abilities.
2. All the individuals' ADL data in the home is being collected by paper data. The ADL program data sheets are being reviewed and revised as necessary to ensure that data is collected accurately, contain accurate definitions of the program objectives and is reflective of individuals' abilities in the home.
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 program data sheets contain accurate definitions of the program objectives, 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.
5. Person Responsible: Program Supervisor-QIDP, Program Manager
6. Completion Date: October 3, 2015.

Please see responses given under W214, W257 & W488.

W214

1. Individuals 2 and 3's behavioral assessments are being revised to include comprehensive and accurate information. Individual 2 and 3's behavior assessments are being revised and all areas are being assessed. In addition, Individual 2 and 3's CFA's are being reviewed and revised as necessary to ensure the CFA identifies their specific developmental and behavioral management needs.
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 CFA identifies their specific developmental and behavioral management needs.
3. We are 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: QIDP, Program Manager
6. Completion Date: October 3, 2015.

W257

1. Individuals' 1-3 Individual Program Plans have been reviewed and revised to ensure effective monitoring of all program goals and changes and adjustments are reflective of current functioning levels.
2. All individuals' Individual Program Plans will be reviewed and revised if necessary to ensure effective monitoring of all program goals and changes and adjustments are reflective of current functioning levels.
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.
5. Person Responsible: QIDP, Program Manager
6. Completion Date: October 3, 2015.

W322

1. On August 5, 2015, Primary Care Provider reviewed Individual #2's most recent lipid profile dated 6/19/2015. Primary Care Provider ordered no treatment due to Total Cholesterol Level being within normal limits. Primary Care provider does not wish to prescribe the fish oil supplement at this time.
2. Dietician recommendations are being written out and given to LPN every month for any follow up actions.
3. On 8/5/2015, LPN attempted to find out reasoning why annual PAP smear for Individual #1 was not completed. Provider has since retired. LPN at Provider's office reported Individual #1 was not cooperative with PAP smear.
4. LPN will reschedule for PAP smear. If Individual #1 does not comply with procedure. IDT will assemble to discuss options to develop plan for obtaining PAP smear. LPN will obtain an appointment by September 30, 2015.
5. The facility is doing chart reviews, part of which is verifying that the dietary recommendations have been followed up with Primary Care Provider through LPN oversight. Also to verify that all annual medical appointments are being met as scheduled.
6. 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.
7. Person Responsible: LPN, RN
8. Completion Date: October 3, 2015.

W325

1. Individual #1 is on a desensitization program for blood draws due to inability to tolerate blood draws and shots (depo, flu). Nursing is running this program one time a week to help her desensitize her to the process. The Primary Physician is aware of the process and realizes blood levels will not be done until desensitization program is complete.
2. LPN and RN have reviewed all individuals' history and identified all individuals that require the same program. Nursing is currently running the desensitization programs on all individuals that do not tolerate blood draws and shots. PCP is aware of all individuals who require these programs.
3. The facility is doing chart reviews, part of which is verifying that blood draws are being completed as they are due. (Ex. Weekly, monthly, semi-annually or annually). On chart reviews nursing will verify that PCP is aware of any out of range lab values.
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: LPN, RN
6. Completion Date: October 3, 2015.

W 356

1. On August 11, 2015 Individual #1 was taken in for dental examination with cleaning and x-rays under sedation with guardian consent obtained 8/10/2015. LPN will follow up on recommendations from Dental Provider for return in six months for cleaning.
2. Nursing is currently seeking dental providers who will accept Medicaid for all other individuals that have been recommendation for dental sedation and cleanings.
3. The facility is doing chart reviews, part of which is verifying that all dental examinations have been completed as scheduled and that the notes from appointment are in the individual's charts.
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: LPN, RN
6. Completion Date: October 3, 2015.

W488

1. All individuals in the home are engaged in family style dining that is consistent with their developmental level. Staff are teaching all individuals in the home the practices of family style dining to provide them the opportunities to participate in appropriate dining skills.
2. Regular dining plates and silverware are being used at all meals. All condiments utilized during the meal are available for individuals during all meals.
3. All staff will be retrained by QIDP in the home on basic concepts and principles of family style dining.
4. QIDP will monitor during meal times ensuring that the individuals in the home are being provided opportunities for family style dining and that is consistent with their developmental level.
5. Person Responsible: RD, QIDP
6. Completion Date: October 3, 2015.

MM080 – Please see response given under W111.

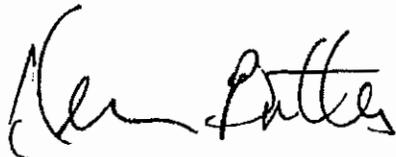
MM134 – Please see responses given under W154 & W157.

MM155 – Please see response given under W159.

MM159 – Please see responses given under W214 & W257.

MM166 – Please see responses given under W322, W325 & W356.

MM366 – Please see response given under W488.



Program Supervisor/QIDP
Aspire Human Services



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

August 19, 2015

Steve Young, Administrator
Yellowstone Group Home #2 Sunnybrook
560 West Sunnyside Lane
Idaho Falls, ID 83402

Provider #13G064

Dear Mr. Young:

An unannounced on-site complaint investigation was conducted from July 27, 2015 to August 3, 2015 at Yellowstone Group Home #2 Sunnybrook. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007065

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 - 7/1/15 was requested for the 3 individuals selected for review. The City Director stated the electronic data collection system the facility had been using had been discontinued. As a result, the facility had to revert to a paper data collection system for ADLs.

The record of one individual selected for review documented she was admitted to the facility on 10/8/14. The individual's record documented admission assessment data was present and had been reviewed or re-assessed as needed within an appropriate timeframe. The individual's record documented ADL programs had been developed based upon the assessment data. However, none of the 3 individuals selected for review had raw ADL data for January and February 2015.

Steve Young, Administrator

August 19, 2015

Page 2 of 6

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 when they were notified the electronic system would be discontinued. As a result, paper data collection sheets had to be created for the individuals' training programs. The QIDP stated the electronic system was still in place through February. The QIDP stated summary data for January and February 2015 was from the electronic system. However, the information from the electronic system related to implementation rates, refusals, etc., of ADLs, 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 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.

Six direct care staff were interviewed from 7/28/15 - 7/29/15. All 6 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.

Three sample individuals' raw paper 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). None of the restraints documented on the Behavior Log forms resulted in injury.

Additionally, 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 an individual's blood draw on 1/13/15 and 4/8/15. The Incident/Accident Report attached was completed on 5/11/15 by the QIDP.

Steve Young, Administrator
August 19, 2015
Page 3 of 6

The Investigation stated a Licensed Practical Nurse (LPN) instructed staff to restrain an individual in order to complete a blood draw. However, the restraint utilized was not in the individual's plan 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.

However, no other incidents of unauthorized restraint use were documented and no other concerns regarding investigations were identified.

Further, 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.

Six 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.

The individuals' paper ADL data sheets documented data collection rates below the stated target of various programs, over multiple months for each of the three individuals. Additionally, each individual's record included a QIDP Tracking Form, which included summary data for each program. The paper data included multiple data sheets for various programs. For example, one individual's record included an objective for toileting. Two data sheets for toileting were present each month, one for the a.m. shift and one for the p.m. shift. Each data sheet was scored separately. The separate totals were then added together, divided by 2, and that figure was added as the monthly percentage on the QIDP Tracking Form.

This process created potential for inaccurate summary data to be documented. For example, if the a.m. data sheet scored 30% and the p.m. data sheet scored 88%, the number scored on the QIDP Tracking Form was recorded as 59% ($(30+88)/2 = 59$). However, if the total number of trials (18 between the two shifts) and total number of successful trials (10 between the two shifts) was utilized, the overall score would only be 55%.

Additionally, 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.

Steve Young, Administrator

August 19, 2015

Page 4 of 6

For example, one individual's hand washing program stated she would self-initiate turning the faucet off with a paper towel at 55%. However, data was being collected on 8 steps, one of which was turning off the faucet. Total task data for 3/2015 documented a success rate of 86%, but the success rate for the identified step (turning the faucet off with a paper towel) 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.

The facility failed to ensure 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 data collection was sufficient in frequency and form, timely data review was completed, program revisions and implementation were made appropriately, and investigations were thorough and appropriate corrective action was taken. Therefore, the allegation was substantiated and deficient practice was cited at W111, W154, W157, and W159 and related standards.

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, from 3/26/15 - 7/27/15, were reviewed. 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, no deficient practice was identified and the allegation was unsubstantiated.

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 investigation, 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.

Steve Young, Administrator
August 19, 2015
Page 6 of 6

Observations were conducted at the facility on 7/28/15 from 9:35 - 10:30 a.m. During that time, individuals were observed to be engaged in vocational and pre-vocational tasks.

Three individuals' records were selected for review. All 3 records documented vocational plans were in place and were consistent with the activities observed on 7/28/15.

Six direct care staff were interviewed between 7/28/15 and 7/29/15. All 6 staff stated the main office, where vocational training usually took place, was being remodeled. As a result, vocational training took place primarily at the facility. All staff stated individuals still completed some programs at the office or at a sister facility where the company had livestock that required care.

It could not be determined that individuals' vocational needs were not being met. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

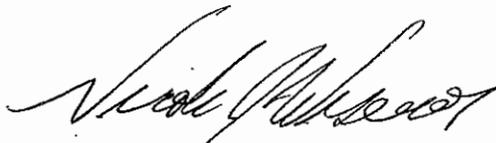
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

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,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt