



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

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

Dear Mr. Young:

This is to advise you of the findings of the complaint survey of Yellowstone Group Home #4 Fox Hollow, 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 27, 2015. If a request for informal dispute resolution is received after August 27, 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: 08/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2015
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402
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(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
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W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation conducted from 7/27/15 to 8/3/15. The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Trish O'Hara, RN Common abbreviations used in this report are: ADL - Activities of Daily Living IPP - Individualized Program Plan QIDP - Qualified Intellectual Disabilities Professional	W 000		
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 complete information. This failure directly impacted 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed and had the potential to impact all individuals (Individuals #1 - #5) residing at the facility. This resulted in a loss of data and information on which to base program and training decisions. The findings include: 1. During the entrance conference on 7/27/15 from 1:40 - 2:20 p.m., the facility's raw behavior	W 111	Please see attached Plan of correction S-g RECEIVED AUG 31 2015 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE: *Dee Butler* TITLE: QIDP/PS (X6) DATE: 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 and ADL data from 1/1/15 - 7/27/15 was requested.</p> <p>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 electronic 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 Individual #3 for the month of January, 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 QIDP Tracking Form prior to 2/28/15 had been transcribed from the electronic system for Individual #3. However, information related to implementation rates, refusals, etc., was not</p>	W 111		

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W 111	Continued From page 2 present or accessible.	W 111			
W 159	<p>The facility failed to ensure a system was in place to collect program data in the event the electronic data collection system was inoperable.</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be 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) and had the potential to impact all individuals (Individuals #1 - #5) 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 program changes would be 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>	W 159			

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W 159	<p>Continued From page 3</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 had a process for timely data review and program revision implementation.</p> <p>2. Individuals #1 - #3's raw data for ADLs, from 1/1/15 - 6/30/15, 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:</p> <p>a. Individual #1's IPP, dated 1/15/15, documented a 17 year old male whose diagnoses included mild intellectual disability.</p> <p>- Brush teeth: Individual #1's program objective stated he would brush his left inside teeth with a light physical cue in 95% of trials. Data was collected on 7 steps which included getting toothpaste and tooth brush, taking items to the bathroom, wetting tooth brush, brushing left inside of teeth, rinsing mouth, and rinsing tooth brush. Each step was scored 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.</p> <p>However, when compared to his score for the identified step that matched the objective</p>	W 159		

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W 159	<p>Continued From page 4 (brushing the inside left teeth), the total task data was not reflective of his actual progress, as follows:</p> <p>January: total task = 72%, step identified in objective = 100% February: total task= 93%, step identified in objective = 54% March: total task = 92%, step identified in objective = 100% April: total task = 100%, step identified in objective = 100% May: total task = 99%, step identified in objective = 100% June: total task = 100%, step identified in objective = 100%</p> <p>- Toileting January: total task = 89%, step identified in objective = 100% February: total task= 97%, step identified in objective = 100% March: total task = 95%, step identified in objective = 100% April: total task = 97%, step identified in objective = 100% May: total task = 100%, step identified in objective = 100% June: total task = 86%, step identified in objective = 100%</p> <p>- Wash hands January: total task = 95%, step identified in objective = 78% February: total task= 91%, step identified in objective = 100% March: total task = 92%, step identified in objective = 100% April: total task = 89%, step identified in objective</p>	W 159		

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W 159	<p>Continued From page 5</p> <p>= 100%</p> <p>May: total task = 90%, step identified in objective = 100%</p> <p>June: total task = 76%, step identified in objective = 72%</p> <p>b. Individual #2's IPP, dated 2/25/15, documented a 15 year old male whose diagnoses included mild intellectual disability. He was admitted to the facility on 1/26/15. Baseline data was collected in February, and formal program objectives were implemented 3/1/15.</p> <p>- Eating program: Individual #2's program objective stated he would empty his mouth between bites with a nonspecific verbal cue in 95% of trials. Data was collected on 7 steps which included takes a bite, chews food, swallows food, repeats steps 1 - 3, sets utensil down, takes a drink, repeats steps 1 - 6. 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 his score for the identified step that matched the objective (swallows food), the total task data was not reflective of his actual progress, as follows:</p> <p>March: total task = 79%, step identified in objective = 100%</p> <p>April: total task = 76%, step identified in objective = 100%</p> <p>May: total task = 80%, step identified in objective = 100%</p> <p>June: total task = 82%, step identified in objective = 100%</p>	W 159		

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W 159	<p>Continued From page 6</p> <p>- Pedestrian Safety March: total task = 89%, step identified in objective = 77% April: total task = 81%, step identified in objective = 100% May: total task = 14%, step identified in objective = 0% June: total task = 100%, step identified in objective = 100%</p> <p>- Request Attention March: total task = 52%, step identified in objective = 55% April: total task = No data May: total task = 60%, step identified in objective = 60% June: total task = 66%, step identified in objective = 0%</p> <p>c. Individual #3's IPP, dated 12/18/14, documented a 36 year old male whose diagnoses included mild intellectual disability. His record did not include raw paper data for the month of January 2015.</p> <p>Individual #3's Pedestrian Safety program stated he would look both ways before crossing the street with a nonspecific verbal cue in 95% of trials. Data was collected on 3 steps including stopping at the curb, looking left, and looking right. Each step was scored successful if Individual #3 completed the step with a nonspecific verbal 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.,</p>	W 159		

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W 159	Continued From page 7 if he was successful looking left but not right, the trial would reflect the objective not being met). For example, for the 05/2015, data was collected on 9 separate occasions for a total of 27 data points (3 steps for each of the 9 occasions). Individual #3's total task data was scored at 77%. However, he independently looked both ways during each trial. Therefore, Individual #3 successfully completed the objective 100% of trials. 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 data was not reflective of individuals' abilities. The facility failed to ensure Individual #1 - #3's data provided sufficient information to evaluate the efficacy of their programs.	W 159		
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	W 252		

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W 252	<p>Continued From page 8</p> <p>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:</p> <p>1. Individuals #1 - #3's raw data for ADLs, from 1/1/15 - 6/30/15, was reviewed. Data was found to not be collected at the frequency dictated by the program plans. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's IPP, dated 1/15/15, documented a 17 year old male whose diagnoses included mild intellectual disability. Individual #1's programs and corresponding data were reviewed, as follows:</p> <p>January 2015:</p> <ul style="list-style-type: none"> - Individual #1's Wash Tops of Hands program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only three entries. - Individual #1's Brush Left Inside Teeth program documented data was to be taken three times per week on the a.m. shift. However, his data sheet contained only three entries. - Individual #1's Comb Hair program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only three entries. <p>February 2015:</p> <ul style="list-style-type: none"> - Individual #1's Identify Men's Restroom Sign program documented data was to be taken two 	W 252			

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W 252	<p>Continued From page 9</p> <p>times per week on the p.m. shift. However, his data sheet contained only two entries.</p> <ul style="list-style-type: none"> - Individual #1's Wash Tops of Hands program documented data was to be taken two times per week on the p.m. shift. However, his data sheet contained only four entries. - Individual #1's Brush Left Inside Teeth program documented data was to be taken three times per week on the p.m. shift. However, his data sheet contained only three entries. <p>March 2015:</p> <ul style="list-style-type: none"> - Individual #1's Participate in Creating His Daily Schedule program documented data was to be taken three times per week on the a.m. shift. However, his data sheet contained only six entries. - Individual #1's Select Activity on His Visual Schedule program documented data was to be taken three times per week on the a.m. shift. However, his data sheet contained only eight entries. <p>April 2015:</p> <ul style="list-style-type: none"> - Individual #1's Wipe After Toileting program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only two entries. - Individual #1's Look Both Ways Before Crossing the Street program documented data was to be taken two times per week on the p.m. shift. However, his data sheet contained only six entries. - Individual #1's Identify a Nickel From a Field of 	W 252			

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W 252	<p>Continued From page 10</p> <p>Three Different Coins program documented data was to be taken two times per week on the p.m. shift. However, his data sheet contained only six entries.</p> <p>May 2015:</p> <ul style="list-style-type: none"> - Individual #1's Wipe After Toileting program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only three entries. - Individual #1's Identify a Nickel From a Field of Three Different Coins program documented data was to be taken two times per week on the p.m. shift. However, his data sheet contained only five entries. - Individual #1's Brush Left Inside Teeth program documented data was to be taken three times per week on the p.m. shift. However, his data sheet contained only six entries. <p>June 2015:</p> <ul style="list-style-type: none"> - Individual #1's Brush Left Inside Teeth program documented data was to be taken three times per week on the a.m. shift. However, his data sheet contained only two entries. - Individual #1's Wash Tops of Hands program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only two entries. - Individual #1's Empty Mouth Between Bites program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only two entries. <p>b. Individual #2's IPP, dated 2/25/15, documented</p>	W 252			

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

PRINTED: 08/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/03/2015
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 252	<p>Continued From page 11</p> <p>a 15 year old male whose diagnoses included mild intellectual disability. He was admitted to the facility on 1/26/15. Formal programs were implemented 3/1/15. Individual #2's programs and corresponding data were reviewed, as follows:</p> <p>March 2015:</p> <ul style="list-style-type: none"> - Individual #2's Walk on Treadmill program documented data was to be taken three times per week on the a.m. shift. However, his data sheet contained only five entries. - Individual #2's Select an Activity of His Choice with a Preferred Staff program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only two entries. - Individual #2's Request Attention Using a Phrase Book program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only one entry. - Individual #2's Self Administration of Medications program documented data was to be taken two per week on the a.m. shift. However, his data sheet contained only two entries. <p>April 2015:</p> <ul style="list-style-type: none"> - Individual #2's Identify Coins and Bills up to \$100.00 program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only one entry. - Individual #2's Select an Activity of His Choice with a Preferred Staff program documented data was to be taken two times per week on the a.m. 	W 252			

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W 252	<p>Continued From page 12</p> <p>shift. However, his data sheet contained only one entry.</p> <p>May 2015:</p> <ul style="list-style-type: none"> - Individual #2's Request Attention Using a Phrase Book program documented data was to be taken two times per week at the day treatment center. However, his two day treatment data sheets contained a total of only three entries. - Individual #2's Write 10 positive Complete Sentences Daily About Himself or Others program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only three entries. <p>June 2015:</p> <ul style="list-style-type: none"> - Individual #2's Walk on Treadmill program documented data was to be taken three times per week at the day treatment center. However, his data sheet contained only one entry. - Individual #2's Write 10 Positive Complete Sentences Daily About Himself or Others program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only one entry. - Individual #2's Discuss With a Staff What he Reads From His Book program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only one entry. <p>c. Individual #3's IPP, dated 12/18/14, documented a 36 year old male whose diagnoses included mild intellectual disability. Individual #3's programs and corresponding data were reviewed,</p>	W 252			

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W 252	<p>Continued From page 13 as follows:</p> <p>Individual #3's record did not have raw paper data for January 2015.</p> <p>February 2015:</p> <ul style="list-style-type: none"> - Individual #3's Self Administration of Medication program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only two entries. - Individual #3's Assemble a Three Piece Project program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only five entries. - Individual #3's Look Up 10 Common Words in the Dictionary and Write the Definition of Each program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only four entries. - Individual #3's Read the Newspaper for 30 Minutes program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only four entries. <p>March 2015:</p> <ul style="list-style-type: none"> - Individual #3's Complete Showering Routine program documented data was to be taken two times per week on the p.m. shift. However, his data sheet contained only one entry. - Individual #3's Put on Deodorant program documented data was to be taken two times per week on the a.m. shift. However, his data sheet 	W 252			

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W 252	<p>Continued From page 14 contained only six entries.</p> <p>April 2015:</p> <ul style="list-style-type: none"> - Individual #3's Maintain a Distance of 3 Feet During Interaction program documented data was to be taken two times per week on the a.m. shift. However, his data sheet contained only four entries. - Individual #3's Practice Spelling Skills for 30 Minutes program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only six entries. - Individual #3's Read the Newspaper for 30 Minutes program documented data was to be taken two times per week at the day treatment center. However, his data sheet contained only six entries. <p>June 2015:</p> <ul style="list-style-type: none"> - Individual #3's Use a Towel to Dry Entire Body and Hair program documented data was to be taken two times per week on the p.m. shift. However, his data sheet contained only four entries. <p>During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated data should have been collected at the frequency listed on the data sheet for each shift. The QIDP stated the documentation did not indicate the data had been collected in a sufficient frequency.</p> <p>The facility failed to ensure Individual #1 - #3's data was collected at the frequency specified in their programs.</p>	W 252			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2015
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLL	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the 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	please see attached Plan of Correction <i>See</i>	
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: 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),	MM159		

RECEIVED
AUG 31 2015

FACILITY STANDARDS

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

[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: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/03/2015
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MM159	Continued From page 1 Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W252.	MM159		



August 31, 2015

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

RE: Fox Hollow, Provider #13G066

Dear Michael Case:

Thank you for your considerateness during the recent complaint survey at the Fox Hollow 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: 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: QIDP, Program Manager
6. Completion Date: October 3, 2015

Please refer to the response given under W252.

W252

1. Revised ADL data sheets will be 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. In addition, all staff will receive training on data documentation and collection in the home by QIDP.
2. The revised ADL data sheets will be used to collect data for all individuals in the home. QIDP will make weekly checks on the data being collected in the home for all individuals ensuring that there is sufficient information available to judge efficacy of the programs being provided.
3. The facility is doing chart reviews, part of which is verifying that that ADL program data is obtained and summarized sufficiently 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.
5. Person Responsible: QIDP, Program Manager
6. Completion Date: October 3, 2015

MM080 – Please see response given under W111.

MM155 – Please see response given under W159.

MM159 – Please see response given under W252.



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

Provider #13G066

Dear Mr. Young:

An unannounced on-site complaint investigation was conducted from July 27, 2015 to August 3, 2015 at Yellowstone Group Home #4 Fox Hollow. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007066

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

Findings #1: During the survey, 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 for the 3 individuals selected for review. 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.

Steve Young, Administrator
August 19, 2015
Page 2 of 5

One individual's record documented he was admitted to the facility on 1/26/15. His record included baseline ADL data collected for the month of February 2015, and ADL data for developed programmatic objectives initiated the first of March. A second individual's record included paper ADL data collection starting in January 2015. The third individual's record included paper ADL data for the months of February through June of 2015, but did not have ADL data for the month of January 2015.

During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP stated no paper data system for ADLs 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, so paper and electronic systems overlapped for a period. The QIDP stated summary data for the individual without paper ADL data sheets in January 2015 was from the electronic system. However, the information from the electronic system related to implementation rates, refusals, etc., was not present or accessible.

The City Director also provided an email from the corporate office, dated 7/28/15 at 1:30 p.m., stating the electronic data collection system used 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 program data in the event the electronic data collection system was inoperable.

The 3 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 a 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 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. None of the direct care staff were aware of restraints being used that were not part of an individual's plan. All staff stated new or emerging behaviors were to be documented on a Behavior Log, along with identified maladaptive behaviors and restraint.

Steve Young, Administrator
August 19, 2015
Page 3 of 5

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 3 individuals. None of the restraints documented on the Behavior Log forms resulted in injury or were outside of the 3 sample individuals' approved forms of restraint.

Additionally, the facility's Investigations and Incident/Accident Report forms, from 3/26/15 - 7/27/15, were reviewed. None of the Investigations or Incident/Accident Report forms documented unauthorized restraint use or injury from restraint.

Further, the 3 individual's 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.

Deficient practice related to behavior data collection and restraint use was not identified. However, the 3 individuals' paper ADL data sheets documented data collection rates which were below the stated target of various programs over multiple months for each of the 3 individuals.

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. One of the 7 staff stated the facility was sometimes short of forms, but all staff stated the Program Supervisor was able to get new forms when asked. All direct care staff stated 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. Summary data for January 2015 was present on the QIDP Tracking Form for the individual missing January 2015 paper data. Additionally, 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 tooth brushing program stated he would brush the left inside teeth with a light physical cue at 95%. However, data was being collected on 7 steps, one of which was brushing the left inside teeth. Total task data for 2/2015 documented a success rate of 91%, but the success rate for the identified step (brushing the left inside teeth) was 38%.

During an interview on 7/30/15 from 9:30 a.m. - 12:30 p.m., the QIDP and the City Director, both stated data was to be collected at the rate indicated on the individuals' plans. When asked about total task data, the QIDP and City Director stated it did not give an accurate reflection of individuals' progress.

The facility failed to ensure data was collected at the frequency specified in the individuals' plans and that summary data accurately reflect 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 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, and program revisions and implementation were made appropriately. Therefore, the allegation was substantiated and deficient practice was cited at W111, W159 and W252.

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.

Steve Young, Administrator
August 19, 2015
Page 5 of 5

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.

Two individuals' guardians were interviewed on 7/31/15. Both guardians stated there had been some concern with timely notification of events. However, both guardians stated they had discussed the concerns with the QIDP and the concerns had been resolved at the first of the year. Both guardians stated they had not filed formal grievances with the facility, only discussed concerns with the QIDP. Both guardians stated the discussions with the QIDP were sufficient to address their concerns. Both guardians stated they were being informed of events in a timely manner, and of the events they requested to be notified of. When asked about specific events, both guardians confirmed they had been notified of the events.

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.

Concerns related to timely notification had been expressed by guardians, therefore the allegation was substantiated. However, documentation and guardian interviews indicated the concerns had been addressed and resolved by the facility, and notification was taking place as requested. Therefore, no current deficient practices were identified.

Conclusion #2: Substantiated. No deficiencies related to the allegation are cited.

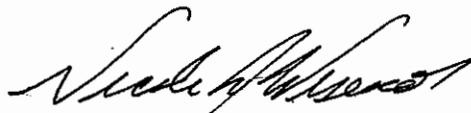
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

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