

SEP 03 2015



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
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Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 1, 2015

Rex Redden, Administrator
Idaho Falls Group Home #3 Periska
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #3 Periska, Provider #13G045

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #3 Periska, which was conducted on August 27, 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

Rex Redden, Administrator
September 1, 2015
Page 2 of 2

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 **September 14, 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 September 14, 2015. If a request for informal dispute resolution is received after September 14, 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: 08/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #3 PERISKA			STREET ADDRESS, CITY, STATE, ZIP CODE 950 PERISKA WAY IDAHO FALLS, ID 83405	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 8/24/15 to 8/27/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: ITTP - Interdisciplinary Treatment Team Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QAM - Quality Assurance Manager QIDP - Qualified Intellectual Disability Professional	W 000		
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation, review of policy and staff interviews, it was determined the facility failed to ensure practices were implemented that promoted the growth and development for 1 of 6 individuals (Individual #2) observed. This resulted in an individual's ostomy bag being exposed in public settings. The findings include: 1. The facility's Resident Rights policy, dated 7/1/80, stated each individual admitted to the facility must be "Treated with consideration, respect and full recognition of his dignity and	W 268	W 268 1. A "Staff Conduct Toward Client's" Policy will be implemented and will address the importance of maintaining the dignity and respect off all individuals. All staff will be trained on the new policy. Staff in the facility will also be retrained on the importance of keeping the ostomy bag covered at all times. In addition, longer shirts will be purchased for this individual to ensure the ostomy bag is covered at all times. 2. All individuals have the potential to be affected by this practice. All staff in all facilities will be trained on the new policy to ensure that staff are providing individuals with dignity and respect at all times.	

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SEP 14 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Alex H. Redden* TITLE *Administrator* (X6) DATE *9/9/15*

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 268	<p>Continued From page 1</p> <p>individuality, including privacy in treatment and in care for his personal needs."</p> <p>Individual #2's 8/14/14 ITTP stated he was a 46 year old male whose diagnoses included severe mental retardation, seizure disorder and chronic depression. His record documented he utilized a gait belt with handles when ambulating, a helmet to protect from falls during seizures, and had an ostomy bag (a bag connected to an opening in the abdominal wall to collect fecal matter).</p> <p>During observations, staff were not observed to maintain Individual #2's dignity by keeping his ostomy bag covered. Examples included:</p> <p>a. During an observation on 8/25/15, from 7:15 - 8:38 a.m., Individual #2 was observed to have approximately 3 inches of his ostomy bag exposed below his shirt line while at the dining room table. The QAM, who was present during the observation, was notified of the situation. The QAM pulled Individual #2's shirt over the bag and stated it should not have been exposed.</p> <p>b. During a subsequent observation on 8/26/15 from 8:35 - 8:50 a.m., Individual #2 was observed to participate in a community purchase outing. Individual #2 was accompanied by a direct care staff. The direct care staff walked with Individual #2, holding onto his gait belt. Individual #2 and the direct care staff entered a large combination grocery and department store by the northwest entrance, walked through the store to the southeast corner of the store to select a fishing rod. Individual #2 then selected a drink and took the purchases to the front of the store. After purchasing his items, Individual #2 and the direct care staff left the store.</p>	W 268	<p>W 268 cont'd</p> <p>3. The Home Supervisor and QAM will provide on-going training while in the homes on dignity and respect. Anytime an issue arises in regards to dignity and respect, the Home Supervisor/QAM will train the staff member on the issue and document it on a staff training form. The staff member will be required to sign the form stating they have been trained on the issue. In addition, the Home Supervisor will review the "Staff Conduct Toward Client's" policy at every monthly staff meeting. The Home Supervisor and QAM will also review the importance of keeping the ostomy bag covered at all times while in the home and in the community during the monthly staff meetings.</p> <p>4. The Home Supervisor and QAM will turn in all staff training forms to the QIDP for review. The QIDP will also attend staff meetings to ensure that staff are being trained on appropriate conduct towards clients.</p> <p>5. The Home Supervisor, QAM, and QIDP will be responsible for implementing this plan of correction.</p> <p>6. Target date for completion will be October 26, 2015.</p>	

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W 268	Continued From page 2 During the observation, no less than 4 inches of Individual #2's ostomy bag was noted to be exposed and hanging out of the underside of his shirt. The facility's training logs were requested and reviewed. Staff meeting notes from April and May of 2015 both documented dignity issues, including making sure ostomy bags were covered, had been addressed. The direct care staff observed with Individual #2 during the outing was present during both meetings. Additionally, a Staff Training note, marked Incidental Training and dated 7/16/15, documented the direct care staff observed with Individual #2 during the outing had been trained individually on ensuring catheter bags, ostomy bags, and Attends were kept covered and out of sight at all times while in the community and the facility. The document was signed by the direct care staff and the QAM. During an interview on 8/27/15 from 9:05 - 9:50 a.m., the QAM and QIDP both stated Individual #2's ostomy bag should have been covered. During an interview on 8/27/15 from 10:05 - 10:10 a.m., the direct care staff observed with Individual #2 during the outing, stated Individual #2's ostomy bag should have remained covered, and he had not been paying close enough attention. The facility failed to ensure Individual #2's ostomy bag remained covered in public settings in order to protect his dignity.	W 268			
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369			

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W 369	<p>Continued From page 3</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 2 individuals (Individual #4) observed to take medications. This resulted in an individual's medication being improperly administered. The findings include:</p> <p>1. Individual #4's 10/23/14 ITTP stated he was a 26 year old male whose diagnoses included severe mental retardation. His Physician's Order, dated 7/24/15, stated he received tamsulosin HCL (an alpha blocker drug) 0.4 mg. The Physician's Order stated he was to take the drug "1/2 hour after supper."</p> <p>An observation was conducted at the facility on 8/24/15 from 3:15 - 4:35 p.m. During that time, Individual #4 was observed to participate in a self administration of medication program.</p> <p>At 4:25 p.m., Individual #4 entered his bedroom with his direct care staff. The direct care staff assisted Individual #4 to prepare his 4:30 p.m. medications. However, the direct care staff assisted Individual #4 to administer his tamsulosin HCL along with his other 4:30 p.m. medications.</p> <p>Individual #4's MAR was reviewed during the observation. Tamsulosin HCL was listed on the same page as Individual #4's 4:30 p.m.</p>	W 369	<p>W 369</p> <p>1. A new MAR has been implemented for the Tamsulosin HCL so that it is now separate from the individual's 4:30 p.m. medications. In addition, the staff assisting the individual with their medications during the surveyors observation will be required to retake the medication administration test. Once the staff member has passed the medication administration test, the Home Supervisor will conduct three medication administration observations. If the staff member then passes those observations, the LPN will conduct a final medication administration observation to ensure the staff member is assisting all individuals with their medications as prescribed.</p> <p>2. All individuals have the potential to be affected by this practice. All MARs will be reviewed for accuracy to ensure that medications that are given at separate times are not listed on the wrong time frame. In addition, all staff in all facilities will be retrained on the Medication Administration Policy.</p> <p>3. The HCA and the LPN's will review all Physician's Orders and MARs to ensure they are accurate. In addition, the Home Supervisor will review the Medication Administration Policy in every monthly staff meeting.</p> <p>4. The QIDP will conduct quarterly chart reviews to ensure that the Physician's orders and the MARs are accurate. In addition, the QIDP will review all medication observation forms that are conducted by the Home Supervisor, QAM, and LPN to ensure staff are following the Medication Administration Policy.</p>	

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W 369	<p>Continued From page 4</p> <p>medications, but indicated the drug was to be given at 7:30 p.m. A note on the MAR stated "take 1/2 hour after supper."</p> <p>During an interview on 8/27/15 from 9:05 - 9:50 a.m., the LPN stated Individual #4's tamsulosin HCL was given at an incorrect time and should not have been administered with his 4:30 p.m. medications.</p> <p>The facility failed to ensure Individual #4's tamsulosin HCL was accurately administered.</p>	W 369	<p>W 369 cont'd</p> <p>5. The Home Supervisor, QAM, HCA, LPN's and QIDP will be responsible for implementing this plan of correction.</p> <p>6. Target date for completion will be October 26, 2015.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER
IDAHO FALLS GROUP HOME #3 PERISKA

STREET ADDRESS, CITY, STATE, ZIP CODE
**950 PERISKA WAY
IDAHO FALLS, ID 83405**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 8/24/15 to 8/27/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP	M 000		
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W268.	MM162	MM162 Refer to W 268	
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 W369.	MM166	MM166 Refer to W 369	

RECEIVED
SEP 14 2015
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dex A Redden* TITLE: Administrator (X6) DATE: 9/9/15

STATE FORM 6899 KB9S11 If continuation sheet 1 of 1