



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
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E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7012 3050 0001 2125 5631

September 15, 2015

Thair Pond, Administrator
Tomorrow's Hope - Meridian
1655 Fairview Avenue, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Meridian, Provider #13G033

Dear Mr. Pond:

Based on the Medicaid/Licensure survey completed at Tomorrow's Hope - Meridian on August 27, 2015, we have determined that Tomorrow's Hope - Meridian is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Client Protections (42 CFR 483.420)** and **Active Treatment Services (42 CFR 483.440)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Tomorrow's Hope - Meridian to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

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

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

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

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

Such corrections must be achieved and compliance verified by this office, before October 11, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 30, 2015.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 28, 2015.**

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

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Tomorrow's Hope - Meridian ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective August 27, 2015, through December 25, 2015. The conditions of the Provisional License are as follows:

1. Post the provisional license.

Thair Pond
September 15, 2015
Page 3 of 4

2. Correct all cited deficiencies and maintain compliance.

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

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **October 13, 2015**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

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

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

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

www.icfmr.dhw.idaho.gov

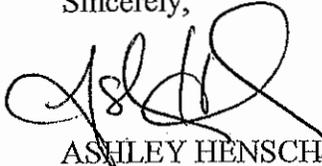
Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

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

Thair Pond
September 15, 2015
Page 4 of 4

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,

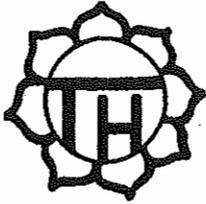


ASHLEY HENSCHLID
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures



TOMORROW'S HOPE, INC.

1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Nicole Wisenor
Co-Supervisor
Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
Boise, Idaho 83720-0009

RECEIVED
SEP 28 2015
FACILITY STANDARDS

September 28, 2015

RE: Credible Allegation/Plan of Correction for Tomorrow's Hope _ Meridian

Dear Ms. Wisenor,

Please find attached our plan of Correction for deficiencies found during the recent survey of our Tomorrow's Hope Meridian ICF/ID. All deficiencies have been addressed as outlined in your letter dated September 15, 2015. All corrections will be completed by 30 September, 2015.

We are prepared to have our home resurveyed to ensure that we are currently in compliance with Intellectual Disabilities Conditions of Participation of governing Body and Management, Client Protections, and active Treatment Services.

Sincerely

Thair Pond

Administrator

Enclosure

Copy: Meridian home, file, PD

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

PRINTED: 09/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642	
(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 recertification survey conducted from 8/18/15 to 8/27/15.</p> <p>The surveyors conducting your survey were:</p> <p>Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment DCS - Direct Care Staff IPP - Individual Program Plan MAR - Medication Administration Record OT - Occupational Therapy/Therapist PT - Physical Therapy/Therapist QA - Quality Assurance QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian SIB - Self-Injurious Behavior VCR - Video Cassette Recorder</p>	W 000	<p>RECEIVED</p> <p>SEP 28 2015</p> <p>FACILITY STANDARDS</p>	
W 102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the facility's Governing Body failed to take actions that identified and resolved systematic problems.</p>	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Chai S. Pong* TITLE *Administrator* (X6) DATE *9/28/15*

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 102	Continued From page 1 This failure resulted in inadequate protections and active treatment being provided to individuals. The findings include:	W 102	<i>Refer to W102</i>		
W 104	1. Refer to W104 as it relates to the facility's failure to ensure the Governing Body provided sufficient operating direction over the facility. 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the facility's Governing Body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems for 7 of 7 individuals (Individuals #1 -#7) residing at the facility. This failure resulted in the Governing Body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met and that sustained regulatory compliance was achieved. The findings include: 1. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they relate to the failure of the Governing Body to provide sufficient monitoring and oversight to ensure policies were adequately implemented and monitored necessary to ensure individuals were not subjected to violations of their individual rights. a. Refer to W124 as it relates to the Governing Body's failure to ensure sufficient information was	W 104		<i>Refer to W122</i> <i>Refer to W124</i> <i>Refer to 159, 186, 195</i> <i>196, 214, 249</i> <i>and 484</i>	

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W 104	<p>Continued From page 2</p> <p>provided to individuals' parents/guardians on which to base consent decisions. The facility was previously cited at W124 during an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved.</p> <p>2. Refer to W159 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight. The facility was previously cited at W159 during an annual recertification survey dated 12/20/10 and an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved.</p> <p>3. Refer to W186 as it relates the Governing Body's failure to ensure sufficient direct care staff were provided to manage and supervise individuals in accordance with their IPPs. The facility was previously cited at W186 during an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved.</p> <p>4. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the Governing Body's failure to ensure the facility provided each individual with continuous active treatment designed to meet their individualized needs. The facility was previously cited at W195 during an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved.</p> <p>a. Refer to W196 as it relates to the Governing Body's failure to ensure individuals were provided with continuous and consistent active treatment</p>	W 104			

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W 104	Continued From page 3 services in accordance with their individualized needs. The facility was previously cited at W196 during an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved. b. Refer to W214 as it relates to the Governing Body's failure to ensure individuals' assessments contained comprehensive information. The facility was previously cited at W214 during an annual recertification survey dated 12/20/10, an annual recertification survey dated 11/2/12, and an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved. c. Refer to W249 as it relates to the Governing Body's failure to ensure individuals' programs were consistently implemented. The facility was previously cited at W249 during an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved. 5. Refer to W484 as it relates to the Governing Body's failure to ensure an individual ate in a manner consistent with his developmental level. The facility was previously cited at W484 during an annual recertification survey dated 12/13/13. The Governing Body failed to ensure sustained compliance was achieved. The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet the individuals' ongoing needs.	W 104		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a	W 111		

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W 111	<p>Continued From page 4</p> <p>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 observation, record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained complete information for 3 of 7 individuals (Individual #2, #4, and #5) residing at the facility. This resulted in a lack of comprehensive, consistent information being available. The findings include:</p> <p>1. Individual #4's IPP, dated 5/21/15, documented a 32 year old male whose diagnoses included profound intellectual disability.</p> <p>Individual #4's record contained QA logs, dated 2/2015 - 7/2015, Client Fall Records, dated 2/2015 - 8/2015, and Progress Notes, dated 6/1/15 - 7/31/15, that were compared, with the following discrepancies noted:</p> <p>- 2/2015: His QA log review documented he had 3 falls and his Client Fall Record documented he had 6 falls.</p> <p>- 3/2015: His QA log review documented he had 1 fall and his Client Fall Record documented he had 2 falls.</p> <p>- 5/2015: His QA log review documented he had 5 falls and his Client Fall Record documented he had 6 falls.</p> <p>- 6/2015: His QA log review documented he had 10 falls and his Client Fall Record documented he</p>	W 111	<p>Individual #2, #4 & #5) Records have been reviewed and updated to ensure all health care, active treatment and social information and client protections are current to each individual. TC Responsible by 9/25/15</p> <p>All individuals records will be reviewed to ensure all information in the records reflect what is current. TC Responsible by 9/30/15</p> <p>The Record review form will be update to ensure any changes in status in health, active treatment, social and client protections are documented by TC monthly and turned in to PD at monthly QA.</p>		

PD responsible by 9/30/15
→ Fall Record form has been updated and turned in to PD at monthly QA.
PD Responsible by 9/15/15
→ The record review form & fall record will be reviewed at the monthly →

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W 111	<p>Continued From page 5 had 12 falls.</p> <p>- 7/2015: His QA log review documented he fell on 7/1, 7/2 and 7/30. His Client Fall Record also documented he had 3 falls. However, his Progress Notes documented an additional fall on 7/12/15 and 2 falls on 7/17/15, for a total of 6 falls in July.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP and the Treatment Coordinator both stated management was actively involved in the review of falls in the facility.</p> <p>The facility failed to ensure Individuals #4's fall record contained complete information.</p> <p>2. Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation. He was admitted from a sister facility on 12/3/14.</p> <p>His IPP stated he received a Dysphagia 2 mechanically altered diet with nectar thick liquids. Individual #2's 7/29/15 Physician's Orders also stated his diet was Dysphagia 2 mechanical altered, nectar thick liquids, and dry bread moistened with liquid.</p> <p>However, Individual #2's 12/18/14 CFA documented he was to receive pureed food, thickened drinks, and a mechanically soft diet. His 7/7/15 AM and PM Active Treatment Schedules both stated that all of his food needed to be chopped up with a food processor and all of his drinks needed to be thickened.</p> <p>When asked during an interview on 8/20/15 at</p>	W 111	<p>Will Continued</p> <p>QA meeting, discussion of any changes in health, Behavioral, Social, Active Treatment and alert probations will be noted and added to action list</p> <p>PD Responsible by 9/30/15</p> <p>Fall Record form will be reviewed at monthly QA</p> <p>PD Responsible by 9/30/15</p>

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W 111	<p>Continued From page 6</p> <p>1:32 p.m., the facility's RD stated Individual #2's Dysphagia Level 2 solid food consistency should be between mechanically soft and pureed in texture.</p> <p>During another interview on 8/26/15 from 1:58 - 3:40 p.m., both the Treatment Coordinator and the Home Manager stated when Individual #2 was admitted his diet was pureed with thickened liquids.</p> <p>Individual #2's records did not consistently reflect his diet order.</p> <p>3. Individual #5's 5/8/15 IPP documented he was a 22 year old male whose diagnoses included profound mental retardation and epilepsy.</p> <p>Individual #5's 4/22/15 CFA documented he wore a wrist weight during dining. However, the Adaptive Equipment section of his IPP stated he used a weighted spoon and lip plated, and clothing protector.</p> <p>Additionally, during observations conducted on 8/18/15 from 3:03 - 3:48 p.m. and 4:43 - 6:40 p.m., and on 8/19/15 from 8:12 - 9:15 a.m., Individual #5 was observed eating. He was not observed to be wearing a wrist weight.</p> <p>During interviews conducted on 8/24/15 from 1:49 - 3:35 p.m. and 8/25/15 from 12:50 - 1:20 p.m., 2 DCS stated weights were used at one time, but were not currently in place.</p> <p>Individual #5's records did not consistently reflect his adaptive dining equipment.</p>	W 111		
W 122	483.420 CLIENT PROTECTIONS	W 122		

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W 122	Continued From page 7 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on policy review, observation, record review and staff interview, it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals' rights. These failures resulted in a lack of effective systems to uphold individuals' rights. The findings include: 1. Refer to W124 as it relates to the facility's failure to ensure sufficient information was provided to guardians on which to base consent decisions. 2. Refer to W125 as it relates to the facility failure to ensure individuals were encouraged to exercise their rights. 3. Refer to W149 as it relates to the facility's failure to ensure written policies and procedures that prohibited abuse, neglect and mistreatment were adequately implemented and monitored.	W 122	<i>Refer to W124, 125, 149</i>	
W 124	The cumulative effect of these deficient practices resulted in individuals' rights being violated. 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental	W 124		

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W 124	<p>Continued From page 8 and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</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 sufficient information was provided to parents/guardians on which to base consent decisions for 2 of 3 individuals (Individuals #2 and #3) who used psychotropic medications and whose written informed consents were reviewed. This resulted in a lack of accurate information being provided to the individuals' parents/guardians regarding drugs used for behavioral control. The findings include:</p> <p>1. Individual #2's 1/2/15 IPP stated he was a 24 year old male whose diagnoses included profound mental retardation and mood disorder.</p> <p>Individual #2's 7/29/15 Physician's Orders documented an order for 7.5 mg of Abilify (an antipsychotic drug) every day. His August 2015 MAR documented he received Abilify every day as ordered.</p> <p>According to the 2014 Nursing Drug Handbook, adverse reactions to the use of Abilify may include increased suicide risk and suicidal thoughts, neuroleptic malignant syndrome (a potentially fatal neurological disorder), and seizures.</p> <p>Individual #2's record included an Abilify consent for medication form, dated 10/21/14, for mood disorder. However, his consent for medication did not include the adverse reactions of increased</p>	W 124	<p>Individuals #2 & #3 medication consents have been update to reflect include all significant adverse reactions to medication TC Responsible by 9/15/15</p> <p>→ All residents med consents will be reviewed to ensure all significant adverse reactions to the medication are included on consent. PD Responsible by 9/30/15</p> <p>→ At the medication and behavior Review staff completing the review will ensure all significant adverse reactions are listed on med consents by automatic checking side effects against the Nursing Drug hand</p>	

Book & pharmacy list of side effects
PD responsible by 9/30/15
→ PD to put together the list of side effects from Pharmacology & Nursing hand book →

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W 124	<p>Continued From page 9 suicide risk and suicidal thoughts, neuroleptic malignant syndrome, and seizures.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated Individual #2's consent did not include all significant adverse reactions for Abilify.</p> <p>The facility failed to ensure Individual #2's consent for medication contained sufficient information on which to make decisions.</p> <p>2. Individual #3's 3/19/15 IPP documented she was a 33 year old female whose diagnoses included moderate mental retardation.</p> <p>Individual #3's 1/13/15 physician's order form contained an order for Seroquel (an antipsychotic drug) 150 mg three times a day. Her July and August 2015 MARs documented she received Seroquel as ordered.</p> <p>According to the 2014 Nursing Drug Handbook, adverse reactions to the use of Seroquel may include neuroleptic malignant syndrome, seizures, and leukopenia (a reduction in white blood cells).</p> <p>Individual #3's record contained a Seroquel medication consent form, dated 1/13/15, which documented the medication was used for severe agitation/aggression. However, her medication consent form did not include the adverse reactions of neuroleptic malignant syndrome, seizures, and leukopenia.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated consents did not include all adverse reactions.</p>	W 124	<p>on drugs that will be available at medication reviewed PD Responsible By 9/30/15</p> <p>→ The SOP for completing the medication consent will be update to include include comparing side effects listed on program and the List Program director put together PD Responsible By 9/30/15</p>		

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W 124	Continued From page 10	W 124		
W 125	<p>The facility failed to ensure Individual #3's medication consent form contained sufficient information on which to make decisions.</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 6 of 7 individuals (Individuals #1 - #5, and #7) residing at the facility. This resulted in implementation of restrictions not based on individual need and without assuring due process protections. The findings include:</p> <p>1. During observations conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, the door from the laundry room to the garage was noted to be locked on the garage side of the door. Staff were also noted to use a key to open the door from inside the laundry room to gain access to the garage.</p> <p>Interviews were conducted with 7 DCS on 8/24/15 and 8/25/15. During the interviews, all DCS stated the door from the laundry room to the garage and the front door were locked to prevent elopement and due to Individuals #4 and #6's</p>	W 125	<p>→ The front door will be kept unlocked and staff trained to keep door unlocked and all resident's personal items have been removed from the garage TC Responsible by 9/28/15</p> <p>→ The garage has been cleaned out of all individuals personal items HM Responsible by 9/28/15</p> <p>→ HM walk through updated to include checking to ensure no personal items are in</p>	

The garage
HM responsible by 9/28/15

→ PD to review the HM walk through monthly to ensure personal items have not been in garage
PD Responsible by 9/28/15

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W 125	<p>Continued From page 11</p> <p>previous attempts to leave the facility by themselves. The DCS stated locking the doors allowed them extra time to ensure a client safely left the facility.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said the door from the laundry to the garage and the front door were kept locked to keep individuals from leaving without staff knowing they had left.</p> <p>Individual #6's Behavior Intervention Plan and Written Informed Consent for elopement, undated, stated "The door from the laundry room into the garage is to be locked at all times." However, none of the other 6 individuals' assessments included information related to restricted garage access, and consents related to the restrictions for the other 6 individuals could not be found.</p> <p>When asked during an interview with the Treatment Coordinator, QIDP and Home Manager, on 8/26/15 from 1:58 - 3:40 p.m., the Home Manager acknowledged the garage door was locked from the inside and stated it was to prevent individuals from rummaging through the items in the garage. The Treatment Coordinator stated none of the individuals were assessed for restriction to the garage and its consents. The QIDP stated the front door was locked as normal practice in a residence, not to prevent individuals from leaving.</p> <p>The facility failed to ensure individuals' access to the garage was not restricted without justification or due process.</p> <p>2. Refer to W137 as it relates to the facility's</p>	W 125	refer to 137		

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W 125 W 137	<p>Continued From page 12 failure to ensure each individual had free access to personal possessions.</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure individuals had free access to their personal possessions for 1 of 7 individuals (Individual #3) residing in the facility. This resulted in an individual not being able to freely access her personal belongings. The findings include:</p> <p>1. During observations conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, the door from the laundry room to the garage was noted to be locked on the garage side of the door. Staff were also noted to use a key to open the door from inside the laundry room to gain access to the garage. It was also noted there were various activities and items, including a plastic bin in the garage that contained a minimum of 15 bottles of nail polish.</p> <p>On 8/19/15 at 12:40 p.m., the Home Manager stated the nail polish belonged to Individual #3.</p> <p>However, Individual #3's record did not include any information related to storing her possessions in the locked garage.</p>	W 125 W 137	<p>→ All items belong to resident # 3 were taken out of garage HM Responsible By 9/30/15</p> <p>→ all items that belong to residents will be removed from the garage. HM responsible. By 9/30/15</p> <p>→ the training to be completed with all staff that they are not putting client's possessions in the garage HM responsible, By 9/30/15</p>	

→ HM to complete weekly walk through PSR to ensure client's personal possessions are not in the garage
HM responsible By 9/30/15

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W 137	Continued From page 13	W 137	PD to update PSR to include personal possessions are not locked up. PSR will be reviewed by PD at monthly EA	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored. This failure directly impacted 2 of 4 sample individuals (Individuals #3 and #4), and had the potential to impact all individuals (Individuals #1 - #7) residing in the facility. This resulted in a lack of fall patterns being identified and thorough investigations being completed. The findings include: The facility's Right to Protection from Abuse policy, dated 7/28/14, stated the facility "will not tolerate abuse of any type, duration, or severity." The policy defined abuse as "ill-treatment, violation, revilement, malignant [sic], exploitation, and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator." Neglect was defined as "failure to provide goods or services necessary to avoid physical harm ..." The policy documented examples of neglect, which included "grossly ignoring or violating safety procedures that place a client in immediate	W 149	PD responsible by 9/30/15 → individual #4 fall protocol has been update to include potentials times and areas that may cause him to fall and what preventive measures will be taken. TC Responsible by 9/30/15 → all individual's with fall protocols will have the protocol reviewed and update to include areas & times and activities that may cause the client to fall and what preventive measures will be taken TC responsible by 9/30/15	

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W 149	<p>Continued From page 14</p> <p>harm, failing to follow safety procedures and take protective action for any situations that can be potentially harmful to clients, failure to give proper or required care ..."</p> <p>The policy stated the "Program Director will keep an ongoing list of incident reports involving ...safety issues involving the client to review each month to ensure there are no patterns or trends."</p> <p>1. Individual #4's IPP, dated 5/21/15, documented a 33 year old male whose diagnoses included profound intellectual disability. His record documented he had an increased fall risk.</p> <p>Individual #4's Service Program for Falls, dated 5/21/15, stated "his postural alignment secondary to his decrease in Para spinal muscular tone changes his center of gravity. His righting reflex in sitting, standing, and during gait is minimally to moderately delayed and his environmental awareness is only fair. All of these factors contribute to an increased fall risk."</p> <p>The facility's Client Fall Records, from 2/1/15 - 8/17/15, were reviewed and documented Individual #4 had fallen a total of 42 times during the 7½ month period. However, there was no documentation the facility had assessed Individual #4's falls to identify patterns and implement appropriate corrective action to prevent future falls. Failure to identify repeated patterns would inhibit the facility's ability to identify potential neglect and take appropriate corrective action. For example:</p> <p>a. Individual #4's Client Fall Record documented he fell while in the back yard, as follows:</p>	W 149	<p>→ Program Director to update SOP on documentation of falls and how that will be reviewed at the monthly QA PD Responsible by 9/30/15</p> <p>→ Fall record data sheet has been updated to include where, when and how the resident fell. PD responsible 9/10/15</p> <p>→ The fall record data sheet and the fall protocol will be reviewed at the monthly QA with recommendation and need action added to the QA Log and the action list</p>	

AD responsible by 9/30/15

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W 149	<p>Continued From page 15</p> <ul style="list-style-type: none"> - 5/28/15, "was walking, went to sit down on the porch swing." - 6/5/15, "fall walking on [left] side." - 6/11/15, "was in backyard stepped on some uneven ground fell." - 6/12/15, "was in the backyard lost balance landed on back." - 6/12/15, "was in the backyard tried putting his hands in pants, lost balance." - 6/22/15, "was walking fell on [right] side." - 6/24/15, "was walking outside fell back" at 9:05 a.m. - 6/24/15, "was outside playing in the backyard" at 10:30 a.m., type of fall not documented. - 7/2/15, "was walking in back yard and fell to the ground." - 8/5/15, "fall lost balance, fell on [left] side." Bruising on left shoulder. - 8/27/15, "was by the front door lost his balance." <p>b. Individual #4's Client Fall Record documented he fell from the chair in the medication administration area, as follows:</p> <ul style="list-style-type: none"> - 2/1/15, "in med room on chair, fell to floor, but nobody saw it." - 3/16/15, "sitting in chair in med room [and] fell out of chair." - 6/21/15, "was in med room about to get out of chair and fell on Right side body [sic]." <p>c. Individual #4's Client Fall Record documented he fell over other individuals residing in the facility, as follows:</p> <ul style="list-style-type: none"> - 2/24/15, "tripped over [Individual #2]" at 3:40 p.m. and 4:15 p.m. - 5/16/15, "tripped over another client." - 7/1/15, "Fell over other client [and] landed on 	W 149		

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W 149	<p>Continued From page 16 client."</p> <p>- 8/24/15, "was playing with ball in living room, stepped backwards and fell over another clients wheelchair."</p> <p>d. Individual #4's Client Fall Record documented he fell standing up from the couch, as follows:</p> <p>- 2/1/15, "was sitting on couch, got up unsteady, fell to the floor." - 2/14/15, "Sitting on couch, got up quickly [and] fell on floor, stood up [and] fell again." - 6/16/15, "went to get up off the couch and screamed and fell back landing on back." - 8/14/15, "was getting up from couch and tripped over arm and landed on right shoulder."</p> <p>The facility's QA logs from 2/2015 - 8/2015 were reviewed. The QA reviews documented the number of Individual #4's falls for each month. However, comprehensive information related to patterns (e.g., falls in the backyard, falls from the chair in the medication administration area, falls over other individuals, falls when standing up from the couch, location of staff during falls, etc.) could not be found.</p> <p>An interview was conducted, on 8/26/15 from 1:58 - 3:40 p.m., with the QIDP, Treatment Coordinator and Home Manager. The QIDP stated she tracked all falls and reviewed them with the team during monthly QA meetings. The Treatment Coordinator stated she completed regular observations and involved health care professionals (physical therapists, OT, etc.) when needed. The Home Manager stated staff were trained to take measures to ensure falls were prevented, such as keeping the floor clear.</p>	W 149		

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W 149	Continued From page 17 When asked what measures had been implemented to reduce Individual #4's falls, the Treatment Coordinator stated Individual #4's anticonvulsant medications had been identified as a potential factor and were reduced. When asked if the facility monitored for patterns related to falls, such as time of day, shifts, etc., the Treatment Coordinator stated they had not. The facility failed to ensure Individual #4's falls were sufficiently monitored to identify patterns and potential neglect.	W 149	<i>9.29.15 9:14 AM KM Per telecom with the PD refer to W154</i>	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure a thorough investigation was conducted for all allegations of abuse for 1 of 1 individuals (Individual #3) involved in a facility investigation. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include: 1. The facility's Right to Protection from Abuse policy, dated 7/28/14, stated the facility "will not tolerate abuse of any type, duration, or severity ... Each staff will be able to identify, prevent, document, and report incidents of abuse." The	W 154		

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W 154	<p>Continued From page 18</p> <p>policy stated "Individuals must not be subjected to abuse by anyone (including, but not limited to...family members or legal guardians ..."</p> <p>The policy defined physical abuse as "any physical motion or action, (i.e. Hitting [sic], slapping, punching, kicking, pinching, etc.) by which potential or actual bodily harm or trauma could occur." Additionally, the policy stated if staff witnessed abuse, they were to "Ensure the safety of the client, provide any care needed and assure the client's safety" and "Call the Administrator IMMEDIATELY [sic]."</p> <p>The facility's investigations from 12/1/14 - 8/17/15 were reviewed. Included in the documentation was an Incident/Accident Report, dated 12/20/14 at 3:15 p.m., which documented Individual #3 stated her mother slapped her. Attached to the Incident/Accident Report was a document titled Incident Report Investigation Attachment. The form documented the date, time, and alleged incident, and included space for narrative information and a suggested plan of correction. The form did not include sufficient information to document a thorough investigation of the allegation, as follows:</p> <p>The Incident Report Investigation Attachment documented Individual #3, 6 other individuals residing at the facility, and 4 DCS that were on shift at the time of the incident, were interviewed. However, the attachment did not indicate the date or time the interviews were conducted.</p> <p>The attachment documented Individual #3 stated she hit her mother and her mother hit her. However, the documentation did not indicate the severity of the hit, whether it caused Individual #3</p>	W 154			

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W 154	<p>Continued From page 19</p> <p>pain, if Individual #3 knew where DCS were at the time of the incident or not, etc.</p> <p>The attachment documented DCS L stated she witnessed Individual #3's mother take Individual #3 by the wrist and take her to her bedroom. DCS L stated Individual #3 slapped her mother, at which point Individual #3's mother slapped Individual #3 on the face, told her to stop yelling, and then slapped Individual #3 on the arm. DCS L stated "Then I walked away and went to work with my clients." DCS L stated Individual #3's mother wanted to speak with the Home Manager at some point, and the Home Manager was contacted and spoke with Individual #3's mother on the phone.</p> <p>The attachment documented DCS I witnessed Individual #3's mother slap Individual #3 on the right arm while they were in Individual #3's bedroom. DCS I stated Individual #3 then went out to the kitchen, then Individual #3's mother took Individual #3 by the wrist and "began pushing/pulling" Individual #3 back to her bedroom. Once inside, Individual #3's mother shut the door. DCS I stated she entered the room to remove Individual #3's roommate, but then left Individual #3 in the bedroom with her mother.</p> <p>The statements documented both DCS L and DCS I witnessed Individual #3 being slapped by her mother. However, there was no evidence DCS L or DCS I had intervened to protect Individual #3 per the facility's policy, or had reported the incident to the Administrator. Additionally, there was no evidence the facility had investigated the failure to protect or the failure to immediately report the incident.</p>	W 154	<p>→ All professional staff will be trained on how to adequately investigate an incident PD responsible by 9/30/15</p> <p>→ all staff are will be trained on what to do if they believe a parent hit their child while at the group home How to intervene and to report immediately TC responsible by 9/30/15</p> <p>→ PD had tried made an SOP for how to complete a thorough investigation By 9/30/15 PD responsible</p> <p>→ The investigation document has been update to ensure there is a space for all</p>		

needed ~~the~~ information
PD responsible By 9/30/15

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W 154	<p>Continued From page 20</p> <p>The attachment documented the Home Manager had spoken with Individual #3's mother on 12/21/14 and Informed her an investigation was being completed due to the allegation. The Home Manager documented "She said she did not do that at the house. And that it was a tap on the chin to get her attention." However, there was no additional evidence Individual #3's mother had been interviewed about the allegation.</p> <p>The Incident/Accident Report was completed by the Home Manager and documented the incident took place on 12/20/14 at 3:15 p.m. However, the report did not document when it was completed by the Home Manager, and the notification section of the report documented the Administrator was not notified until 12/21/14 at 7:20 a.m. Additionally, the Home Manager documented on the report "Completed an investigation - Slapping [Individual #3] was found to be unclear. See Investigation [sic]."</p> <p>However, with the exception of the of the Incident Report Investigation Attachment, no documentation a thorough investigation had been completed was present (e.g., evidence Individual #3 had been assessed for injury at the time, completion of a thorough interview with Individual #3's mother, investigation of delayed reporting and lack of protection, summary of conclusions, etc.).</p> <p>During an interview on 8/18/15 at 1:34 p.m., the QIDP stated Individual #3 had experienced an extreme escalation in maladaptive behaviors around the time of the incident. The QIDP stated as a result of Individual #3's behaviors, the team focused more on the maladaptive behavior than</p>	W 154			

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W 154	Continued From page 21 on the investigation of potential abuse.	W 154			
W 159	<p>The facility failed to ensure all allegations of abuse were thoroughly investigated.</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 observation, record review, policy review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W111 as it relates to the facility's failure to ensure the QIDP ensured each individual's record contained accurate information. 2. Refer to W124 as it relates to the facility's failure to ensure the QIDP ensured sufficient information was provided to guardians on which to base consent decisions. 3. Refer to W125 as it relates to the facility's failure to ensure the QIDP ensured individual rights were not restricted through lack of choice. 4. Refer to W137 as it relates to the facility's failure to ensure the QIDP ensured individuals' 	W 159	<p><i>Refer to W111, W124</i></p> <p><i>W125, W137, W186</i></p> <p><i>W195, W268, W454</i></p> <p><i>W460, W484</i></p>		

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W 159	Continued From page 22 access to personal possessions was not restricted. 5. Refer to W186 as it relates to the facility's failure to ensure the QIDP ensured sufficient staffing for individual needs. 6. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the QIDP's failure to ensure active treatment services were provided to each individual. 7. Refer to W268 as it relates to the facility's failure to ensure the QIDP ensured the policy for growth and independence was implemented. 8. Refer to W454 as it relates to the facility's failure to ensure the QIDP ensured individuals were provided a sanitary environment. 9. Refer to W460 as it relates to the facility's failure to ensure each individual received modified diets as prescribed. 10. Refer to W484 as it relates to the facility's failure to ensure the QIDP ensured an individual had appropriate equipment to meet his dining needs.	W 159			
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.	W 186			

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W 186	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, record review, review of staff schedules and staff interview, it was determined the facility failed to provide sufficient direct care staff to manage and supervise individuals in accordance with their IPPs for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the inability of staff to consistently meet the individuals' identified needs. The findings include: 1. The facility housed seven individuals diagnosed with moderate to profound mental retardation. Individual #1 - #7's IPPs were reviewed, and documented the following: - Individual #1's IPP, dated 7/27/15, documented he was deaf and blind and required physical assistance for bathing, dressing and toileting. His CFA, dated 6/30/15, documented Individual #1 required multiple verbal cues or physical assistance to complete personal hygiene and food preparation tasks. The CFA also documented Individual #1 could ambulate without staff assistance. Individual #1's Behavior Intervention Plan for SIB, undated, stated he engaged in SIB (defined as biting his left forearm, hitting himself and aggression when SIB attempts were blocked) an average of 495 times per month and stated episodes lasted anywhere from seconds to 15 minutes. The plan stated staff were to block SIB attempts and offer choices via sign language. Individual #1's AM Active Treatment Schedule, dated 8/19/15, documented Individual #1 required	W 186		

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W 186	<p>Continued From page 24</p> <p>staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 30 - 60 minutes, interacting with Individual #1 every 10 - 15 minutes, encouraging Individual #1 to use the restroom every 60 - 90 minutes and checking on Individual #1 "every couple of minutes" during showers to monitor water temperature.</p> <p>- Individual #2 was admitted to the facility on 12/3/14. Individual #2's IPP, dated 7/27/15, documented he required physical assistance for medication administration, hand washing, dressing, toothbrushing and money management. His CFA, dated 12/18/14, documented Individual #2 required complete physical assistance for food preparation tasks.</p> <p>Individual #2's Behavior Intervention Plan for SIB, dated 1/2/15, stated he engaged in SIB, defined as face slaps or head hits. The plan stated staff were to block SIB attempts, check his basic needs (thirst, hunger, etc.), offer sensory items and call the nurse for a pain medication.</p> <p>Individual #2's Behavior Intervention Plan for maladaptive attention seeking, dated 1/2/15, stated he engaged in attention seeking behavior, defined as pulling others' hair or pinching others. The plan stated staff were to move away from Individual #2, give as little attention as possible and resume interaction when he requested attention appropriately.</p> <p>Individual #2's AM and PM Active Treatment Schedules, both dated 7/17/15, documented Individual #2 required staff assistance throughout the day. Staff assistance included, but was not</p>	W 186			

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W 186	<p>Continued From page 25</p> <p>limited to, encouraging Individual #2 to use the restroom every 60 - 90 minutes and monitoring him near water as Individual #2 "HAS SEIZURES. NEVER LEAVE HIM ALONE AROUND WATER." Additionally, Individual #2's 3/15/15 Fall Protocol documented he was sometimes a little unsteady on his feet, could walk for short distances, and could ambulate around the house without help.</p> <p>- Individual #3's IPP, dated 3/19/15, documented she engaged in SIB, aggression, outbursts and obsessing. Individual #3's Behavior Intervention Plan for SIB, aggression and outbursts, dated 3/19/15, stated she engaged in SIB (defined as banging her head on walls or objects, hitting her head with her hand or biting her hand) an average of 91 times per month. The plan stated she engaged in aggression (defined as hitting, kicking, scratching or biting others) an average of 16 times per month. The plan documented Individual #3 engaged in outbursts (defined as 3 of the following: screaming, yelling, hitting walls with her hand, throwing things, SIB or aggression) an average of 42 times per month. The plan stated staff were to attempt to problem solve with Individual #3 and redirect her to a preferred activity. Additional instructions for staff assistance included writing down what she wants, blocking aggression attempts, offering choices with picture cards and cueing Individual #3 to take a break.</p> <p>Individual #3's Behavior Intervention Plan for obsessive behavior, dated 3/19/15, stated she engaged in obsessive behavior (defined as perseverating on something) an average of 88 times per month. The plan stated staff were to write down what Individual #3 was obsessing over, cue her back to the paper if still obsessing</p>	W 186			

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W 186	<p>Continued From page 26 and direct her to a preferred activity.</p> <p>- Individual #4's IPP, dated 5/21/15, documented he required physical assistance for medication administration, dressing, toileting, toothbrushing and bathing. His CFA, dated 5/13/15, documented Individual #4 required physical or complete assistance during meal preparation tasks.</p> <p>Individual #4's Behavior Intervention Plan for head butting, dated 5/21/15, stated he engaged in head butting an average of 3 times per month. The plan stated staff were to re-cue Individual #4 to task if he head butted.</p> <p>Individual #4's Behavior Intervention Plan for eloping, undated, stated he engaged in eloping (defined as going out the front door and closing it behind him without staff) an average of 3 times per month. The plan stated staff were to re-cue Individual #4 to task, go outside and direct him back in or, if Individual #4 could not be visually located, call the police.</p> <p>Individual #4's AM Active Treatment Schedule, dated 6/11/15, documented Individual #4 required staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 60 minutes, encouraging Individual #4 to use the restroom every 60 - 90 minutes and "continuously check the water temperature to make sure it is warm enough" during showers. Additionally, Individual #4's PT Service Program, dated 5/21/15, stated staff were to assist him to practice keeping balance when helping him stand.</p>	W 186			

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W 186	<p>Continued From page 27</p> <p>- Individual #5's IPP, dated 5/8/15, documented he required physical assistance for dressing and bathing. His CFA, dated 4/22/15, documented Individual #5 required physical or complete assistance during meal preparation tasks.</p> <p>Individual #5's AM Active Treatment Schedule, dated 8/13/15, documented Individual #5 required staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 60 - 90 minutes and encouraging Individual #5 to use the restroom every 60 - 90 minutes. Individual #5's PM Active Treatment Schedule, dated 3/13/15, documented Individual #5 "is very unstable in the shower...Staff need to be in close contact with [Individual #5] at all times for safety precautions. Staff need to check the water temperature every few minutes to ensure that it is still warm." Additionally, Individual #5's PT Home Program note, dated 7/7/15, documented he should be encouraged to stand as tall as possible.</p> <p>- Individual #6's 2/6/15 IPP documented he required physical assistance for hand-washing, toileting, grooming, oral hygiene, and bathing. His CFA, updated 1/15/15, stated he required multiple verbal cues or physical assistance to complete food preparation tasks, and needed constant supervision in the kitchen for safety reasons.</p> <p>Individual #6's Behavior Intervention Plan for agitation, dated 2/6/15, stated he engaged in agitation (defined as stomping his feet, slamming doors, dropping to his knees, screaming/crying, knocking over chairs, slamming a shirt onto the floor, pushing through staff, and wiggling his</p>	W 186			

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W 186	<p>Continued From page 28</p> <p>fingers in front of his face) an average of 14 times per month and stated episodes could last up to 2 hours. The plan stated staff were to body position and redirect to his room as needed to protect others, and required staff to monitor him in his room if he was slamming the door.</p> <p>Individual #6's Behavior Intervention Plan for eloping, undated, stated he engaged in eloping (defined as leaving the facility through a door or window without staff's knowledge) an average of 1 time per month. The plan stated staff were to check on him every 5 minutes while in his room, and his door was to remain open unless he was "having private time." If individual #6 was having private time, staff were to remain close to the room and listen for the window alarm.</p> <p>Individual #6's AM Active Treatment Schedule, updated 8/17/15, and PM Active Treatment Schedule, updated 8/18/15, both stated he was to be encouraged to use the restroom every 60 - 90 minutes during waking hours, was to be engaged in sensory input at least 5 minutes out of every hour, required assistance for dressing, and needed encouragement to engage in 20 - 30 minutes of physical activity daily. Additionally, Individual #6's CFA, dated 1/15/15, documented Individual #6 was ambulatory and could walk independently for short distances, but required a wheelchair for long distances.</p> <p>- Individual #7's IPP, dated 2/26/15, documented she required physical assistance for toileting, grooming, hygiene and toothbrushing. Her CFA, dated 1/23/15, documented Individual #7 required physical or complete assistance during meal preparation tasks.</p>	W 186		

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W 186	<p>Continued From page 29</p> <p>Individual #7's Behavior Intervention Plan for putting her hands in her mouth or biting her hands, undated, documented Individual #7 engaged in the behaviors an average of 157 times per month. The plan documented if Individual #7 placed her hand in her mouth, staff were to check her basic needs (thirst, hunger, etc.), offer a hand massage and a quiet place, go on a walk with her or put gloves on Individual #7.</p> <p>Individual #7's AM and PM Active Treatment Schedules, both dated 8/15/15, documented Individual #7 required staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 60 minutes, encouraging Individual #7 to use the restroom every 60 - 90 minutes and if she was utilizing her wheelchair, for one staff to hold her gait belt and assist her to walk 10 - 15 minutes each hour. Her corresponding 2/26/15 - 2/26/16 PT Service Program documented she was unable to ambulate independently and her Falling Service Program, dated 2/26/15, documented she needed to be monitored closely. Additionally, Individual #7's PM Active Treatment Schedule documented Individual #7 "has seizures and cannot be left alone in the bathtub."</p> <p>Observations were conducted at the facility on 8/18/15 and 8/19/15 for a cumulative 5 hours 44 minutes. During the observations, a minimum of 4 staff were present to assist Individuals #1 - #7.</p> <p>However, the facility's as worked schedules from 5/1/15 - 7/31/15 were reviewed and documented shifts were worked with less than 4 staff. This happened no less than 18 times in May, 18 times in June and 19 times in July. For example, the</p>	W 186			

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W 186	Continued From page 30 PM shift of 7/27/15 was worked with 3 staff. Individuals #1 - #7 were all present during the shift. Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. All DCS stated they had worked a shift with only 3 staff, though it did not happen very often. They stated when 3 staff were working a shift, it was hard to ensure everything was done properly. The DCS stated with 3 staff on shift, the staff present were required to run around a lot which could be tiring, hectic and chaotic. One DCS stated utilizing only 3 staff was not fair to the staff working or the individuals. During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated she completed observations and noted any needs for additional staff training. The Treatment Coordinator stated the facility deployed staff based on individual need, but the facility housed multiple individuals that required significant physical assistance. The facility failed to maintain a minimum of 4 staff to ensure individuals' needs were consistently met.	W 186	→ Scheduled and needs reviewed to ensure there are 4 staff on shift FM responsible by 9/30/15 → Reviewed client's needs and the zoning schedule and update the clienting groupings TC responsible by 9/30/15 → Active treatment PSR to be update to include does the observe feel there is adequate staffing PD responsible by 9/30/15 → Client needs and staffing issues will be reviewed at the monthly QA to ensure clients needs		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	W 195			

9.29.15 9:14am. *EM*
per telecom with PD,
the observer will ASK
staff if they are
adequately staffed.

are being met. will
document discussion
and recommendations
on the QA Log
PD responsible by 9/30/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 09/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642		
(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 195	Continued From page 31 ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of necessary services and supports being provided to individuals in order to adequately address their individualized needs. The findings include: 1. Refer to W196 as it relates to the facility's failure to ensure each individual was provided with continuous and consistent active treatment services in accordance with their identified needs. 2. Refer to W214 as it relates to the facility's failure to ensure the individuals' assessments provided information on which to base program intervention decisions. 3. Refer to W240 as it relates to the facility's failure to ensure individual program plans described relevant interventions to support independence.	W 195	<i>Refer to W196, W214 W240</i>		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review and staff	W 196			

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W 196	<p>Continued From page 32</p> <p>interview, it was determined the facility failed to ensure individuals were provided specialized and generic training necessary to meet the needs of 6 of 7 individuals (Individuals #1, #2 and #4 - #7) whose active treatment programs were reviewed. That failure resulted in individuals not being provided with continuous active treatment. The findings include:</p> <p>1. Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation.</p> <p>a. Individual #2 was observed at the facility on 8/18/15 from 12:00 - 12:55 p.m. Individual #2's morning Active Treatment Schedule, dated 7/17/15, documented he was to assist with lunch during the time period. Individual #2's lunch assistance included "getting all of the necessary items (clothing protector, napkin, spoon, plate, cup, glasses)," serving himself and pouring his own drink.</p> <p>During the 55 minute observation, the following was noted:</p> <p>At 12:00 p.m., Individual #2 was observed to be alone in the living room. At 12:06 p.m., staff entered the living room and assisted him to the dining room table where he sat unengaged, then back to the living room at 12:10 p.m. Once in the living room, Individual #2 laid on the couch and then the floor until 12:20 p.m. At that time, Individual #2 walked with staff assistance to the dining room table where he sat unengaged. At 12:25 p.m., Individual #2 got up from the table, walked back to the living room and laid on the floor.</p>	W 196		

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W 196	<p>Continued From page 33</p> <p>At 12:30 p.m., Individual #2 went into the restroom with DCS J for 2 minutes, and then sat at the dining table unengaged for 5 minutes. Individual #2 got up from the table and returned to the living room. Individual #2 laid on the living room floor and looked through a bin of toys. At 12:40 p.m., Individual #2 sat at the dining table unengaged. At 12:50 p.m., DCS J assisted Individual #2 to wash his hands and return to the table where he remained unengaged in activity until the observation ended at 12:55 p.m.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the 55 minute observation.</p> <p>b. Individual #2 was observed at the facility on 8/18/15 from 3:05 - 3:50 p.m.</p> <p>i. Individual #2's PM Active Treatment Schedule, dated 7/17/15, documented he was to have a snack and use the bathroom from 3:00 to 3:30 p.m. The Active Treatment Schedule stated he was to wash his hands, make a choice of snack from 2 choices, help prepare the snack, get all necessary items (e.g. obtaining his clothing protector, napkin, spoon, etc.), and pour his own drink. Once the meal was finished, he was to take his dishes to the sink, rinse them off and place them in the dish drainer.</p> <p>On 8/18/15 from 3:05 - 3:50 p.m., the following was observed:</p> <p>From 3:05 - 3:15 p.m., Individual #2 walked to the dining area with DCS D and sat down at the dining table. DCS D prepared thickened orange</p>	W 196	<p>→ All residents Active Treatment Schedules have been trained to all staff TC Responsible by 9/30/15</p> <p>→ Active treatment in general will be trained to all staff so they understand what active treatment is. TC Responsible by 9/30/15</p> <p>→ QIDP to complete an active treatment PSR hersey lab month or more as needed PD responsible by 9/30/15</p> <p>→ When active treatment PSR are turned in card</p>	

There are consistent low score will be discussed at QA with recommendations and needed actions note in the QA log. PD Responsible by 9/30/15

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W 196	<p>Continued From page 34</p> <p>juice and placed it on the table with a prepared snack. Individual #2 proceeded to eat the snack.</p> <p>Staff were not observed to elicit Individual #2's participation in choosing, preparing, serving himself or rinsing and placing his dishes in the drainer.</p> <p>From 3:15 - 3:30 p.m., Individual #2 walked with DCS D to his bedroom. DCS D walked behind Individual #2 with her arms around him. DCS D and Individual #2 came out of the bedroom and went to the living room where Individual #2 sat in the corner chair. DCS D offered Individual #2 sensory items. Individual #2 stood up and tried to go out the back door. DCS D intervened and left the area, stating she needed to check the temperature. Staff stated the temperature was 84 degrees and individuals were not allowed outside if the temperature was 90 degrees or above. Individual #2 went back to the living room and sat on the couch.</p> <p>At 3:26 p.m., Individual #2 attempted to enter the bedroom shared by Individual #3 and #7. DCS D wrapped her arms around Individual #2's midsection and pulled him away from the door stating "Honey, you can't take a bath right now." Individual #2 again attempted to go in the bedroom and was again physically redirected. Staff physically assisted him down the hall and released the physical hold when he was at the table in the living room. DCS D stood by the table with Individual #2, blocking his access to Individual #3 and #7's bedroom. Individual #2, picked up a cloth from the table and began shaking it. DCS D asked if Individual #2 wanted to help wiping off the table and provided hand over hand assistance in order for him to do so.</p>	W 196			

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W 196	<p>Continued From page 35</p> <p>DCS D was not observed to allow Individual #2 independence in wiping the table or provide less restrictive prompting (gestural cues, etc.) prior to providing hand over hand assistance.</p> <p>After DCS D ended the hand over hand assistance, Individual #2 walked around her and back to Individual #3 and #7's bedroom. DCS D again told him he could not take a bath now, wrapped her arms around his midsection, and attempted to physically redirect him back to the living room. Individual #2 dropped to the floor, got up, and was directed to the backyard at 3:32 p.m.</p> <p>Staff was not observed to honor Individual #2's choices.</p> <p>ii. Individual #2's PM Active Treatment Schedule, dated 7/17/15, documented if a community outing was not planned, then he was to engage in "Domestic Training" including dishes, wiping tables/counters, laundry, vacuuming, etc.), engage in a group activity, or engage in a leisure activity. The Active Treatment Schedule stated "Individual #2 likes to watch movies, playing outside, listening to music, and play with toys. Formal leisure program to choose a leisure activity when 2 are presented to him..."</p> <p>From 3:32 - 3:55 p.m., Individual #2 laid on the back patio holding toys. At 3:45 p.m., DCS D assisted Individual #2 up off the patio and onto the swing.</p> <p>Staff was not observed to offer Individual #2 a choice of leisure activities to choose from.</p> <p>Individual #2 was not observed to be consistently</p>	W 196			

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W 196	<p>Continued From page 36</p> <p>encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the 45 minute observation.</p> <p>c. Individual #2 was observed at the facility on 8/18/15 from 4:43 - 6:40 p.m.</p> <p>i. Individual #2's PM Active Treatment Schedule, dated 7/17/15, documented he was to use the restroom and engage in "Structured/Leisure time" from 4:30 - 5:00 p.m. The Active Treatment Schedule stated "Individual #2 likes to watch movies, playing outside, listening to music, and play with toys. Formal leisure program to choose a leisure activity when 2 are presented to him..."</p> <p>On 8/18/15 from 4:43 - 5:00 p.m., the following was observed:</p> <p>At 4:43 p.m., Individual #2 was observed in the common area of the facility. Individual #2 was laying on the living room floor before he scooted himself into the kitchen. At 4:49 p.m., Individual #2 stood up, walked back to the living room and sat on the couch. At 4:54 p.m., Individual #2 slid off the couch onto the floor and laid on the living room rug. DCS A verbally cued Individual #2 to a fishing game.</p> <p>Staff was not observed to offer Individual #2 a choice of leisure activities to choose from.</p> <p>At 4:55 p.m., Individual #2 walked into the kitchen. DCS D came up behind him and put her arms around Individual #2's arms and chest to block him from the oven. The Home Manger entered the facility, and Individual #2 held her fingers while she walked backwards with him to</p>	W 196			

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W 196	<p>Continued From page 37</p> <p>the living room. The Home Manager attempted to engage Individual #2 with the fishing game. DCS A then relieved the Home Manager and continued trying to engage Individual #2 in the fishing game.</p> <p>The Home Manager and staff were not observed to offer Individual #2 a choice of leisure activities to choose from.</p> <p>ii. Individual #2's PM Active Treatment Schedule documented from 5:00 - 5:30 p.m. he was to engage in a group activity, wash his hands, and help place food on the table when it was ready. The Active Treatment Schedule stated "Individual #2 has a hard time staying at the group activity. Reinforce with social praise and pats on the back. It might be helpful if [Individual #2] had a toy to play with during group."</p> <p>At 5:00 p.m., Individual #2 entered the bedroom shared by Individual #3 and Individual #7. DCS A followed Individual #2 and told him it was not his bedroom. At 5:05 p.m., DCS A stated she was going to assist Individual #2. DCS D stated Individual #2 wanted a bath but she was going to do it when dinner was going. DCS A told Individual #2 he could have a bath later when "there's more people to help you."</p> <p>Staff was not observed to honor Individual #2's choices.</p> <p>At 5:10 p.m., Individual #2 returned to the living room and looked through the toys. Individual #2 chose a padded toy and laid on the floor. DCS D handed Individual #2 a padded lion mirror. DCS A verbally cued Individual #2 to the wax scents, with no response. DCS A held Individual #2's</p>	W 196		

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W 196	<p>Continued From page 38</p> <p>hands as the Home Manager walked by and instructed DCS A to try using lotion. DCS A stated she was providing deep pressure.</p> <p>At 5:20 p.m. DCS A began reading an ABC book aloud while Individual #2 laid on the living room rug. Individual #2 started at this hands and rolled around on the rug as she read.</p> <p>Staff were not noted to reinforce Individual #2 with social praise and pats on the back or provide him with a toy to play with, per his Active Treatment Schedule.</p> <p>iii. Individual #2's PM Active Treatment Schedule documented from 5:30 - 6:30 p.m. he was to engage in eating dinner and clean up.</p> <p>At 5:35 p.m., DCS D stood behind Individual #2 and placed her arms and hands around his upper torso as they walked out of the living room. Individual #2 appeared to struggle with DCS D. He grabbed hold of the corner table against the wall behind the couch. He resisted as DCS D pulled him. He released his hold on the corner of the table and DCS D took him into the hallway bathroom counting 1, 2, 3, 4.</p> <p>At 5:40 p.m., DCS D brought Individual #2 to the dining area, holding his wrists. DCS D placed a towel-like clothing protector on Individual #2 and Individual #2 sat at the dining table.</p> <p>Staff were not observed to elicit Individual #2's participation in obtaining the clothing protector or putting it on.</p> <p>DCS D went to the laundry room and Individual #2 removed his clothing protector, went to the</p>	W 196			

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W 196	<p>Continued From page 39</p> <p>living room and sat on the couch. At 5:45 p.m., Individual #2 leaned on DCS E, who was next to him on the couch. Individual #2 slapped himself in the head then laid on the floor with his feet up on the couch. DCS E handed Individual #2 a mirror toy. Individual #2 attempted to slap his head, but DCS E blocked the attempts. DCS E verbally cued Individual #2 to wash his hands with no response. At 6:00 p.m., DCS A assisted Individual #2 up off the living room floor. She held his hands and led him to the kitchen. Individual #2 washed his hands and sat at the dining room table. Staff placed a clothing protector on him and the Home Manger provided hand over hand physical assistance for Individual #2 to serve himself.</p> <p>Individual #2's was not observed to assist in obtaining his dining equipment (e.g. clothing protector, napkin, spoon, plate, cup, etc.) and the Home Manager was not observed to allow Individual #2 independence or verbally prompt him to serve himself prior to providing hand over hand assistance.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the 1 hour and 57 minute observation.</p> <p>d. Individual #2 was observed at the facility on 8/19/15 from 8:15 - 9:15 p.m. Individual #2's morning Active Treatment Schedule, dated 7/17/15, documented he was to use the restroom and bathe from 7:30 - 8:30 a.m. From 8:30 - 9:00 a.m., Individual #2 was to have breakfast. The Active Treatment Schedule stated he was to wash his hands, assist in the preparation of</p>	W 196		

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W 196	<p>Continued From page 40</p> <p>breakfast, get all necessary items (e.g. obtaining his clothing protector, napkin, spoon, etc.), serve himself, and pour his own drink.</p> <p>On 8/18/15 from 4:43 - 5:00 p.m., the following was observed:</p> <p>At 8:15 a.m., Individual #2 was in his bedroom, where he remained until 8:20 a.m. At 8:20 a.m., Individual #2 and DCS B came into the dining area. DCS B verbally prompted Individual #2 to wash his hands then provided him with physical assistance to do so. Individual #2 then entered the laundry room, where DCS G assisted him with his medications. He left the laundry room and then returned to his bedroom, where he remained until 9:00 a.m.</p> <p>At 9:03 a.m., DCS B turned on Individual #2's bedroom light and verbally prompted him to get up for breakfast. DCS B assisted Individual #2 to the dining table. From 9:03 to 9:10 a.m., DCS B prepared his breakfast. At 9:07 a.m., Individual #2 got up from the dining table, walked towards DCS B while she prepared his breakfast, and then returned to the dining table. At 9:10 a.m., DCS B served Individual #2 breakfast.</p> <p>Individual #2's was not observed to be prompted or assist in preparing his breakfast, obtaining his dining equipment or serving himself.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the hour observation.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40</p>	W 196		

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W 196	Continued From page 41 p.m., the Treatment Coordinator stated individuals were to be provided with active treatment. The facility failed to ensure Individual #2 was provided with specialized and generic training necessary to meet his active treatment needs, promote his independence and maximize his developmental potential.	W 196			
W 214	2. Refer to W249 as it relates to the facility's failure to ensure individuals received interventions and services consistent with their IPPs. 3. Refer to W251 as it relates to the facility's failure to ensure transfer and ambulation assistance was consistently implemented. 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure assessments contained comprehensive information for 2 of 7 individuals (Individuals #3 and #6) whose assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individuals were observed to utilize a token reinforcement system, as follows: a. Individual #6's IPP, dated 2/6/15, documented	W 214	<i>km 9.29.15 9:14am revised com with PD refer to w249 refer to w251</i>		

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W 214	<p>Continued From page 42</p> <p>a 24 year old male whose diagnoses included profound intellectual disability.</p> <p>During an observation on 8/18/15 at 3:15 p.m., Individual #6 went in his bedroom and touched the buttons of his VCR. The Home Manager told Individual #6 he needed to earn tokens for his cable and pointed to the area between Individual #6's VCR and his television which was mounted to his bedroom wall. The Home Manager then prompted Individual #6 to do laundry to earn tokens. Individual #6 went with the Home Manager to the laundry room, then exited the laundry room. The Home Manager thanked him for checking the laundry and handed him a paper ticket. She stated he had earned his tokens and directed him to sit on the couch in the living room. The Home Manager then retrieved a step ladder and placed it in front of the television in the living room, which was mounted on the wall near the ceiling. The Home Manager stood on the ladder, removed the cables from the living room television and put the step ladder away. She then accompanied Individual #6 into his room.</p> <p>However, Individual #6's CFA, dated 1/15/15, did not contain assessment information related to Individual #6's ability to understand and use a token exchange system, how many tokens Individual #6 was required to earn prior to an exchange, or a schedule for token exchange.</p> <p>b. Individual #3's IPP, dated 3/19/15, documented a 33 year old female whose diagnoses included moderate intellectual disability.</p> <p>During observations on 8/18/15 from 12:00 - 12:55 p.m. and 8/18/15 from 4:43 - 6:40 p.m., Individual #3 was observed to exchange tokens</p>	W 214	<p>→ individual # 3 = # 6 Behavior assessment's have been update to include a reinforcement assessment - and to identify type of reinforcement and schedule of reinforcement TC responsible by 9/30/15</p> <p>→ all residents behavior assessment will be update to include a reinforcement assessment TC responsible by 9/30/15</p> <p>→ PD to update the behavior assessment to include a reinforcement assessment PD responsible by 9/30/15</p> <p>→ all professional staff will be trained on</p>		

the use of reinforcement
PD responsible by 9/30/15

→ Behavior PSR to be update to ~~the~~ have staff ide completers PSR identify what type of reinforcement is being use. PD responsible by 9/30/15

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W 214	Continued From page 43 for extra coffee and soda. However, Individual #3's CFA, dated 1/21/15, did not contain assessment information related to Individual #3's ability to understand and use a token exchange system, how many tokens Individual #3 was required to earn prior to an exchange, or a schedule for token exchange. When asked on 8/26/15 from 1:08 - 3:40 p.m., the Treatment Coordinator stated there were no assessments for the use of the tokens. The QIDP, who was present during the interview, stated the individuals' records did not include reinforcement schedules.	W 214		
W 240	The facility failed to ensure CFAs for Individuals #3 and #6 contained comprehensive information. 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the individual program plan described relevant interventions to support independence for 1 of 7 individuals (Individual #7) whose program plans were reviewed. This resulted in insufficient information being available to staff related to an individual's gait belt use. The findings include: 1. Individual #7's 2/26/15 IPP stated she was a 36 year old female whose diagnoses included	W 240		

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W 240	<p>Continued From page 44 profound mental retardation.</p> <p>Individual #7's Falling Service Program, dated 2/26/15, documented she needed to be monitored closely and wear a gait belt. Her 2/26/15 - 2/26/16 PT Service Program documented she was unable to ambulate independently. There was no additional information in the IPP regarding the gait belt (e.g., how it was to be applied, if staff were to be holding it at all times, if staff were to be holding it with one hand or both hands, with their palms up or down, etc.).</p> <p>Observations were completed on 8/18/15 and 8/19/15 for a cumulative of 5 hours and 44 minutes. During those times, Individual #7 was observed to be wearing a gait belt. The gait belt was observed to be used inconsistently by DCS staff throughout the observations. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:55 p.m., DCS A assisted Individual #7 to walk to the kitchen. Individual #7 had a gait belt on. DCS A had the gait belt bunched in her fist. - On 8/18/15 at 6:05 p.m., DCS F assisted Individual #7 to ambulate in the kitchen. DCS F held onto Individual #7's gait belt with her left hand while assisting Individual #5 with her right hand. - On 8/18/15 at 6:36 p.m., DCS F assisted Individual #7 to ambulate to the kitchen. Individual #7 was wearing a gait belt that was loose around her middle torso. As they entered the kitchen area, DCS F directed Individual #7's movements by pulling her sideways using the gait 	W 240	<p>At individual #7 IPP and fall protocol has been updated to include all information regarding the gait belt and when and how to use it responsible by 9/30/15</p> <p>→ all individuals plans will be reviewed to ensure the plans describe relevant information to support the individual toward independence. TC responsible by 9/30/15</p> <p>→ IPP & active treatment plans to be reviewed at monthly QA PD responsible by 9/30/15</p> <p>→ PD to review all protocol at monthly QA PD responsible by 9/30/15</p>	

PD responsible by 9/30/15

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W 240	Continued From page 45 belt. - On 8/19/15 at 8:49 a.m., Individual #7 had a gait belt on and was walking to the kitchen to wash her hands. As she passed the food that was at her place at the dining table, she attempted to sit at the table. DCS H pulled sideways on her gait belt and directed her to the kitchen sink to wash her hands. Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #7 for standing and ambulation, staff stated the following: - One staff stated to hold her hand and keep one hand on her back. - A second staff stated to walk behind her and hold her under her arms. - Three staff stated to hold her gait belt. - A sixth staff stated to place your hand under her arm and help her up. - A seventh staff stated to stand beside her and give her a hand or arm for support. When asked during a follow-up interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said staff were not to pull sideways on the gait belt or bunch the gait belt in their fist. The Treatment Coordinator stated staff should not be assisting another individual while assisting Individual #7. The facility failed to ensure Individual #7's IPP specified when and how the gait belt was to be used.	W 240			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249			

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W 249	Continued From page 46 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 2 of 4 individuals (Individuals #1 and #2) whose programs were reviewed. This resulted in individuals' programs not being implemented. The findings include: 1. Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation. Individual #2's 1/2/15 SIB Behavior Intervention Plan documented he was non-verbal and engaged in face slaps and head hits. The Behavior Intervention Plan included, but was not limited to, the following interventions: - Encourage more time off the floor: "...encourage him to stand as often as possible. When [Individual #2] is on the floor through the day, cue '[Individual #2] stand up'...If [Individual #2] doesn't stand up, cue again..." - Face slaps: "If [Individual #2] starts to slap his	W 249		

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W 249	<p>Continued From page 47</p> <p>face, if [Individual #2] is laying on the floor assist him to get up and see if he needs changed or if he is hungry or thirsty..."</p> <p>- Head hits: "If [Individual #2] hits his head - hard enough to be heard, at a slower pace, leaving red marks - block with your hand or a pillow...If he does not appear hungry, thirsty or need to be changed then get his box and cue 'get a toy' staff are to engage in this activity with him."</p> <p>However, during observations completed on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes. Staff were not observed to implement Individual #2's behavior plan, as follows:</p> <p>8/18/15 from 12:00 - 12:55 p.m.:</p> <p>- 12:15 p.m., Individual #2 laid vertically upside down on the couch while staff were engaged with other individuals.</p> <p>- 12:25 p.m., Individual #2 walked into the living room from the kitchen and laid on the floor while DCS J watched him.</p> <p>- 12:37 p.m., Individual #2 returned to the living room with DCS J following and sat on the floor looking through the toy bins.</p> <p>8/18/15 from 4:43 - 6:40 p.m.:</p> <p>- 4:43 p.m., Individual #2 laid on the living room floor, moved to the kitchen, and sat on the dining area floor.</p> <p>- 4:49 p.m., Individual #2 moved from dining area floor to the living room floor.</p>	W 249	<p>Individual #2 & #1 plans have been trained on how to implement TC responsible by 9/30/15</p> <p>- all individuals plans will be tracked to ensure staff know and understand on how to implement.</p> <p>TC responsible by 9/30/15</p> <p>Client observation → Active treatment PSR to be update to include more components to score on regarding behavior program's PD responsible by 9/30/15</p> <p>Client observation to be reviewed at monthly BA with recommendation</p>	

and need action added to the QA log and action list PD responsible by 9/30/15

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W 249	<p>Continued From page 48</p> <p>- 5:10 - 5:17 p.m., Individual #2 laid on the living room floor. He was observed and heard to slap himself on his left ear with his left hand multiple times.</p> <p>- 5:25 - 5:35 p.m., Individual #2 laid on the living room floor, looked at his hands, and touched the rug. He then laid on his right side bouncing his head up and down in the air and was heard to slap himself on the head a minimum of two times.</p> <p>Further, during this timeframe at 5:30 p.m., DCS E assisted Individual #4 from the dining table to the chair in the corner of the living room. As they were walking through the living room, both DCS E and Individual #4 stumbled over Individual #2 laying on the living room floor.</p> <p>- 5:50 p.m., Individual #2 laid on floor with his hands in his mouth.</p> <p>- 5:55 p.m., Individual #2 laid on the floor and was heard to hit his left ear with his left hand. DCS E sat beside him on the floor.</p> <p>- 6:00 p.m., Individual #2 continued to lie on the floor.</p> <p>However, other than at 5:17 p.m., staff were not observed to cue Individual #2 off the floor or attempt to block him when he hit himself on the head.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated all behavior plans should have been implemented as written.</p> <p>The facility failed to ensure Individual #2 received</p>	W 249			

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W 249	<p>Continued From page 49</p> <p>interventions consistent with his behavior intervention plan.</p> <p>2. Individual #1's 7/27/15 IPP documented he was a 31 year old male whose diagnoses included severe mental retardation, blindness, and deafness.</p> <p>Individual #1's 6/30/15 CFA documented he used sign language for the words please or want, eat, help, drink, food, leisure words, household words, and with other signers. The CFA also stated communication was usually initiated by other signers. His 8/19/15 AM and PM Active Treatment Schedules documented that staff would have to sign with him while he participated in group activities.</p> <p>However, during an observation on 8/19/15 from 2:30 - 3:15 p.m., staff were not observed to use sign language with Individual #1, as follows:</p> <ul style="list-style-type: none"> - 2:50 - 2:55 p.m., Individual #1 sat in the living room on a couch by himself with a balloon in his hands. DCS F sat on another couch in the living room while talking with Individual #5. - 2:56 p.m. DCS F sat beside Individual #1 on the couch. DCS F was heard to say "duck" and "dolphin" and asked him if he wanted some candy. He did not respond to the verbal cues. <p>When asked during interviews on 8/24/15 from 1:49 - 3:35 p.m. and 8/25/15 from 12:50 - 1:20 p.m., 7 DCS all stated Individual #1 communicated using sign language. When asked how Individual #1 could see the sign language, all 7 DCS said they placed their hand over his hand and he could read their sign</p>	W 249			

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W 249	Continued From page 50 language (e.g. tactile sign). During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated staff were to use tactile sign language when communicating with Individual #1. The facility failed to ensure Individual #1 received interventions consistent with his program.	W 249		
W 251	483.440(d)(3) PROGRAM IMPLEMENTATION Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure staff provided a uniformed approach consistent with individual's identified strengths and needs for 6 of 7 individuals (Individuals #1, #2, #4, #5, #6 and #7) in the facility. This resulted in a lack of proper techniques being implemented to transfer and assist individuals with ambulation. The findings include: 1. Observations were completed on 8/18/15 and 19/15 for a cumulative of 5 hours and 44 minutes. During the observations, staff were not observed to consistently use proper techniques to transfer and assist individuals with ambulation, as follows: a. Individual #4's 5/21/15 IPP stated he was a 33	W 251	⇒ individual #1, #2, #4 - #7 ambulation and transfer and assisting has been written out with specific instructions on how to implement TC responsible by 9/30/15 ⇒ All staff have been trained (verbally and through modeling) on how to assist with walking and transfer TC responsible by 9/30/15 ⇒ CI observations and active treatment	

PSR have been updated to include observation of staff assisting individuals w/ ambulation and transfer and assisting PD responsible by 9/30/15

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W 251	<p>Continued From page 51 year old male whose diagnoses included profound mental retardation.</p> <p>Individual #4's PT Service Program, dated 5/21/15, stated he was to walk without holding onto staff's arm and practice keeping balance by helping him stand. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 3:05 p.m., as Individual #4 walked through the kitchen DCS E placed his arms under Individual #4's armpits and walked behind him. - On 8/18/15 at 5:25 p.m., DCS E was behind Individual #4 and holding him under his armpits while assisting him to ambulate. - On 8/18/15 at 5:33 p.m., DCS E walked behind Individual #4 and placed his hands on Individual #4's chest as he walked to the couch. - On 8/19/15 at 7:05 a.m., DCS J assisted Individual #4 to walk to his bedroom while holding one of his hands and walking backwards in front of him. - On 8/19/15 at 8:35 a.m., DCS A used her left hand to assist Individual #4 to walk towards the kitchen as she used her right hand to propel Individual #7 in her wheelchair. - On 8/19/15 at 9:05 a.m., as Individual #4 walked to his room, DCS G held his left hand and walked backwards in front of him. - On 8/19/15 at 3:10 p.m., as Individual #4 walked to the dining table, DCS E walked backwards in front of him and held onto his hands. 	W 251	<p><i>- all PSR will be Reviewed at monthly QA with notes regarding discuss and any recommendations documented on QA Log and added to action list - PD responsible by 9/30/15</i></p>	

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W 251	<p>Continued From page 52</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #4 for ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to walk behind him and hold him under his arms. - A second staff stated do not allow him to walk without holding your hand or arm. - A third staff stated to brace your arms under his arms. - A fourth staff stated depending on how he felt at the time, allow him to hold on to you. - Two staff stated to walk side-by-side with him. - A sixth staff stated to keep arm's reach away from him when assisting him to walk. <p>b. Individual #2's IPP, dated 1/2/15, documented a 24 year old male diagnosed with profound mental retardation.</p> <p>Individual #2's 3/15/15 Fall Protocol documented he was sometimes a little unsteady on his feet, could walk for short distances, and could ambulate around the house without help. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 3:18 p.m., DCS D had her hands and arms around Individual #2 while she walked with him to the bedroom. - On 8/18/15 at 4:56 p.m., the Home Manager assisted Individual #2 to walk from the laundry room area to the living room. The Home Manager walked behind him with his body between her legs. - On 8/18/15 at 5:35 p.m., DCS D stood behind 	W 251			

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W 251	<p>Continued From page 53</p> <p>Individual #2 and placed her arms and hands around his upper torso as they walked out of the living room. Individual #2 appeared to struggle with DCS D. He grabbed hold of the corner table against the wall behind the couch. He resisted as DCS D pulled him. He released his hold on the corner of the table and DCS D took him into the hallway bathroom counting 1, 2, 3, 4.</p> <p>- On 8/18/15 at 6:02 p.m., DCS A assisted Individual #2 up off the living room floor. She held his hand and led him into the kitchen.</p> <p>- On 8/18/15 at 6:32 p.m., DCS D walked backwards and pulled on Individual #2's wrists while assisting him to walk.</p> <p>- On 8/19/15 at 2:35 p.m., DCS K walked behind Individual #2 with both arms under his armpits and around his upper torso.</p> <p>- On 8/19/15 at 2:52 p.m., DCS K walked behind Individual #2 with both arms under his armpits and her hand on his right wrist as she walked behind him.</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #2 for standing and ambulation, staff stated the following:</p> <p>- One staff stated he was unsteady but walked and did not use a wheelchair.</p> <p>- Another staff stated his hands were to be held.</p> <p>- A third staff stated staff were to allow him to walk more and hold out their hand to help him walk to the bathroom.</p> <p>- A fourth staff stated he was unsteady and staff</p>	W 251		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642		
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W 251	<p>Continued From page 54</p> <p>were to brace their arms under his arms.</p> <ul style="list-style-type: none"> - A fifth staff stated staff were to pull him up from the front and walk behind him. - A sixth staff stated staff were to pull him up from a sitting position and hold onto his arms. - A seventh staff stated he would pull himself himself up by holding onto staffs' hands and he could walk by himself. <p>c. Individual #6's IPP, dated 2/6/15, documented a 24 year old male whose diagnoses included profound mental retardation.</p> <p>Individual #6's CFA, dated 1/15/15, documented Individual #6 was ambulatory and could walk independently for short distances, but required a wheelchair for long distances. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:30 p.m., DCS D verbally cued Individual #6 to wash his hands. DCS D grabbed Individual #6's wrists, and then his biceps. She held his biceps while she assisted him down the hall. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #6 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated he can stand up with a verbal cue and sometimes you needed to hold his hands or hold him under his arms. - A second staff stated to hold both his hands. - Five staff stated he was independent. <p>d. Individual #5's 5/8/15 IPP documented he was a 22 year old male whose diagnoses included</p>	W 251			

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W 251	<p>Continued From page 55 profound mental retardation and epilepsy.</p> <p>Individual #5's PT Home Program note, dated 7/7/15, documented he should be encouraged to stand as tall as possible. The PT did not recommend or direct staff to hold his hands when ambulating. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:29 p.m., as Individual #5 walked into the house, DCS D walked in front of him backwards while holding onto his hands. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #5 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to hold both his hands. - Two staff stated he did not require assistance. - A fourth staff stated to put your leg between his legs when he was seated to help him up. Then he can walk around by himself. - A fifth staff stated to grab both of his hands and have him pull himself up. He can walk well independently. - A sixth staff stated to plant your feet, and pull him up. Individual #5 would only get up and walk when he wanted to. - A seventh staff stated that sometimes one staff needed to stand on either side of him while he ambulated. <p>e. Individual #7's 2/26/15 IPP stated she was a 36 year old female whose diagnoses included profound mental retardation.</p> <p>Individual #7's Falling Service Program, dated</p>	W 251			

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W 251	<p>Continued From page 56</p> <p>2/26/15, documented she needed to be monitored closely and wear a gait belt. Her 2/26/15 - 2/26/16 PT Service Program documented she was unable to ambulate independently. During observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:55 p.m., DCS A assisted Individual #7 to walk to the kitchen. Individual #7 had a gait belt on. DCS A had the gait belt bunched in her fist. - On 8/18/15 at 6:05 p.m., DCS F assisted Individual #7 to ambulate in the kitchen. DCS F held onto Individual #7's gait belt with her left hand while assisting Individual #5 with her right hand. - On 8/18/15 at 6:36 p.m., DCS F assisted Individual #7 to ambulate to the kitchen. Individual #7 was wearing a gait belt that was loose around her middle torso. As they entered the kitchen area, DCS F directed Individual #7's movements by pulling her sideways using the gait belt. - On 8/19/15 at 8:49 a.m., Individual #7 had a gait belt on and was walking to the kitchen to wash her hands. As she passed the food that was at her place at the dining table, she attempted to sit at the table. DCS H pulled sideways on her gait belt and directed her to the kitchen sink to wash her hands. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #7 for standing and ambulation, staff stated the following:</p>	W 251			

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W 251	<p>Continued From page 57</p> <ul style="list-style-type: none"> - One staff stated to hold her hand and keep one hand on her back. - A second staff stated to walk behind her and hold her under her arms. - Three staff stated to hold her gait belt. - A sixth staff stated to place your hand under her arm and help her up. - A seventh staff stated to stand beside her and give her a hand or arm for support. <p>f. Individual #1's 7/27/15 IPP documented he was a 31 year old male whose diagnoses included severe mental retardation, blindness, and deafness.</p> <ul style="list-style-type: none"> - On 8/19/15 at 8:30 a.m., Individual #1 had an episode of urine incontinence on the chair in the corner of the living room. DCS B held Individual #1's hands and walked backwards with him to the bathroom. - On 8/19/15 at 8:55 a.m., Individual #1 came out of the laundry room and went into the bathroom off the bedroom shared by Individual #3 and Individual #7. Individual #1 came out of the bathroom with DCS G, who held his hands as she walked backwards to his bedroom. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #1 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to use tactile sign language to cue him to move. You can also tap his shoulder or leg. - A second staff stated to link arms with him. 	W 251			

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W 251	Continued From page 58 - A third staff stated to touch Individual #1 so he knows you are next to him. Individual #1 liked to walk at staff's side. - A fourth staff stated Individual #1 did not require any physical assistance. He stated staff could guide Individual #1 if needed. - A fifth staff stated Individual #1 was independent. - A sixth staff stated staff should offer Individual #1 their hands. - A seventh staff stated Individual #1 did not require more than a light touch to stand and ambulate. When asked during a follow-up interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said staff should not lift individuals up from off the floor by pulling on their hands. She stated staff should ask each individual if they are ready to get up and offer their hands to the individuals. The Treatment Coordinator stated staff should not be walking behind individuals with the individuals between their legs. Staff should not hold onto individuals' hands and walk backwards while assisting the individuals with ambulation. She also stated assistance up shouldn't involve staff muscle, but that individuals should be pulling themselves up.	W 251			
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT The facility failed to ensure staff implemented individuals' transfer and ambulation assistance programs and guidelines. These policies and procedures must promote the growth, development and independence of the client.	W 268			

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W 268	Continued From page 59 This STANDARD is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the facility failed to ensure practices were implemented that promoted growth and development for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in individuals' growth, independence, dignity and privacy not being promoted. The findings include: 1. The facility's policy for Client Rights, revised March 2015, included a section titled "Right to Dignity and Privacy," which stated "Each client admitted to [name of facility] must be treated with consideration, respect and full recognition of his/her dignity and individuality; with privacy, freedom of communication and personal preferences." The Client Rights SOP (Standard Operating Procedure), updated 9/16/13, stated "Personal dignity encompasses the right of the individual to engage in and demonstrate through personal choice his/her preferences in all aspects of life and living." During observations conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, the facility's policies were not consistently implemented, as follows: a. Staff did not consistently ensure the individuals' attire promoted the individuals' dignity. Examples included, but were not limited to, the following: i. On 8/18/15 at 3:21 p.m., 5:55 p.m., 5:57 p.m. and 6:36 p.m., Individual #7's adult incontinence briefs were visible outside of the shorts/pants she	W 268	<p>→ All Staff Trained to ensure individual's incontinence briefs are not showing and what to do if they are HM Responsible By 9/30/15</p> <p>→ Staff trained on all Dignity & Respect issues client rights HM Responsible By 9/30/15</p> <p>→ Actual treatment and client observation update to ensure individuals are treated w/ dignity & respect. (more information added to PSR)</p> <p>→ PD To update SOP on Client Rights</p>		

including dignity and respect.
PD responsible By 9/30/15

→ PSR reviewed at monthly QA with any issues discussed and added to QA Log & action List. PD responsible by 9/30/15

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W 268	<p>Continued From page 60 was wearing.</p> <p>ii. On 8/18/15 from 5:10 - 5:30 p.m., Individual #2's adult incontinence briefs were visible at the back of his pants.</p> <p>iii. On 8/18/15 at 3:21 p.m. and 6:10 p.m., Individual #7 was wearing a towel-like, ripped clothing protector.</p> <p>iv. On 8/18/15 at 6:25 p.m., Individual #5 was wearing a towel-like clothing protector that was brown in color and ripped.</p> <p>v. On 8/19/15 at 6:43 a.m., Individual #4 was wearing a towel-like clothing protector that was tattered.</p> <p>vi. On 8/19/15 at 8:49 a.m., DCS H placed a towel-like clothing protector that was tattered on Individual #7.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated staff should have used the aprons that were hung on a hook in the dining area for clothing protectors. The QIDP, who was present during the interview, stated the facility should get rid of the old towel-like clothing protectors.</p> <p>The facility failed to ensure individuals' attire promoted their dignity.</p> <p>b. Staff did not consistently ensure staff communication promoted the individuals' dignity. Examples included, but were not limited to, the following:</p> <p>i. On 8/18/15 at 4:43 p.m., DCS D spoke with</p>	W 268	<p>- towel like clothing protectors removed HM Responsible By 9/30/15</p>		

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W 268	<p>Continued From page 61 Individual #2 and said, "okay handsome."</p> <p>ii. On 8/18/15 at 4:44 p.m., DCS D called Individual #2 "Sweet Cheeks" and "Sweetie" 2 times during the conversation.</p> <p>iii. On 8/18/15 at 5:10 p.m., DCS D called Individual #6 "big guy" and "handsome."</p> <p>iv. On 8/18/15 at 5:30 p.m., DCS D called Individual #6 "honey."</p> <p>Additionally, on 8/19/15 at 2:56 p.m., DCS F sat beside Individual #1 in the living room. DCS F was heard to say "duck," "dolphin" and "want some candy." He did not respond to the verbal cues. DCS F did not use tactile sign language while communicating with Individual #1 although Individual #1's 7/27/15 IPP documented blindness and deafness as secondary diagnoses.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator and QIDP stated pet names should not be used. The QIDP also stated staff were to use tactile sign language when communicating with Individual #1.</p> <p>The facility failed to ensure staff communication was appropriate to meet Individual #1's needs and promoted all individuals' dignity.</p> <p>c. Throughout the observations completed on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, items were noted to be kept in the living room in fabric bins. Individuals were observed to manipulate items from the bins which were not age appropriate and did not promote the individuals' dignity and growth. Examples included, but were not limited to, the following:</p>	W 268	<p>→ all staff to be trained on what Dignity and Respect means across all areas of training HM Responsible By 9/30/15</p> <p>* see the first 1/2 of correction for W268</p> <p>→ the items that are not age appropriate have been sent back to guardians HM Responsible by 9/30/15</p> <p>→ all individuals</p>

That Perifer non age appropriate leisure items will have a leisure program in place to help them acquire skills that are more age appropriate
Te Responsible by 9/30/15

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W 268	Continued From page 62 i. On 8/18/15 at 3:12 p.m., Individual #5 was seated on the couch chewing on plastic rings. ii. On 8/18/15 at 5:10 p.m., Individual #2 looked through the sensory bins and picked out a plastic, yellow lion mirror with padding around the edges to manipulate. iii. On 8/18/15 at 5:45 p.m., DCS F pressed the squeaker in a book she was reading to the individuals. She directed Individual #6 to look and listen to "the bird." iv. On 8/18/15 from 5:45 - 5:50 p.m., Individual #5 was holding two different plastic toys, one was a toy car he periodically placed in his mouth. v. On 8/19/15 at 8:20 a.m., Individual #1 was taken to the bins where he chose a stuffed penguin with a #2 on the shirt to manipulate. vi. On 8/19/15 at 8:25 a.m., Individual #1 was swinging around a stuffed penguin with a #5 on the shirt. vii. On 8/19/15 at 9:08 a.m., DCS H bounced a long-armed and long-legged, gray and red stuffed animal toy in an up and down motion for Individual #7. viii. On 8/19/15 at 2:35 p.m., DCS K provided Individual #2 with the yellow, plastic lion mirror which he held as he sat on the swing in the backyard. An inventory of items located in the sensory bins was taken on 8/19/15 from 12:28 to 2:00 p.m. Items in the sensory bins included, but were not	W 268	<p>→ PSR client observation and active treatment PSR will include observation of other individuals engage in age appropriate activity. PD responsible by 9/1/2015</p> <p>→ PEP to be update to provide direction regarding individuals right to retain and use appropriate personal possession PD responsible by 9/30/15</p>		

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W 268	<p>Continued From page 63 limited to, the following:</p> <ul style="list-style-type: none"> - A plastic caterpillar - A brown plastic milk jug with a hippopotamus picture on it - A 4-inch long green plastic frog - Numerous wooden blocks with numbers - A 7-inch long soft cloth green cat - An 18-inch long cloth reindeer with dangly legs and arms - A Fisher Price cell phone - Small rubber animals (a monkey, horse, bear and hippopotamus) - An Infantino elephant rattle - A Fisher Price computer - Infantino stuffed penguins with numbered shirts (#1, #2, #5 and #6) - A Sesame Street remote control - A Playskool plastic guitar - A Little Tikes plastic camera - An Infantino cell phone - A HAP-P-KID plastic pig - A Fisher Price fishing pole - A Little Tikes screwdriver - A Sassy Baby's Sense-Ations book - A Nuby teething ring set <p>Age appropriate items were not noted to be available in the sensory bins in the living room.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said there were toys in the living room that were not age appropriate and most belonged to Individual #2 who was admitted from a sister facility with the toys. When asked about a program to encourage Individual #2 to use age appropriate items, the Treatment Coordinator stated no program had been developed.</p>	W 268		

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W 268	<p>Continued From page 64</p> <p>The facility failed to ensure age appropriate items were made available for the individuals.</p> <p>d. During observations completed on 8/18/15 and 8/19/15 it was noted the facility had two bathrooms, one off of the hallway with a shower, and one off of the bedroom shared by Individual #3 and Individual #7 with a bathtub. Observations were conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes. During that time, individuals were noted to enter Individual #3 and Individual #7's bedroom to utilize the bathroom, as follows:</p> <p>i. During an observation on 8/18/15 at 5:05 p.m., Individual #2 was observed to go through Individual #3 and #7's bedroom with DCS A to use the bathroom. Individual #2 then left the bathroom at 5:10 p.m.</p> <p>ii. During an observation on 8/18/15 at 6:02 p.m., Individual #4 was observed to go through Individual #3 and #7's bedroom with DCS E to use the bathroom.</p> <p>iii. During an observation on 8/19/15 at 8:42 a.m., Individual #5 was observed to go with DCS J through Individual #3 and #7's bedroom to use the bathroom. Individual #3 was laying on her bed at the time. When asked, DCS A, who was present at the time, stated Individual #3 liked to rest before work. Individual #5 then left the bathroom at 8:49 a.m.</p> <p>During interviews conducted with 7 DCS on 8/24/15 and 8/25/15, the staff all stated when the bathroom off the hallway was occupied, individuals used the bathroom off Individual #3</p>	W 268	<p>→ Consent was obtained from individual #7 guardian to allow other individuals to use the bathroom TC Responsible By 9/30/15</p> <p>→ Staff have been trained they are to ask individual #7 & #3 to allow other individuals walk through their room. TC Responsible by 9/30/15</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/27/2015
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W 268	Continued From page 65 and Individual #7's bedroom. The staff all stated they tried to be quiet when taking individuals into that bathroom in an attempt to not disturb Individual #3 and Individual #7. When asked how traffic in and out of the bathroom impacted Individual #3 and Individual #7, including their right to privacy, during an interview on 8/24/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated they had not even thought about the effects. The facility failed to ensure consideration was given to Individual #3 and Individual #7, necessary to ensure their right to privacy was respected and upheld.	W 268			
W 269	483.450(a)(1)(ii) CONDUCT TOWARD CLIENT These policies and procedures must address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible. This STANDARD is not met as evidenced by: Based on record review, and staff interview it was determined the facility failed to ensure a policy that promoted opportunities for choice, decision-making and self-management was developed and implemented. This failure directly impacted 2 of 7 individuals (Individuals #2 and #4) observed and had the potential to impact 7 of 7 individual (Individuals #1 - #7) residing at the facility. This resulted in individual choice and self direction not being maximized. The findings include:	W 269	→ Individual #2 and #4 active treatment program and schedule has been update to include opportunities in choice making, self determination and self management TC responsible by 9/30/15 → all individual active treatment program will be reviewed to		

ensure it provides staff with direction on allowing choice, self management and self direction
TC responsible by 9/30/15

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W 269	Continued From page 66 1. Observations were conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes. During the observations, individual self direction and choices were not honored, as follows: a. On 8/18/15 at 3:31 p.m., DCS D assisted Individual #2 while walking. Individual #2 attempted to go into Individuals #3 and #7's room. DCS D said it was not bath time and redirected him outside. b. On 8/18/15 at 4:55 p.m., DCS D assisted Individual #2 as he walked out of the kitchen into the hallway. When Individual #2 attempted to go into Individuals #3 and #7's room, DCS D told him "no shower right now." c. On 8/18/15 at 5:35 p.m., DCS D stood behind Individual #2 and placed her arms and hands around his upper torso as they walked out of the living room. Individual #2 appeared to struggle with DCS D. He grabbed hold of the corner table against the wall behind the couch. He resisted as DCS D pulled him. He released his hold on the corner of the table and DCS D took him into the hallway bathroom counting 1, 2, 3, 4. d. On 8/19/15 at 8:45 a.m., Individual #4 was in the living room and stood up beside DCS A. He did not respond to DCS A when she said "let's sit down so that you don't fall." When asked during an interview with the Treatment Coordinator, QIDP and Home Manager, on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated DCS should be encouraging and honoring client choice and individuals should be able to take a bath when they wanted.	W 269	<i>SOP → PSR to be update regarding client choice, self determination and self management to provide more direction on how Tomorrow's Hope will implement. PD responsible by 9/30/15 → All staff will be trained on the update SOP T/M responsible by 9/30/15 → actual treatment and client observation will be update to ensure</i>	

*TRICIDP are making note of this occurring and PSR reviewed at monthly QA
PD Responsible by 9/30/15*

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W 269	Continued From page 67 The facility's policy for Client Rights, revised March 2015, was reviewed and did not include information related to client choice. When asked on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated she was not sure if client choice was in the policy and that she would get back with the surveyor. On 8/28/15 at approximately 10:45 a.m., the QIDP faxed a document to the surveyor which stated providing client choice was in their philosophy, but not in their policy, and that that policy would be updated. The facility failed to develop and implement policy related to client choice necessary to ensure individuals' choices were allowed and encouraged.	W 269		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a sanitary environment to avoid sources and transmission of infections was provided for 4 of 7 individuals (Individuals #1, #2, #5 and #6) and had the potential to effect all individuals residing in the facility. This resulted in the potential for transmission of infections. The findings include: 1. The facility's Nursing/Medical policy, dated 3/2015, documented "Hygiene and sanitation	W 454	→ Hygiene and Sanitation procedures have been update to ensure it gives more direction on how to implement these procedures PD responsible by 9/30/15 → all staff trained on	

The new Hygiene and Sanitation procedure

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W 454	Continued From page 68 procedures will be implemented throughout the facility for control of communicable diseases..." During observations completed on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, items were noted to be kept in the living room in fabric bins. An inventory of items located in the fabric bins was taken on 8/19/15 from 12:28 to 2:00 p.m. Items in the fabric bins included, but were not limited to, the following: - A plastic caterpillar - A brown plastic milk jug with a hippopotamus picture on it - A 4-inch long green plastic frog - Numerous wooden blocks with numbers - A Fisher Price cell phone - Small rubber animals (a monkey, horse, bear and hippopotamus) - An Infantino elephant rattle - A Fisher Price computer - A Sesame Street remote control - A Playskool plastic guitar - A Little Tikes plastic camera - An Infantino cell phone - A HAP-P-KID plastic pig - A Fisher Price fishing pole - A Little Tikes screwdriver - A Sassy Baby's Sense-Actions book - A Nuby teething ring set - A 7-inch long soft cloth green cat - An 18-inch long cloth reindeer with dangly legs and arms - Infantino stuffed penguins with numbered shirts (#1, #2, #5 and #6) Individuals were observed to manipulate items	W 454	<p>→ Hygiene and Sanitation procedures will be posted in com log and throughout the house HM Responsible By 9/30/15</p> <p>→ HM walk through to be updated to ensure staff are following Hygiene and Sanitation procedures HM Responsible By 9/30/15</p> <p>→ HM walk through to be reviewed at monthly QA with recommendation and needed action added to the QA log and action list PD responsible by 9/30/15</p>		

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W 454	<p>Continued From page 69</p> <p>from the bins, including placing the items in their mouths. Examples included, but were not limited to, the following:</p> <p>a. On 8/18/15 at 12:10 p.m., Individual #1 was laying in bed with a soft-sided toy approximately 5 inches long in his mouth.</p> <p>b. On 8/18/15 at 3:12 p.m. and 3:30 p.m., Individual #5 was chewing on plastic rings and carrying a second toy.</p> <p>c. On 8/18/15 at 4:43 p.m., DCS D handed Individual #2 a yellow plastic toy which he threw on the floor.</p> <p>d. On 8/18/15 at 5:10 p.m., Individual #2 looked through the fabric bins and picked out a plastic, yellow lion mirror with padding around the edges to manipulate.</p> <p>e. On 8/18/15 at 5:20 p.m. and 5:50 p.m., Individual #6 looked through the fabric bins, removed toys from the bins, and was on the floor playing with the toys.</p> <p>f. On 8/18/15 from 5:45 - 5:50 p.m., Individual #5 was holding two different plastic toys, one was a toy car which he periodically placed in his mouth.</p> <p>g. On 8/19/15 at 8:20 a.m., Individual #1 was taken to the bins where he chose a stuffed penguin with a #2 on the shirt to manipulate. On 8/19/15 at 8:25 a.m., Individual #1 was swinging around a stuffed penguin with a #5 on the shirt.</p> <p>At no point during the observations were DCS noted to sanitize the items after use.</p>	W 454			

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W 454	Continued From page 70 Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. All of the DCS stated sanitizing the items was the responsibility of graveyard staff and they had never completed sanitization. However, information related to how staff were to sanitize the items, including the stuffed animals and the fabric bins, could not be found. During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated an item should not be put back in the bins if an individual put it in their mouth. The Treatment Coordinator stated DCS should separate used items into a bucket if they do not want to immediately sanitize the item.	W 454			
W 460	The facility failed to ensure individuals were provided with a sanitary environment. 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure each individual received modified diets as prescribed for 1 of 4 individuals (Individual #2) whose nutritional records were reviewed. This resulted in an individual receiving modified food texture which was not in accordance with his prescribed diet. The findings include:	W 460			

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W 460	Continued From page 71 1. Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation. His IPP also stated he received a Dysphagia 2 mechanically altered diet with nectar thick liquids. Individual #2's 7/29/15 Physician's Orders stated his diet was Dysphagia 2 mechanical altered, nectar thick liquids, and dry bread moistened with liquid. When asked during an interview on 8/20/15 at 1:32 p.m., the facility's RD stated Individual #2's Dysphagia Level 2 solid food consistency should be between mechanically soft and pureed in texture. However, during observations on 8/18/15 from 4:43 - 6:40 p.m. and 8/19/15 from 8:12 - 10:35 a.m., staff were observed preparing, and Individual #2 was observed eating pureed foods. During follow-up interviews on 8/24/14 from 1:49 - 3:35 p.m. and on 8/25/15 from 12:50 - 1:20 p.m., 6 of 7 DCS stated Individual #2's food consistency was pureed. The facility failed to ensure Individual #2 was provided a modified diet as prescribed by the physician.	W 460	Individual #2 diet has been readdressed by the dietitian. Dietitian responsible by 9/30/15 All staff have been trained on resident's #2 dietary recommendations. TM responsible by 9/30/15 All individuals will have the dietary evaluation to be ensure it is being followed. TC responsible by 9/30/15 Individual #2 eating program has been update to ensure it give adequate direction. TC Responsible.	
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.	W 484		

→ TC / DDP will review dietary and eating program quarterly to ensure recommendations are being followed. Documented in DDR. TC Responsible by 9/30/15

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W 484	<p>Continued From page 72</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all areas were equipped with adaptations designed to meet individual needs for 1 of 5 individuals (Individual #5) who required adaptive eating equipment in the facility. This resulted in an individual not being provided with equipment necessary to meet his dining needs. The findings include:</p> <p>1. Individual #5's 5/8/15 IPP documented he was a 22 year old male whose diagnoses included profound mental retardation and epilepsy.</p> <p>Individual #5's 5/1/15 Dietary Evaluation documented he had hand tremors which made it difficult for him to keep food on a spoon and the intensity of the tremors varied from day to day. At times he required assistance holding his cup due to tremors and he was much more independent with eating when he ate at a raised table (chest height) where his arms could be supported.</p> <p>During observations conducted on 8/18/15 from 3:03 - 3:48 p.m. and 4:43 - 6:40 p.m., and on 8/19/15 from 8:12 - 9:15 a.m., Individual #5 was eating at the kitchen counter that separated the dining area from the kitchen. When Individual #5 was seated, the height of the counter was approximately at the top of his ribcage.</p> <p>On 8/18/15 at 6:25 p.m., DCS A assisted him to dine by holding his plate off the counter and under his chin.</p> <p>During an interview on 8/26/15 from 1:58 to 3:40 p.m., the Treatment Coordinator stated no efforts had been made to equip the dining table to meet Individual #5's needs. The QIDP, who was</p>	W 484	<p>→ Individual #5 eating program was re-evaluated by an OT. OT Responsible by 9/15/15</p> <p>- individual program was update to ensure all staff running the same and consistently with all need materials available TA Responsible by 9/30/15</p> <p>→ all individual needs will be reviewed ^{to ensure they} are being met with all equipment to meet those needs</p>		

prevent
TCI Responsible By 9/30/15

→ Client observation PSR update to include all need materials and equipment

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W 484	Continued From page 73 present during the interview, stated staff do not need to hold Individual #5's plate. The QIDP stated at the day program, Individual #5 had a raised table, which allowed him to eat independently. The facility failed to ensure Individual #5's dining table was equipped with the use of adaptive equipment designed to meet his dining needs.	W 484	are present to enable the individual to perform as independently as possible by 9/30/15 PD responsible → all client observation PSR will be reviewed at monthly cmt noting any concerns or needs and added to action list. PD responsible By 9/30/15		

Bureau of Facility Standards

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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the state licesure survey conducted from 8/18/15 to 8/27/15.</p> <p>The surveyors conducting your survey were:</p> <p>Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>CFA - Comprehensive Functional Assessment DCS - Direct Care Staff IPP - Individual Program Plan MAR - Medication Administration Record OT - Occupational Therapy/Therapist PT - Physical Therapy/Therapist QA - Quality Assurance QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian SIB - Self-Injurious Behavior UV - Ultraviolet VCR - Video Cassette Recorder</p>	M 000	<p>RECEIVED</p> <p>SEP 28 2015</p> <p>FACILITY STANDARDS</p>	
MM080	<p>16.03.11100 Governing Body and Management</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the facility's Governing Body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems for 7 of 7 individuals (Individuals #1 - #7) residing at the</p>	MM080		

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

[Handwritten Signature]

TITLE

9/29/15

(X6) DATE

Bureau of Facility Standards

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MM080	<p>Continued From page 1</p> <p>facility. This failure resulted in the Governing Body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include:</p> <p>1. The facility failed to maintain a record keeping system that contained complete information, as follows:</p> <p>a. Individual #4's IPP, dated 5/21/15, documented a 32 year old male whose diagnoses included profound intellectual disability.</p> <p>Individual #4's record contained QA logs, dated 2/2015 - 7/2015, Client Fall Records, dated 2/2015 - 8/2015, and Progress Notes, dated 6/1/15 - 7/31/15, that were compared, with the following discrepancies noted:</p> <p>- 2/2015: His QA log review documented he had 3 falls and his Client Fall Record documented he had 6 falls.</p> <p>- 3/2015: His QA log review documented he had 1 fall and his Client Fall Record documented he had 2 falls.</p> <p>- 5/2015: His QA log review documented he had 5 falls and his Client Fall Record documented he had 6 falls.</p> <p>- 6/2015: His QA log review documented he had 10 falls and his Client Fall Record documented he had 12 falls.</p> <p>- 7/2015: His QA log review documented he fell on 7/1, 7/2 and 7/30. His Client Fall Record also documented he had 3 falls. However, his Progress Notes documented an additional fall on 7/12/15 and 2 falls on 7/17/15, for a total of 6 falls</p>	MM080	<p><i>refer to W111</i></p>	

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642		
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MM080	<p>Continued From page 2</p> <p>in July.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP and the Treatment Coordinator both stated management was actively involved in the review of falls in the facility.</p> <p>The facility failed to ensure Individuals #4's fall record contained complete information.</p> <p>b. Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation. He was admitted from a sister facility on 12/3/14.</p> <p>His IPP stated he received a Dysphagia 2 mechanically altered diet with nectar thick liquids. Individual #2's 7/29/15 Physician's Orders also stated his diet was Dysphagia 2 mechanical altered, nectar thick liquids, and dry bread moistened with liquid.</p> <p>However, Individual #2's 12/18/14 CFA documented he was to receive pureed food, thickened drinks, and a mechanically soft diet. His 7/7/15 AM and PM Active Treatment Schedules both stated that all of his food needed to be chopped up with a food processor and all of his drinks needed to be thickened.</p> <p>When asked during an interview on 8/20/15 at 1:32 p.m., the facility's RD stated Individual #2's Dysphagia Level 2 solid food consistency should be between mechanically soft and pureed in texture.</p> <p>During another interview on 8/26/15 from 1:58 - 3:40 p.m., both the Treatment Coordinator and the Home Manager stated when Individual #2</p>	MM080		

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MM080	<p>Continued From page 3</p> <p>was admitted his diet was pureed with thickened liquids.</p> <p>Individual #2's records did not consistently reflect his diet order.</p> <p>c. Individual #5's 5/8/15 IPP documented he was a 22 year old male whose diagnoses included profound mental retardation and epilepsy.</p> <p>Individual #5's 4/22/15 CFA documented he wore a wrist weight during dining. However, the Adaptive Equipment section of his IPP stated he used a weighted spoon and lip plated, and clothing protector.</p> <p>Additionally, during observations conducted on 8/18/15 from 3:03 - 3:48 p.m. and 4:43 - 6:40 p.m., and on 8/19/15 from 8:12 - 9:15 a.m., Individual #5 was observed eating. He was not observed to be wearing a wrist weight.</p> <p>During interviews conducted on 8/24/15 from 1:49 - 3:35 p.m. and 8/25/15 from 12:50 - 1:20 p.m., 2 DCS stated weights were used at one time, but were not currently in place.</p> <p>Individual #5's records did not consistently reflect his adaptive dining equipment.</p> <p>2. Refer to M134 as it relates to the Governing Body's failure to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored and that individual rights were upheld and promoted.</p> <p>3. Refer to M155 as it relates to the Governing Body's failure to ensure sufficient staff were available to meet individuals' needs and the QIDP</p>	MM080	<p><i>Refer to M134 and W149</i></p> <p><i>Refer to M155 and W186 W196</i></p>

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MM080	Continued From page 4 provided sufficient monitoring and oversight. 4. Refer to M162 as it relates to the Governing Body's failure to ensure policies that promoted opportunities for choice, decision-making, self-management, growth and development were developed and consistently implemented.	MM080	<i>Refer to M162 and W269</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: Based on policy review, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored and that individual rights were upheld and promoted for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of comprehensive protections being provided to individuals. 1. The facility's Right to Protection from Abuse policy, dated 7/28/14, stated the facility "will not tolerate abuse of any type, duration, or severity." The policy defined abuse as "ill-treatment, violation, revilement, malignant [sic], exploitation, and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator." Neglect was defined as "failure to provide goods or services necessary to avoid physical harm ..."	MM134	<i>Refer to W149 W154 W125 W124</i>	

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MM134	<p>Continued From page 5</p> <p>The policy documented examples of neglect, which included "grossly ignoring or violating safety procedures that place a client in immediate harm, failing to follow safety procedures and take protective action for any situations that can be potentially harmful to clients, failure to give proper or required care ..."</p> <p>The policy stated the "Program Director will keep an ongoing list of incident reports involving ...safety issues involving the client to review each month to ensure there are no patterns or trends."</p> <p>Individual #4's IPP, dated 5/21/15, documented a 33 year old male whose diagnoses included profound intellectual disability. His record documented he had an increased fall risk.</p> <p>Individual #4's Service Program for Falls, dated 5/21/15, stated "his postural alignment secondary to his decrease in Para spinal muscular tone changes his center of gravity. His righting reflex in sitting, standing, and during gait is minimally to moderately delayed and his environmental awareness is only fair. All of these factors contribute to an increased fall risk."</p> <p>The facility's Client Fall Records, from 2/1/15 - 8/17/15, were reviewed and documented Individual #4 had fallen a total of 42 times during the 7½ month period. However, there was no documentation the facility had assessed Individual #4's falls to identify patterns and implement appropriate corrective action to prevent future falls. Failure to identify repeated patterns would inhibit the facility's ability to identify potential neglect and take appropriate corrective action. For example:</p> <p>a. Individual #4's Client Fall Record documented</p>	MM134		

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MM134	<p>Continued From page 6</p> <p>he fell while in the back yard, as follows:</p> <ul style="list-style-type: none"> - 5/28/15, "was walking, went to sit down on the porch swing." - 6/5/15, "fall walking on [left] side." - 6/11/15, "was in backyard stepped on some uneven ground fell." - 6/12/15, "was in the backyard lost balance landed on back." - 6/12/15, "was in the backyard tried putting his hands in pants, lost balance." - 6/22/15, "was walking fell on [right] side." - 6/24/15, "was walking outside fell back" at 9:05 a.m. - 6/24/15, "was outside playing in the backyard" at 10:30 a.m., type of fall not documented. - 7/2/15, "was walking in back yard and fell to the ground." - 8/5/15, "fall lost balance, fell on [left] side." Bruising on left shoulder. - 8/27/15, "was by the front door lost his balance." <p>b. Individual #4's Client Fall Record documented he fell from the chair in the medication administration area, as follows:</p> <ul style="list-style-type: none"> - 2/1/15, "in med room on chair, fell to floor, but nobody saw it." - 3/16/15, "sitting in chair in med room [and] fell out of chair." - 6/21/15, "was in med room about to get out of chair and fell on Right side body [sic]." <p>c. Individual #4's Client Fall Record documented he fell over other individuals residing in the facility, as follows:</p> <ul style="list-style-type: none"> - 2/24/15, "tripped over [Individual #2]" at 3:40 p.m. and 4:15 p.m. - 5/16/15, "tripped over another client." 	MM134		

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MM134	<p>Continued From page 7</p> <p>- 7/1/15, "Fell over other client [and] landed on client."</p> <p>- 8/24/15, "was playing with ball in living room, stepped backwards and fell over another clients wheelchair."</p> <p>d. Individual #4's Client Fall Record documented he fell standing up from the couch, as follows:</p> <p>- 2/1/15, "was sitting on couch, got up unsteady, fell to the floor."</p> <p>- 2/14/15, "Sitting on couch, got up quickly [and] fell on floor, stood up [and] fell again."</p> <p>- 6/16/15, "went to get up off the couch and screamed and fell back landing on back."</p> <p>- 8/14/15, "was getting up from couch and tripped over arm and landed on right shoulder."</p> <p>The facility's QA logs from 2/2015 -8/2015 were reviewed. The QA reviews documented the number of Individual #4's falls for each month. However, comprehensive information related to patterns (e.g., falls in the backyard, falls from the chair in the medication administration area, falls over other individuals, falls when standing up from the couch, location of staff during falls, etc.) could not be found.</p> <p>An interview was conducted, on 8/26/15 from 1:58 - 3:40 p.m., with the QIDP, Treatment Coordinator and Home Manager. The QIDP stated she tracked all falls and reviewed them with the team during monthly QA meetings. The Treatment Coordinator stated she completed regular observations and involved health care professionals (physical therapists, OT, etc.) when needed. The Home Manager stated staff were trained to take measures to ensure falls were prevented, such as keeping the floor clear.</p>	MM134		

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MM134	<p>Continued From page 8</p> <p>When asked what measures had been implemented to reduce Individual #4's falls, the Treatment Coordinator stated Individual #4's anticonvulsant medications had been identified as a potential factor and were reduced.</p> <p>When asked if the facility monitored for patterns related to falls, such as time of day, shifts, etc., the Treatment Coordinator stated they had not.</p> <p>The facility failed to ensure Individual #4's falls were sufficiently monitored to identify patterns and potential neglect.</p> <p>2. The facility's Right to Protection from Abuse policy, dated 7/28/14, stated "Each staff will be able to identify, prevent, document, and report incidents of abuse." The policy stated "Individuals must not be subjected to abuse by anyone (including, but not limited to...family members or legal guardians ..."</p> <p>The policy defined physical abuse as "any physical motion or action, (i.e. Hitting [sic], slapping, punching, kicking, pinching, etc.) by which potential or actual bodily harm or trauma could occur." Additionally, the policy stated if staff witnessed abuse, they were to "Ensure the safety of the client, provide any care needed and assure the client's safety" and "Call the Administrator IMMEDIATELY [sic]."</p> <p>The facility's investigations from 12/1/14 - 8/17/15 were reviewed. Included in the documentation was an Incident/Accident Report, dated 12/20/14 at 3:15 p.m., which documented Individual #3 stated her mother slapped her. Attached to the Incident/Accident Report was a document titled Incident Report Investigation Attachment. The form documented the date, time, and alleged</p>	MM134		

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MM134	<p>Continued From page 9</p> <p>incident, and included space for narrative information and a suggested plan of correction. The form did not include sufficient information to document a thorough investigation of the allegation, as follows:</p> <p>The Incident Report Investigation Attachment documented Individual #3, 6 other individuals residing at the facility, and 4 DCS that were on shift at the time of the incident, were interviewed. However, the attachment did not indicate the date or time the interviews were conducted.</p> <p>The attachment documented Individual #3 stated she hit her mother and her mother hit her. However, the documentation did not indicate the severity of the hit, whether it caused Individual #3 pain, if Individual #3 knew where DCS were at the time of the incident or not, etc.</p> <p>The attachment documented DCS L stated she witnessed Individual #3's mother take Individual #3 by the wrist and take her to her bedroom. DCS L stated Individual #3 slapped her mother, at which point Individual #3's mother slapped Individual #3 on the face, told her to stop yelling, and then slapped Individual #3 on the arm. DCS L stated "Then I walked away and went to work with my clients." DCS L stated Individual #3's mother wanted to speak with the Home Manager at some point, and the Home Manager was contacted and spoke with Individual #3's mother on the phone.</p> <p>The attachment documented DCS I witnessed Individual #3's mother slap Individual #3 on the right arm while they were in Individual #3's bedroom. DCS I stated Individual #3 then went out to the kitchen, then Individual #3's mother took Individual #3 by the wrist and "began</p>	MM134		

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MM134	<p>Continued From page 10</p> <p>pushing/pulling" Individual #3 back to her bedroom. Once inside, Individual #3's mother shut the door. DCS I stated she entered the room to remove Individual #3's roommate, but then left Individual #3 in the bedroom with her mother.</p> <p>The statements documented both DCS L and DCS I witnessed Individual #3 being slapped by her mother. However, there was no evidence DCS L or DCS I had intervened to protect Individual #3 per the facility's policy, or had reported the incident to the Administrator. Additionally, there was no evidence the facility had investigated the failure to protect or the failure to immediately report the incident.</p> <p>The attachment documented the Home Manager had spoken with Individual #3's mother on 12/21/14 and informed her an investigation was being completed due to the allegation. The Home Manager documented "She said she did not do that at the house. And that it was a tap on the chin to get her attention." However, there was no additional evidence Individual #3's mother had been interviewed about the allegation.</p> <p>The Incident/Accident Report was completed by the Home Manager and documented the incident took place on 12/20/14 at 3:15 p.m. However, the report did not document when it was completed by the Home Manager, and the notification section of the report documented the Administrator was not notified until 12/21/14 at 7:20 a.m. Additionally, the Home Manager documented on the report "Completed an investigation - Slapping [Individual #3] was found to be unclear. See Investigation [sic]."</p> <p>However, with the exception of the of the Incident</p>	MM134		

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MM134	<p>Continued From page 11</p> <p>Report Investigation Attachment, no documentation a thorough investigation had been completed was present (e.g., evidence Individual #3 had been assessed for injury at the time, completion of a thorough interview with Individual #3's mother, investigation of delayed reporting and lack of protection, summary of conclusions, etc.).</p> <p>During an interview on 8/18/15 at 1:34 p.m., the QIDP stated Individual #3 had experienced an extreme escalation in maladaptive behaviors around the time of the incident. The QIDP stated as a result of Individual #3's behaviors, the team focused more on the maladaptive behavior than on the investigation of potential abuse.</p> <p>The facility failed to ensure all allegations of abuse were thoroughly investigated.</p> <p>3. During observations conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, the door from the laundry room to the garage was noted to be locked on the garage side of the door. Staff were also noted to use a key to open the door from inside the laundry room to gain access to the garage. It was also noted there were various activities and items, including a plastic bin in the garage that contained a minimum of 15 bottles of nail polish.</p> <p>On 8/19/15 at 12:40 p.m., the Home Manager stated the nail polish belonged to Individual #3.</p> <p>Interviews were conducted with 7 DCS on 8/24/15 and 8/25/15. During the interviews, all DCS stated the door from the laundry room to the garage and the front door were locked to prevent elopement and due to Individuals #4 and #6's previous attempts to leave the facility by</p>	MM134		

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MM134	<p>Continued From page 12</p> <p>themselves. The DCS stated locking the doors allowed them extra time to ensure a client safely left the facility.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said the door from the laundry to the garage and the front door were kept locked to keep individuals from leaving without staff knowing they had left.</p> <p>Individual #6's Behavior Intervention Plan and Written Informed Consent for elopement, undated, stated "The door from the laundry room into the garage is to be locked at all times." However, none of the other 6 individuals' assessments included information related to restricted garage access, and consents related to the restrictions for the other 6 individuals could not be found. Further, Individual #3's record did not include any information related to storing her possessions in the locked garage.</p> <p>When asked during an interview with the Treatment Coordinator, QIDP and Home Manager, on 8/26/15 from 1:58 - 3:40 p.m., the Home Manager acknowledged the garage door was locked from the inside and stated it was to prevent individuals from rummaging through the items in the garage. The Treatment Coordinator stated none of the individuals were assessed for restriction to the garage and its consents. The QIDP stated the front door was locked as normal practice in a residence, not to prevent individuals from leaving.</p> <p>The facility failed to ensure individuals' access to the garage was not restricted without justification or due process.</p> <p>4. Sufficient information was not provided to</p>	MM134		

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MM134	<p>Continued From page 13</p> <p>parents/guardians on which to base consent decisions, as follows:</p> <p>a. Individual #2's 1/2/15 IPP stated he was a 24 year old male whose diagnoses included profound mental retardation and mood disorder.</p> <p>Individual #2's 7/29/15 Physician's Orders documented an order for 7.5 mg of Abilify (an antipsychotic drug) every day. His August 2015 MAR documented he received Abilify every day as ordered.</p> <p>According to the 2014 Nursing Drug Handbook, adverse reactions to the use of Abilify may include increased suicide risk and suicidal thoughts, neuroleptic malignant syndrome (a potentially fatal neurological disorder), and seizures.</p> <p>Individual #2's record included an Abilify consent for medication form, dated 10/21/14, for mood disorder. However, his consent for medication did not include the adverse reactions of increased suicide risk and suicidal thoughts, neuroleptic malignant syndrome, and seizures.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated Individual #2's consent did not include all significant adverse reactions for Abilify.</p> <p>The facility failed to ensure Individual #2's consent for medication contained sufficient information on which to make decisions.</p> <p>b. Individual #3's 3/19/15 IPP documented she was a 33 year old female whose diagnoses included moderate mental retardation.</p>	MM134		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642		
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MM134	Continued From page 14 Individual #3's 1/13/15 physician's order form contained an order for Seroquel (an antipsychotic drug) 150 mg three times a day. Her July and August 2015 MARs documented she received Seroquel as ordered. According to the 2014 Nursing Drug Handbook, adverse reactions to the use of Seroquel may include neuroleptic malignant syndrome, seizures, and leukopenia (a reduction in white blood cells). Individual #3's record contained a Seroquel medication consent form, dated 1/13/15, which documented the medication was used for severe agitation/aggression. However, her medication consent form did not include the adverse reactions of neuroleptic malignant syndrome, seizures, and leukopenia During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated consents did not include all adverse reactions. The facility failed to ensure Individual #3's medication consent form contained sufficient information on which to make decisions.	MM134		
MM155	16.03.11300 Facility Staffing The requirements of Sections 300 through 399 of these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Based on observation, record review, policy review, review of staff schedules and staff	MM155	<i>refer to W186</i>	

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MM155	<p>Continued From page 15</p> <p>interview, it was determined the facility failed to provide sufficient direct care staff to manage and supervise individuals in accordance with their IPPs for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the inability of staff to consistently meet the individuals' identified needs. The findings include:</p> <p>1. The facility housed seven individuals diagnosed with moderate to profound mental retardation. Individual #1 - #7's IPPs were reviewed, and documented the following:</p> <p>- Individual #1's IPP, dated 7/27/15, documented he was deaf and blind and required physical assistance for bathing, dressing and toileting. His CFA, dated 6/30/15, documented Individual #1 required multiple verbal cues or physical assistance to complete personal hygiene and food preparation tasks. The CFA also documented Individual #1 could ambulate without staff assistance.</p> <p>Individual #1's Behavior Intervention Plan for SIB, undated, stated he engaged in SIB (defined as biting his left forearm, hitting himself and aggression when SIB attempts were blocked) an average of 495 times per month and stated episodes lasted anywhere from seconds to 15 minutes. The plan stated staff were to block SIB attempts and offer choices via sign language.</p> <p>Individual #1's AM Active Treatment Schedule, dated 8/19/15, documented Individual #1 required staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 30 - 60 minutes, interacting with Individual #1 every 10 - 15 minutes, encouraging Individual #1 to use the restroom every 60 - 90</p>	MM155		

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MM155	<p>Continued From page 16</p> <p>minutes and checking on Individual #1 "every couple of minutes" during showers to monitor water temperature.</p> <p>- Individual #2 was admitted to the facility on 12/3/14. Individual #2's IPP, dated 7/27/15, documented he required physical assistance for medication administration, hand washing, dressing, toothbrushing and money management. His CFA, dated 12/18/14, documented Individual #2 required complete physical assistance for food preparation tasks.</p> <p>Individual #2's Behavior Intervention Plan for SIB, dated 1/2/15, stated he engaged in SIB, defined as face slaps or head hits. The plan stated staff were to block SIB attempts, check his basic needs (thirst, hunger, etc.), offer sensory items and call the nurse for a pain medication.</p> <p>Individual #2's Behavior Intervention Plan for maladaptive attention seeking, dated 1/2/15, stated he engaged in attention seeking behavior, defined as pulling others' hair or pinching others. The plan stated staff were to move away from Individual #2, give as little attention as possible and resume interaction when he requested attention appropriately.</p> <p>Individual #2's AM and PM Active Treatment Schedules, both dated 7/17/15, documented Individual #2 required staff assistance throughout the day. Staff assistance included, but was not limited to, encouraging Individual #2 to use the restroom every 60 - 90 minutes and monitoring him near water as Individual #2 "HAS SEIZURES. NEVER LEAVE HIM ALONE AROUND WATER." Additionally, Individual #2's 3/15/15 Fall Protocol documented he was sometimes a little unsteady on his feet, could walk for short distances, and</p>	MM155		

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MM155	<p>Continued From page 17</p> <p>could ambulate around the house without help.</p> <p>- Individual #3's IPP, dated 3/19/15, documented she engaged in SIB, aggression, outbursts and obsessing. Individual #3's Behavior Intervention Plan for SIB, aggression and outbursts, dated 3/19/15, stated she engaged in SIB (defined as banging her head on walls or objects, hitting her head with her hand or biting her hand) an average of 91 times per month. The plan stated she engaged in aggression (defined as hitting, kicking, scratching or biting others) an average of 16 times per month. The plan documented Individual #3 engaged in outbursts (defined as 3 of the following: screaming, yelling, hitting walls with her hand, throwing things, SIB or aggression) an average of 42 times per month. The plan stated staff were to attempt to problem solve with Individual #3 and redirect her to a preferred activity. Additional instructions for staff assistance included writing down what she wants, blocking aggression attempts, offering choices with picture cards and cueing Individual #3 to take a break.</p> <p>Individual #3's Behavior Intervention Plan for obsessive behavior, dated 3/19/15, stated she engaged in obsessive behavior (defined as perseverating on something) an average of 88 times per month. The plan stated staff were to write down what Individual #3 was obsessing over, cue her back to the paper if still obsessing and direct her to a preferred activity.</p> <p>- Individual #4's IPP, dated 5/21/15, documented he required physical assistance for medication administration, dressing, toileting, toothbrushing and bathing. His CFA, dated 5/13/15, documented Individual #4 required physical or complete assistance during meal preparation</p>	MM155		

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MM155	<p>Continued From page 18</p> <p>tasks.</p> <p>Individual #4's Behavior Intervention Plan for head butting, dated 5/21/15, stated he engaged in head butting an average of 3 times per month. The plan stated staff were to re-cue Individual #4 to task if he head butted.</p> <p>Individual #4's Behavior Intervention Plan for eloping, undated, stated he engaged in eloping (defined as going out the front door and closing it behind him without staff) an average of 3 times per month. The plan stated staff were to re-cue Individual #4 to task, go outside and direct him back in or, if Individual #4 could not be visually located, call the police.</p> <p>Individual #4's AM Active Treatment Schedule, dated 6/11/15, documented Individual #4 required staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 60 minutes, encouraging Individual #4 to use the restroom every 60 - 90 minutes and "continuously check the water temperature to make sure it is warm enough" during showers. Additionally, Individual #4's PT Service Program, dated 5/21/15, stated staff were to assist him to practice keeping balance when helping him stand.</p> <p>- Individual #5's IPP, dated 5/8/15, documented he required physical assistance for dressing and bathing. His CFA, dated 4/22/15, documented Individual #5 required physical or complete assistance during meal preparation tasks.</p> <p>Individual #5's AM Active Treatment Schedule, dated 8/13/15, documented Individual #5 required staff assistance throughout the day. Staff</p>	MM155		

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MM155	<p>Continued From page 19</p> <p>assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 60 - 90 minutes and encouraging Individual #5 to use the restroom every 60 - 90 minutes. Individual #5's PM Active Treatment Schedule, dated 3/13/15, documented Individual #5 "is very unstable in the shower...Staff need to be in close contact with [Individual #5] at all times for safety precautions. Staff need to check the water temperature every few minutes to ensure that it is still warm." Additionally, Individual #5's PT Home Program note, dated 7/7/15, documented he should be encouraged to stand as tall as possible.</p> <p>- Individual #6's 2/6/15 IPP documented he required physical assistance for hand-washing, toileting, grooming, oral hygiene, and bathing. His CFA, updated 1/15/15, stated he required multiple verbal cues or physical assistance to complete food preparation tasks, and needed constant supervision in the kitchen for safety reasons.</p> <p>Individual #6's Behavior Intervention Plan for agitation, dated 2/6/15, stated he engaged in agitation (defined as stomping his feet, slamming doors, dropping to his knees, screaming/crying, knocking over chairs, slamming a shirt onto the floor, pushing through staff, and wiggling his fingers in front of his face) an average of 14 times per month and stated episodes could last up to 2 hours. The plan stated staff were to body position and redirect to his room as needed to protect others, and required staff to monitor him in his room if he was slamming the door.</p> <p>Individual #6's Behavior Intervention Plan for eloping, undated, stated he engaged in eloping (defined as leaving the facility through a door or</p>	MM155		

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MM155	<p>Continued From page 20</p> <p>window without staff's knowledge) an average of 1 time per month. The plan stated staff were to check on him every 5 minutes while in his room, and his door was to remain open unless he was "having private time." If Individual #6 was having private time, staff were to remain close to the room and listen for the window alarm.</p> <p>Individual #6's AM Active Treatment Schedule, updated 8/17/15, and PM Active Treatment Schedule, updated 8/18/15, both stated he was to be encouraged to use the restroom every 60 - 90 minutes during waking hours, was to be engaged in sensory input at least 5 minutes out of every hour, required assistance for dressing, and needed encouragement to engage in 20 - 30 minutes of physical activity daily. Additionally, Individual #6's CFA, dated 1/15/15, documented Individual #6 was ambulatory and could walk independently for short distances, but required a wheelchair for long distances.</p> <p>- Individual #7's IPP, dated 2/26/15, documented she required physical assistance for toileting, grooming, hygiene and toothbrushing. Her CFA, dated 1/23/15, documented Individual #7 required physical or complete assistance during meal preparation tasks.</p> <p>Individual #7's Behavior Intervention Plan for putting her hands in her mouth or biting her hands, undated, documented Individual #7 engaged in the behaviors an average of 157 times per month. The plan documented if Individual #7 placed her hand in her mouth, staff were to check her basic needs (thirst, hunger, etc.), offer a hand massage and a quiet place, go on a walk with her or put gloves on Individual #7.</p> <p>Individual #7's AM and PM Active Treatment</p>	MM155		

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MM155	<p>Continued From page 21</p> <p>Schedules, both dated 8/15/15, documented Individual #7 required staff assistance throughout the day. Staff assistance included, but was not limited to, providing sensory stimulation for at least 5 minutes every 60 minutes, encouraging Individual #7 to use the restroom every 60 - 90 minutes and if she was utilizing her wheelchair, for one staff to hold her gait belt and assist her to walk 10 - 15 minutes each hour. Her corresponding 2/28/15 - 2/26/16 PT Service Program documented she was unable to ambulate independently and her Falling Service Program, dated 2/26/15, documented she needed to be monitored closely. Additionally, Individual #7's PM Active Treatment Schedule documented Individual #7 "has seizures and cannot be left alone in the bathtub."</p> <p>Observations were conducted at the facility on 8/18/15 and 8/19/15 for a cumulative 5 hours 44 minutes. During the observations, a minimum of 4 staff were present to assist Individuals #1 - #7.</p> <p>However, the facility's as worked schedules from 5/1/15 - 7/31/15 were reviewed and documented shifts were worked with less than 4 staff. This happened no less than 18 times in May, 18 times in June and 19 times in July. For example, the PM shift of 7/27/15 was worked with 3 staff. Individuals #1 - #7 were all present during the shift.</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. All DCS stated they had worked a shift with only 3 staff, though it did not happen very often. They stated when 3 staff were working a shift, it was hard to ensure everything was done properly. The DCS stated with 3 staff on shift, the staff present were required to run around a lot which could be tiring,</p>	MM155		

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MM155	Continued From page 22 hectic and chaotic. One DCS stated utilizing only 3 staff was not fair to the staff working or the individuals. During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated she completed observations and noted any needs for additional staff training. The Treatment Coordinator stated the facility deployed staff based on individual need, but the facility housed multiple individuals that required significant physical assistance. The facility failed to maintain a minimum of 4 staff to ensure individuals' needs were consistently met. 2. Refer to M159 as it relates to the QIDP's failure to ensure comprehensive active treatment services were provided to individuals. 3. Refer to M169 as it relates to the QIDP's failure to ensure a sanitary environment to avoid sources and transmission of infections was provided. 4. Refer to M215 as it relates to the QIDP's failure to ensure the facility was kept in good repair. 5. Refer to M218 as it relates to the QIDP's failure to ensure all environmental surfaces were kept clean and sanitary. 6. Refer to M366 as it relates to the QIDP's failure to ensure individual dietetic needs were met.	MM155	<i>refer to W 186</i> <i>refer to W 196</i> <i>M 159</i> <i>refer to M 169</i> <i>W 454</i> <i>refer to M 215</i> <i>refer to M 218</i> <i>refer to M 366</i>	
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of	MM159		

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MM159	<p>Continued From page 23</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure individuals were provided with comprehensive active treatment services necessary to meet the needs of 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of assessment information, a lack of information being available in individual IPPs, and a lack of consistent implementation of programs, services and supports necessary to meet the individuals' needs. The findings include:</p> <p>1. Individuals #6 and #3's CFAs did not include comprehensive information. Individuals #6 and #3 were observed to utilize a token reinforcement system, as follows:</p> <p>a. Individual #6's IPP, dated 2/6/15, documented a 24 year old male whose diagnoses included profound intellectual disability.</p> <p>During an observation on 8/18/15 at 3:15 p.m., Individual #6 went in his bedroom and touched the buttons of his VCR. The Home Manager told Individual #6 he needed to earn tokens for his cable and pointed to the area between Individual #6's VCR and his television which was mounted to his bedroom wall. The Home Manager then prompted Individual #6 to do laundry to earn tokens. Individual #6 went with the Home Manager to the laundry room, then exited the laundry room. The Home Manager thanked him for checking the laundry and handed him a paper</p>	MM159	<p><i>Refer to W214</i></p> <p><i>Refer to W111</i></p> <p><i>W196</i></p> <p><i>W269</i></p> <p><i>W268</i></p> <p><i>W240</i></p>	

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MM159	<p>Continued From page 24</p> <p>ticket. She stated he had earned his tokens and directed him to sit on the couch in the living room. The Home Manager then retrieved a step ladder and placed it in front of the television in the living room, which was mounted on the wall near the ceiling. The Home Manager stood on the ladder, removed the cables from the living room television and put the step ladder away. She then accompanied Individual #6 into his room.</p> <p>However, Individual #6's CFA, dated 1/15/15, did not contain assessment information related to Individual #6's ability to understand and use a token exchange system, how many tokens Individual #6 was required to earn prior to an exchange, or a schedule for token exchange.</p> <p>b. Individual #3's IPP, dated 3/19/15, documented a 33 year old female whose diagnoses included moderate intellectual disability.</p> <p>During observations on 8/18/15 from 12:00 - 12:55 p.m. and 8/18/15 from 4:43 - 6:40 p.m., Individual #3 was observed to exchange tokens for extra coffee and soda.</p> <p>However, Individual #3's CFA, dated 1/21/15, did not contain assessment information related to Individual #3's ability to understand and use a token exchange system, how many tokens Individual #3 was required to earn prior to an exchange, or a schedule for token exchange.</p> <p>When asked on 8/26/15 from 1:08 - 3:40 p.m., the Treatment Coordinator stated there were no assessments for the use of the tokens. The QIDP, who was present during the interview, stated the individuals' records did not include reinforcement schedules.</p>	MM159		

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MM159	<p>Continued From page 25</p> <p>The facility failed to ensure CFAs for Individuals #3 and #6 contained comprehensive information.</p> <p>2. Individual #7's IPP did not include comprehensive information regarding all relevant interventions, as follows:</p> <p>Individual #7's 2/26/15 IPP stated she was a 36 year old female whose diagnoses included profound mental retardation.</p> <p>Individual #7's Falling Service Program, dated 2/26/15, documented she needed to be monitored closely and wear a gait belt. Her 2/26/15 - 2/26/16 PT Service Program documented she was unable to ambulate independently. There was no additional information in the IPP regarding the gait belt (e.g., how it was to be applied, if staff were to be holding it at all times, if staff were to be holding it with one hand or both hands, with their palms up or down, etc.).</p> <p>Observations were completed on 8/18/15 and 19/15 for a cumulative of 5 hours and 44 minutes. During those times, Individual #7 was observed to be wearing a gait belt. The gait belt was observed to be used inconsistently by DCS staff throughout the observations. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:55 p.m., DCS A assisted Individual #7 to walk to the kitchen. Individual #7 had a gait belt on. DCS A had the gait belt bunched in her fist. - On 8/18/15 at 6:05 p.m., DCS F assisted Individual #7 to ambulate in the kitchen. DCS F held onto Individual #7's gait belt with her left hand while assisting Individual #5 with her right 	MM159		

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MM159	<p>Continued From page 26</p> <p>hand.</p> <p>- On 8/18/15 at 6:36 p.m., DCS F assisted Individual #7 to ambulate to the kitchen. Individual #7 was wearing a gait belt that was loose around her middle torso. As they entered the kitchen area, DCS F directed Individual #7's movements by pulling her sideways using the gait belt.</p> <p>- On 8/19/15 at 8:49 a.m., Individual #7 had a gait belt on and was walking to the kitchen to wash her hands. As she passed the food that was at her place at the dining table, she attempted to sit at the table. DCS H pulled sideways on her gait belt and directed her to the kitchen sink to wash her hands.</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #7 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to hold her hand and keep one hand on her back. - A second staff stated to walk behind her and hold her under her arms. - Three staff stated to hold her gait belt. - A sixth staff stated to place your hand under her arm and help her up. - A seventh staff stated to stand beside her and give her a hand or arm for support. <p>When asked during a follow-up interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said staff were not to pull sideways on the gait belt or bunch the gait belt in their fist. The Treatment Coordinator stated staff should not be assisting another individual while assisting</p>	MM159		

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MM159	<p>Continued From page 27</p> <p>Individual #7.</p> <p>The facility failed to ensure Individual #7's IPP specified when and how the gait belt was to be used.</p> <p>3. Individual #2 was not consistently provided with specialized and generic training necessary to meet his needs, as follows:</p> <p>Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation.</p> <p>a. Individual #2 was observed at the facility on 8/18/15 from 12:00 - 12:55 p.m. Individual #2's morning Active Treatment Schedule, dated 7/17/15, documented he was to assist with lunch during the time period. Individual #2's lunch assistance included "getting all of the necessary items (clothing protector, napkin, spoon, plate, cup, glasses)," serving himself and pouring his own drink.</p> <p>During the 55 minute observation, the following was noted:</p> <p>At 12:00 p.m., Individual #2 was observed to be alone in the living room. At 12:06 p.m., staff entered the living room and assisted him to the dining room table where he sat unengaged, then back to the living room at 12:10 p.m. Once in the living room, Individual #2 laid on the couch and then the floor until 12:20 p.m. At that time, Individual #2 walked with staff assistance to the dining room table where he sat unengaged. At 12:25 p.m., Individual #2 got up from the table, walked back to the living room and laid on the floor.</p>	MM159		

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MM159	<p>Continued From page 28</p> <p>At 12:30 p.m., Individual #2 went into the restroom with DCS J for 2 minutes, and then sat at the dining table unengaged for 5 minutes. Individual #2 got up from the table and returned to the living room. Individual #2 laid on the living room floor and looked through a bin of toys. At 12:40 p.m., Individual #2 sat at the dining table unengaged. At 12:50 p.m., DCS J assisted Individual #2 to wash his hands and return to the table where he remained unengaged in activity until the observation ended at 12:55 p.m.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the 55 minute observation.</p> <p>b. Individual #2 was observed at the facility on 8/18/15 from 3:05 - 3:50 p.m.</p> <p>i. Individual #2's PM Active Treatment Schedule, dated 7/17/15, documented he was to have a snack and use the bathroom from 3:00 to 3:30 p.m. The Active Treatment Schedule stated he was to wash his hands, make a choice of snack from 2 choices, help prepare the snack, get all necessary items (e.g. obtaining his clothing protector, napkin, spoon, etc.), and pour his own drink. Once the meal was finished, he was to take his dishes to the sink, rinse them off and place them in the dish drainer.</p> <p>On 8/18/15 from 3:05 - 3:50 p.m., the following was observed:</p> <p>From 3:05 - 3:15 p.m., Individual #2 walked to the dining area with DCS D and sat down at the dining table. DCS D prepared thickened orange juice and placed it on the table with a prepared</p>	MM159		

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MM159	<p>Continued From page 29</p> <p>snack. Individual #2 proceeded to eat the snack.</p> <p>Staff were not observed to elicit Individual #2's participation in choosing, preparing, serving himself or rinsing and placing his dishes in the drainer.</p> <p>From 3:15 - 3:30 p.m., Individual #2 walked with DCS D to his bedroom. DCS D walked behind Individual #2 with her arms around him. DCS D and Individual #2 came out of the bedroom and went to the living room where Individual #2 sat in the corner chair. DCS D offered Individual #2 sensory items. Individual #2 stood up and tried to go out the back door. DCS D intervened and left the area, stating she needed to check the temperature. Staff stated the temperature was 84 degrees and individuals were not allowed outside if the temperature was 90 degrees or above. Individual #2 went back to the living room and sat on the couch.</p> <p>At 3:26 p.m., Individual #2 attempted to enter the bedroom shared by Individual #3 and #7. DCS D wrapped her arms around Individual #2's midsection and pulled him away from the door stating "Honey, you can't take a bath right now." Individual #2 again attempted to go in the bedroom and was again physically redirected. Staff physically assisted him down the hall and released the physical hold when he was at the table in the living room. DCS D stood by the table with Individual #2, blocking his access to Individual #3 and #7's bedroom. Individual #2, picked up a cloth from the table and began shaking it. DCS D asked if Individual #2 wanted to help wiping off the table and provided hand over hand assistance in order for him to do so. DCS D was not observed to allow Individual #2 independence in wiping the table or provide less</p>	MM159		

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MM159	<p>Continued From page 30</p> <p>restrictive prompting (gestural cues, etc.) prior to providing hand over hand assistance.</p> <p>After DCS D ended the hand over hand assistance, Individual #2 walked around her and back to Individual #3 and #7's bedroom. DCS D again told him he could not take a bath now, wrapped her arms around his midsection, and attempted to physically redirect him back to the living room. Individual #2 dropped to the floor, got up, and was directed to the backyard at 3:32 p.m.</p> <p>Staff was not observed to honor Individual #2's choices.</p> <p>ii. Individual #2's PM Active Treatment Schedule, dated 7/17/15, documented if a community outing was not planned, then he was to engage in "Domestic Training" including dishes, wiping tables/counters, laundry, vacuuming, etc.), engage in a group activity, or engage in a leisure activity. The Active Treatment Schedule stated "Individual #2 likes to watch movies, playing outside, listening to music, and play with toys. Formal leisure program to choose a leisure activity when 2 are presented to him..."</p> <p>From 3:32 - 3:55 p.m., Individual #2 laid on the back patio holding toys. At 3:45 p.m., DCS D assisted Individual #2 up off the patio and onto the swing.</p> <p>Staff was not observed to offer Individual #2 a choice of leisure activities to choose from.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the 45</p>	MM159		

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MM159	<p>Continued From page 31</p> <p>minute observation.</p> <p>c. Individual #2 was observed at the facility on 8/18/15 from 4:43 - 6:40 p.m.</p> <p>i. Individual #2's PM Active Treatment Schedule, dated 7/17/15, documented he was to use the restroom and engage in "Structured/Leisure time" from 4:30 - 5:00 p.m. The Active Treatment Schedule stated "Individual #2 likes to watch movies, playing outside, listening to music, and play with toys. Formal leisure program to choose a leisure activity when 2 are presented to him..."</p> <p>On 8/18/15 from 4:43 - 5:00 p.m., the following was observed:</p> <p>At 4:43 p.m., Individual #2 was observed in the common area of the facility. Individual #2 was laying on the living room floor before he scooted himself into the kitchen. At 4:49 p.m., Individual #2 stood up, walked back to the living room and sat on the couch. At 4:54 p.m., Individual #2 slid off the couch onto the floor and laid on the living room rug. DCS A verbally cued Individual #2 to a fishing game.</p> <p>Staff was not observed to offer individual #2 a choice of leisure activities to choose from.</p> <p>At 4:55 p.m., Individual #2 walked into the kitchen. DCS D came up behind him and put her arms around Individual #2's arms and chest to block him from the oven. The Home Manger entered the facility, and Individual #2 held her fingers while she walked backwards with him to the living room. The Home Manager attempted to engage Individual #2 with the fishing game. DCS A then relieved the Home Manager and continued trying to engage Individual #2 in the</p>	MM159		

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MM159	<p>Continued From page 32</p> <p>fishing game.</p> <p>The Home Manager and staff were not observed to offer Individual #2 a choice of leisure activities to choose from.</p> <p>ii. Individual #2's PM Active Treatment Schedule documented from 5:00 - 5:30 p.m. he was to engage in a group activity, wash his hands, and help place food on the table when it was ready. The Active Treatment Schedule stated "Individual #2 has a hard time staying at the group activity. Reinforce with social praise and pats on the back. It might be helpful if [Individual #2] had a toy to play with during group."</p> <p>At 5:00 p.m., Individual #2 entered the bedroom shared by Individual #3 and Individual #7. DCS A followed Individual #2 and told him it was not his bedroom. At 5:05 p.m., DCS A stated she was going to assist Individual #2. DCS D stated Individual #2 wanted a bath but she was going to do it when dinner was going. DCS A told Individual #2 he could have a bath later when "there's more people to help you."</p> <p>Staff was not observed to honor Individual #2's choices.</p> <p>At 5:10 p.m., Individual #2 returned to the living room and looked through the toys. Individual #2 chose a padded toy and laid on the floor. DCS D handed Individual #2 a padded lion mirror. DCS A verbally cued Individual #2 to the wax scents, with no response. DCS A held Individual #2's hands as the Home Manager walked by and instructed DCS A to try using lotion. DCS A stated she was providing deep pressure.</p> <p>At 5:20 p.m. DCS A began reading an ABC book</p>	MM159		

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MM159	<p>Continued From page 33</p> <p>aloud while Individual #2 laid on the living room rug. Individual #2 started at this hands and rolled around on the rug as she read.</p> <p>Staff were not noted to reinforce Individual #2 with social praise and pats on the back or provide him with a toy to play with, per his Active Treatment Schedule.</p> <p>iii. Individual #2's PM Active Treatment Schedule documented from 5:30 - 6:30 p.m. he was to engage in eating dinner and clean up.</p> <p>At 5:35 p.m., DCS D stood behind Individual #2 and placed her arms and hands around his upper torso as they walked out of the living room. Individual #2 appeared to struggle with DCS D. He grabbed hold of the corner table against the wall behind the couch. He resisted as DCS D pulled him. He released his hold on the corner of the table and DCS D took him into the hallway bathroom counting 1, 2, 3, 4.</p> <p>At 5:40 p.m., DCS D brought Individual #2 to the dining area, holding his wrists. DCS D placed a towel-like clothing protector on Individual #2 and Individual #2 sat at the dining table.</p> <p>Staff were not observed to elicit Individual #2's participation in obtaining the clothing protector or putting it on.</p> <p>DCS D went to the laundry room and Individual #2 removed his clothing protector, went to the living room and sat on the couch. At 5:45 p.m., Individual #2 leaned on DCS E, who was next to him on the couch. Individual #2 slapped himself in the head then laid on the floor with his feet up on the couch. DCS E handed Individual #2 a mirror toy. Individual #2 attempted to slap his</p>	MM159		

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MM159	<p>Continued From page 34</p> <p>head, but DCS E blocked the attempts. DCS E verbally cued Individual #2 to wash his hands with no response. At 6:00 p.m., DCS A assisted Individual #2 up off the living room floor. She held his hands and led him to the kitchen. Individual #2 washed his hands and sat at the dining room table. Staff placed a clothing protector on him and the Home Manger provided hand over hand physical assistance for Individual #2 to serve himself.</p> <p>Individual #2's was not observed to assist in obtaining his dining equipment (e.g. clothing protector, napkin, spoon, plate, cup, etc.) and the Home Manager was not observed to allow Individual #2 independence or verbally prompt him to serve himself prior to providing hand over hand assistance.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the 1 hour and 57 minute observation.</p> <p>d. Individual #2 was observed at the facility on 8/19/15 from 8:15 - 9:15 p.m. Individual #2's morning Active Treatment Schedule, dated 7/17/15, documented he was to use the restroom and bathe from 7:30 - 8:30 a.m. From 8:30 - 9:00 a.m., Individual #2 was to have breakfast. The Active Treatment Schedule stated he was to wash his hands, assist in the preparation of breakfast, get all necessary items (e.g. obtaining his clothing protector, napkin, spoon, etc.), serve himself, and pour his own drink.</p> <p>On 8/18/15 from 4:43 - 5:00 p.m., the following was observed:</p>	MM159		

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MM159	<p>Continued From page 35</p> <p>At 8:15 a.m., Individual #2 was in his bedroom, where he remained until 8:20 a.m. At 8:20 a.m., Individual #2 and DCS B came into the dining area. DCS B verbally prompted Individual #2 to wash his hands then provided him with physical assistance to do so. Individual #2 then entered the laundry room, where DCS G assisted him with his medications. He left the laundry room and then returned to his bedroom, where he remained until 9:00 a.m.</p> <p>At 9:03 a.m., DCS B turned on Individual #2's bedroom light and verbally prompted him to get up for breakfast. DCS B assisted Individual #2 to the dining table. From 9:03 to 9:10 a.m., DCS B prepared his breakfast. At 9:07 a.m., Individual #2 got up from the dining table, walked towards DCS B while she prepared his breakfast, and then returned to the dining table. At 9:10 a.m., DCS B served Individual #2 breakfast.</p> <p>Individual #2's was not observed to be prompted or assist in preparing his breakfast, obtaining his dining equipment or serving himself.</p> <p>Individual #2 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities in accordance with his Active Treatment Schedule during the hour observation.</p> <p>Further, Individual #2's 1/2/15 SIB Behavior Intervention Plan documented he was non-verbal and engaged in face slaps and head hits. The Behavior Intervention Plan included, but was not limited to, the following interventions:</p> <p>- Encourage more time off the floor: "...encourage him to stand as often as possible. When [Individual #2] is on the floor through the day, cue</p>	MM159		

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MM159	<p>Continued From page 36</p> <p>'[Individual #2] stand up'...If [Individual #2] doesn't stand up, cue again..."</p> <p>- Face slaps: "If [Individual #2] starts to slap his face, if [Individual #2] is laying on the floor assist him to get up and see if he needs changed or if he is hungry or thirsty..."</p> <p>- Head hits: "If [Individual #2] hits his head - hard enough to be heard, at a slower pace, leaving red marks - block with your hand or a pillow...If he does not appear hungry, thirsty or need to be changed then get his box and cue 'get a toy' staff are to engage in this activity with him."</p> <p>However, throughout the observations completed on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, staff were not observed to implement Individual #2's behavior plan, as follows:</p> <p>8/18/15 from 12:00 - 12:55 p.m.:</p> <p>- 12:15 p.m., Individual #2 laid vertically upside down on the couch while staff were engaged with other individuals.</p> <p>- 12:25 p.m., Individual #2 walked into the living room from the kitchen and laid on the floor while DCS J watched him.</p> <p>- 12:37 p.m., Individual #2 returned to the living room with DCS J following and sat on the floor looking through the toy bins.</p> <p>8/18/15 from 4:43 - 6:40 p.m.:</p> <p>- 4:43 p.m., Individual #2 laid on the living room floor, moved to the kitchen, and sat on the dining area floor.</p>	MM159		

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MM159	<p>Continued From page 37</p> <p>- 4:49 p.m., Individual #2 moved from dining area floor to the living room floor.</p> <p>- 5:10 - 5:17 p.m., Individual #2 laid on the living room floor. He was observed and heard to slap himself on his left ear with his left hand multiple times.</p> <p>- 5:25 - 5:35 p.m., Individual #2 laid on the living room floor, looked at his hands, and touched the rug. He then laid on his right side bouncing his head up and down in the air and was heard to slap himself on the head a minimum of two times.</p> <p>Further, during this timeframe at 5:30 p.m., DCS E assisted Individual #4 from the dining table to the chair in the corner of the living room. As they were walking through the living room, both DCS E and Individual #4 stumbled over Individual #2 laying on the living room floor.</p> <p>- 5:50 p.m., Individual #2 laid on floor with his hands in his mouth.</p> <p>- 5:55 p.m., Individual #2 laid on the floor and was heard to hit his left ear with his left hand. DCS E sat beside him on the floor.</p> <p>- 6:00 p.m., Individual #2 continued to lie on the floor.</p> <p>However, other than at 5:17 p.m., staff were not observed to cue Individual #2 off the floor or attempt to block him when he hit himself on the head.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated individuals were to be provided with active</p>	MM159		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642
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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
MM159	<p>Continued From page 38</p> <p>treatment. The QIDP, who was present during the interview also stated all behavior plans should have been implemented as written.</p> <p>The facility failed to ensure Individual #2 was provided with specialized and generic training necessary to meet his active treatment needs, promote his independence and maximize his developmental potential.</p> <p>4. Staff were not observed to consistently communicate with Individual #1 in an effective manner.</p> <p>Individual #1's 7/27/15 IPP documented he was a 31 year old male whose diagnoses included severe mental retardation, blindness, and deafness.</p> <p>Individual #1's 6/30/15 CFA documented he used sign language for the words please or want, eat, help, drink, food, leisure words, household words, and with other signers. The CFA also stated communication was usually initiated by other signers. His 8/19/15 AM and PM Active Treatment Schedules documented that staff would have to sign with him while he participated in group activities.</p> <p>However, during an observation on 8/19/15 from 2:30 - 3:15 p.m., staff were not observed to use sign language with Individual #1, as follows:</p> <p>- 2:50 - 2:55 p.m., Individual #1 sat in the living room on a couch by himself with a balloon in his hands. DCS F sat on another couch in the living room while talking with Individual #5.</p> <p>- 2:56 p.m. DCS F sat beside Individual #1 on the couch. DCS F was heard to say "duck" and</p>	MM159	<p>→ All staff trained on individual #1 communication program TC responsible 9/30/15</p> <p>→ all individuals communication program reviewed and trained TC responsible by 9/30/15</p> <p>→ Communication program to be observed during client observations TC responsible by 9/30/15</p> <p>→ Client observation PSR reviewed at monthly QA and any</p>	

recommendations or actions noted on QA log and action list. PD responsible by 9/30/15

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MM159	<p>Continued From page 39</p> <p>"dolphin" and asked him if he wanted some candy. He did not respond to the verbal cues.</p> <p>When asked during interviews on 8/24/15 from 1:49 - 3:35 p.m. and 8/25/15 from 12:50 - 1:20 p.m., 7 DCS all stated Individual #1 communicated using sign language. When asked how Individual #1 could see the sign language, all 7 DCS said they placed their hand over his hand and he could read their sign language (e.g. tactile sign).</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated staff were to use tactile sign language when communicating with Individual #1.</p> <p>The facility failed to ensure Individual #1 received interventions consistent with his program.</p> <p>5. Individuals #1, #2, #4, #5, #6 and #7 were not provided with appropriate assistance when ambulating and transferring from one surface to another, as follows:</p> <p>Observations were completed on 8/18/15 and 19/15 for a cumulative of 5 hours and 44 minutes. During the observations, staff were not observed to consistently use proper techniques to transfer and assist individuals with ambulation.</p> <p>a. Individual #4's 5/21/15 IPP stated he was a 33 year old male whose diagnoses included profound mental retardation.</p> <p>Individual #4's PT Service Program, dated 5/21/15, stated he was to walk without holding onto staff's arm and practice keeping balance by helping him stand. However, during observations, the following was noted:</p>	MM159		

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MM159	<p>Continued From page 40</p> <ul style="list-style-type: none"> - On 8/18/15 at 3:05 p.m., as Individual #4 walked through the kitchen DCS E placed his arms under Individual #4's armpits and walked behind him. - On 8/18/15 at 5:25 p.m., DCS E was behind Individual #4 and holding him under his armpits while assisting him to ambulate. - On 8/18/15 at 5:33 p.m., DCS E walked behind Individual #4 and placed his hands on Individual #4's chest as he walked to the couch. - On 8/19/15 at 7:05 a.m., DCS J assisted Individual #4 to walk to his bedroom while holding one of his hands and walking backwards in front of him. - On 8/19/15 at 8:35 a.m., DCS A used her left hand to assist Individual #4 to walk towards the kitchen as she used her right hand to propel Individual #7 in her wheelchair. - On 8/19/15 at 9:05 a.m., as Individual #4 walked to his room, DCS G held his left hand and walked backwards in front of him. - On 8/19/15 at 3:10 p.m., as Individual #4 walked to the dining table, DCS E walked backwards in front of him and held onto his hands. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #4 for ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to walk behind him and hold him under his arms. - A second staff stated do not allow him to walk without holding your hand or arm. 	MM159		

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MM159	<p>Continued From page 41</p> <ul style="list-style-type: none"> - A third staff stated to brace your arms under his arms. - A fourth staff stated depending on how he felt at the time, allow him to hold on to you. - Two staff stated to walk side-by-side with him. - A sixth staff stated to keep arm's reach away from him when assisting him to walk. <p>b. Individual #2's IPP, dated 1/2/15, documented a 24 year old male diagnosed with profound mental retardation.</p> <p>Individual #2's 3/15/15 Fall Protocol documented he was sometimes a little unsteady on his feet, could walk for short distances, and could ambulate around the house without help. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 3:18 p.m., DCS D had her hands and arms around Individual #2 while she walked with him to the bedroom. - On 8/18/15 at 4:56 p.m., the Home Manager assisted Individual #2 to walk from the laundry room area to the living room. The Home Manager walked behind him with his body between her legs. - On 8/18/15 at 5:35 p.m., DCS D stood behind Individual #2 and placed her arms and hands around his upper torso as they walked out of the living room. Individual #2 appeared to struggle with DCS D. He grabbed hold of the corner table against the wall behind the couch. He resisted as DCS D pulled him. He released his hold on the corner of the table and DCS D took him into the hallway bathroom counting 1, 2, 3, 4. - On 8/18/15 at 6:02 p.m., DCS A assisted 	MM159		

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MM159	<p>Continued From page 42</p> <p>Individual #2 up off the living room floor. She held his hand and led him into the kitchen.</p> <p>- On 8/18/15 at 6:32 p.m., DCS D walked backwards and pulled on Individual #2's wrists while assisting him to walk.</p> <p>- On 8/19/15 at 2:35 p.m., DCS K walked behind Individual #2 with both arms under his armpits and around his upper torso.</p> <p>- On 8/19/15 at 2:52 p.m., DCS K walked behind Individual #2 with both arms under his armpits and her hand on his right wrist as she walked behind him.</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #2 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated he was unsteady but walked and did not use a wheelchair. - Another staff stated his hands were to be held. - A third staff stated staff were to allow him to walk more and hold out their hand to help him walk to the bathroom. - A fourth staff stated he was unsteady and staff were to brace their arms under his arms. - A fifth staff stated staff were to pull him up from the front and walk behind him. - A sixth staff stated staff were to pull him up from a sitting position and hold onto his arms. - A seventh staff stated he would pull himself himself up by holding onto staffs' hands and he could walk by himself. <p>c. Individual #6's IPP, dated 2/6/15, documented a 24 year old male whose diagnoses included</p>	MM159		

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MM159	<p>Continued From page 43</p> <p>profound mental retardation.</p> <p>Individual #6's CFA, dated 1/15/15, documented Individual #6 was ambulatory and could walk independently for short distances, but required a wheelchair for long distances. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:30 p.m., DCS D verbally cued Individual #6 to wash his hands. DCS D grabbed Individual #6's wrists, and then his biceps. She held his biceps while she assisted him down the hall. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #6 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated he can stand up with a verbal cue and sometimes you needed to hold his hands or hold him under his arms. - A second staff stated to hold both his hands. - Five staff stated he was independent. <p>d. Individual #5's 5/8/15 IPP documented he was a 22 year old male whose diagnoses included profound mental retardation and epilepsy.</p> <p>Individual #5's PT Home Program note, dated 7/7/15, documented he should be encouraged to stand as tall as possible. The PT did not recommend or direct staff to hold his hands when ambulating. However, during observations, the following was noted:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:29 p.m., as Individual #5 walked into the house, DCS D walked in front of him backwards while holding onto his hands. 	MM159		

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MM159	<p>Continued From page 44</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #5 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to hold both his hands. - Two staff stated he did not require assistance. - A fourth staff stated to put your leg between his legs when he was seated to help him up. Then he can walk around by himself. - A fifth staff stated to grab both of his hands and have him pull himself up. He can walk well independently. - A sixth staff stated to plant your feet, and pull him up. Individual #5 would only get up and walk when he wanted to. - A seventh staff stated that sometimes one staff needed to stand on either side of him while he ambulated. <p>e. Individual #7's 2/26/15 IPP stated she was a 36 year old female whose diagnoses included profound mental retardation.</p> <p>Individual #7's Falling Service Program, dated 2/26/15, documented she needed to be monitored closely and wear a gait belt. Her 2/26/15 - 2/26/16 PT Service Program documented she was unable to ambulate independently. There was no additional information in the IPP regarding the gait belt (e.g., how it was to be applied, if staff were to be holding it at all times, if staff were to be holding it with one hand or both hands, with their palms up or down, etc.).</p> <p>Observations were completed on 8/18/15 and 8/19/15 for a cumulative of 5 hours and 44</p>	MM159		

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MM159	<p>Continued From page 45</p> <p>minutes. During those times, Individual #7 was observed to be wearing a gait belt. The gait belt was observed to be used inconsistently by DCS staff throughout the observations. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - On 8/18/15 at 5:55 p.m., DCS A assisted Individual #7 to walk to the kitchen. Individual #7 had a gait belt on. DCS A had the gait belt bunched in her fist. - On 8/18/15 at 6:05 p.m., DCS F assisted Individual #7 to ambulate in the kitchen. DCS F held onto Individual #7's gait belt with her left hand while assisting Individual #5 with her right hand. - On 8/18/15 at 6:36 p.m., DCS F assisted Individual #7 to ambulate to the kitchen. Individual #7 was wearing a gait belt that was loose around her middle torso. As they entered the kitchen area, DCS F directed Individual #7's movements by pulling her sideways using the gait belt. - On 8/19/15 at 8:49 a.m., Individual #7 had a gait belt on and was walking to the kitchen to wash her hands. As she passed the food that was at her place at the dining table, she attempted to sit at the table. DCS H pulled sideways on her gait belt and directed her to the kitchen sink to wash her hands. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #7 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to hold her hand and keep one 	MM159		

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MM159	<p>Continued From page 46</p> <p>hand on her back.</p> <ul style="list-style-type: none"> - A second staff stated to walk behind her and hold her under her arms. - Three staff stated to hold her gait belt. - A sixth staff stated to place your hand under her arm and help her up. - A seventh staff stated to stand beside her and give her a hand or arm for support. <p>f. Individual #1's 7/27/15 IPP documented he was a 31 year old male whose diagnoses included severe mental retardation, blindness, and deafness.</p> <ul style="list-style-type: none"> - On 8/19/15 at 8:30 a.m., Individual #1 had an episode of urine incontinence on the chair in the corner of the living room. DCS B held Individual #1's hands and walked backwards with him to the bathroom. - On 8/19/15 at 8:55 a.m., Individual #1 came out of the laundry room and went into the bathroom off the bedroom shared by Individual #3 and Individual #7. Individual #1 came out of the bathroom with DCS G, who held his hands as she walked backwards to his bedroom. <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. When asked how physical assistance was provided to Individual #1 for standing and ambulation, staff stated the following:</p> <ul style="list-style-type: none"> - One staff stated to use tactile sign language to cue him to move. You can also tap his shoulder or leg. - A second staff stated to link arms with him. - A third staff stated to touch Individual #1 so he knows you are next to him. Individual #1 liked to walk at staff's side. 	MM159		

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MM159	<p>Continued From page 47</p> <ul style="list-style-type: none"> - A fourth staff stated Individual #1 did not require any physical assistance. He stated staff could guide Individual #1 if needed. - A fifth staff stated Individual #1 was independent. - A sixth staff stated staff should offer Individual #1 their hands. - A seventh staff stated Individual #1 did not require more than a light touch to stand and ambulate. <p>When asked during a follow-up interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said staff should not lift individuals up from off the floor by pulling on their hands. She stated staff should ask each individual if they are ready to get up and offer their hands to the individuals. The Treatment Coordinator stated staff should not be walking behind individuals with the individuals between their legs. Staff should not hold onto individuals' hands and walk backwards while assisting the individuals with ambulation. She also stated assistance up shouldn't involve staff muscle, but that individuals should be pulling themselves up.</p> <p>The facility failed to ensure staff implemented individuals' transfer and ambulation assistance programs and guidelines.</p> <p>The facility failed to ensure comprehensive active treatment services were provided to individuals.</p>	MM159		
MM162	<p>16.03.11500 Client Behavior and Facility Practices</p> <p>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)</p>	MM162		

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MM162	<p>Continued From page 48</p> <p>(iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Based on observation, policy review, record review and staff interview it was determined the facility failed to ensure that policies that promoted opportunities for choice, decision-making, self-management, growth and development were developed and consistently implemented for 7 of 7 individual (Individuals #1 - #7) residing at the facility. This resulted in individual choice and self direction not being maximized and a failure to promote the individuals' growth, independence, dignity and privacy. The findings include:</p> <p>1. Observations were conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes. During the observations, individual self direction and choices were not honored, as follows:</p> <p>a. On 8/18/15 at 3:31 p.m., DCS D assisted Individual #2 while walking. Individual #2 attempted to go into Individuals #3 and #7's room. DCS D said it was not bath time and redirected him outside.</p> <p>b. On 8/18/15 at 4:55 p.m., DCS D assisted Individual #2 as he walked out of the kitchen into the hallway. When Individual #2 attempted to go into Individuals #3 and #7's room, DCS D told him "no shower right now."</p> <p>c. On 8/18/15 at 5:35 p.m., DCS D stood behind Individual #2 and placed her arms and hands around his upper torso as they walked out of the living room. Individual #2 appeared to struggle with DCS D. He grabbed hold of the corner table against the wall behind the couch. He resisted as</p>	MM162	<p><i>Refer to W 269</i> <i>refer to W 240</i> <i>W 268</i></p>	

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MM162	<p>Continued From page 49</p> <p>DCS D pulled him. He released his hold on the corner of the table and DCS D took him into the hallway bathroom counting 1, 2, 3, 4.</p> <p>d. On 8/19/15 at 8:45 a.m., Individual #4 was in the living room and stood up beside DCS A. He did not respond to DCS A when she said "let's sit down so that you don't fall."</p> <p>When asked during an interview with the Treatment Coordinator, QIDP and Home Manager, on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated DCS should be encouraging and honoring client choice and individuals should be able to take a bath when they wanted.</p> <p>The facility's policy for Client Rights, revised March 2015, was reviewed and did not include information related to client choice.</p> <p>When asked on 8/26/15 from 1:58 - 3:40 p.m., the QIDP stated she was not sure if client choice was in the policy and that she would get back with the surveyor.</p> <p>On 8/28/15 at approximately 10:45 a.m., the QIDP faxed a document to the surveyor which stated providing client choice was in their philosophy, but not in their policy, and that that policy would be updated.</p> <p>The facility failed to develop and implement policy related to client choice necessary to ensure individuals' choices were allowed and encouraged.</p> <p>2. The facility's policy for Client Rights, revised March 2015, included a section titled "Right to Dignity and Privacy," which stated "Each client</p>	MM162		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642
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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
MM162	<p>Continued From page 50</p> <p>admitted to [name of facility] must be treated with consideration, respect and full recognition of his/her dignity and individuality; with privacy, freedom of communication and personal preferences."</p> <p>The Client Rights SOP (Standard Operating Procedure), updated 9/16/13, stated "Personal dignity encompasses the right of the individual to engage in and demonstrate through personal choice his/her preferences in all aspects of life and living."</p> <p>During observations conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, the facility's policies were not consistently implemented, as follows:</p> <p>a. Staff did not consistently ensure the individuals' attire promoted the individuals' dignity. Examples included, but were not limited to, the following:</p> <p>i. On 8/18/15 at 3:21 p.m., 5:55 p.m., 5:57 p.m. and 6:36 p.m., individual #7's adult incontinence briefs were visible outside of the shorts/pants she was wearing.</p> <p>ii. On 8/18/15 from 5:10 - 5:30 p.m., Individual #2's adult incontinence briefs were visible at the back of his pants.</p> <p>iii. On 8/18/15 at 3:21 p.m. and 6:10 p.m., Individual #7 was wearing a towel-like, ripped clothing protector.</p> <p>iv. On 8/18/15 at 6:25 p.m., Individual #5 was wearing a towel-like clothing protector that was brown in color and ripped.</p> <p>v. On 8/19/15 at 6:43 a.m., Individual #4 was</p>	MM162		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642		
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MM162	<p>Continued From page 51</p> <p>wearing a towel-like clothing protector that was tattered.</p> <p>vi. On 8/19/15 at 8:49 a.m., DCS H placed a towel-like clothing protector that was tattered on Individual #7.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated staff should have used the aprons that were hung on a hook in the dining area for clothing protectors. The QIDP, who was present during the interview, stated the facility should get rid of the old towel-like clothing protectors.</p> <p>The facility failed to ensure individuals' attire promoted their dignity.</p> <p>b. Staff did not consistently ensure staff communication promoted the individuals' dignity. Examples included, but were not limited to, the following:</p> <p>i. On 8/18/15 at 4:43 p.m., DCS D spoke with Individual #2 and said, "okay handsome."</p> <p>ii. On 8/18/15 at 4:44 p.m., DCS D called Individual #2 "Sweet Cheeks" and "Sweetie" 2 times during the conversation.</p> <p>iii. On 8/18/15 at 5:10 p.m., DCS D called Individual #6 "big guy" and "handsome."</p> <p>iv. On 8/18/15 at 5:30 p.m., DCS D called Individual #6 "honey."</p> <p>Additionally, on 8/19/15 at 2:56 p.m., DCS F sat beside Individual #1 in the living room. DCS F was heard to say "duck," "dolphin" and "want some candy." He did not respond to the verbal</p>	MM162		

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MM162	<p>Continued From page 52</p> <p>cues. DCS F did not use tactile sign language while communicating with Individual #1 although Individual #1's 7/27/15 IPP documented blindness and deafness as secondary diagnoses.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator and QIDP stated pet names should not be used. The QIDP also stated staff were to use tactile sign language when communicating with Individual #1.</p> <p>The facility failed to ensure staff communication was appropriate to meet Individual #1's needs and promoted all individuals' dignity.</p> <p>c. Throughout the observations completed on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, items were noted to be kept in the living room in fabric bins. Individuals were observed to manipulate items from the bins which were not age appropriate and did not promote the individuals' dignity and growth. Examples included, but were not limited to, the following:</p> <p>i. On 8/18/15 at 3:12 p.m., Individual #5 was seated on the couch chewing on plastic rings.</p> <p>ii. On 8/18/15 at 5:10 p.m., Individual #2 looked through the sensory bins and picked out a plastic, yellow lion mirror with padding around the edges to manipulate.</p> <p>iii. On 8/18/15 at 5:45 p.m., DCS F pressed the squeaker in a book she was reading to the individuals. She directed Individual #6 to look and listen to "the bird."</p> <p>iv. On 8/18/15 from 5:45 - 5:50 p.m., Individual #5 was holding two different plastic toys, one was a toy car he periodically placed in his mouth.</p>	MM162		

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MM162	<p>Continued From page 53</p> <p>v. On 8/19/15 at 8:20 a.m., Individual #1 was taken to the bins where he chose a stuffed penguin with a #2 on the shirt to manipulate.</p> <p>vi. On 8/19/15 at 8:25 a.m., Individual #1 was swinging around a stuffed penguin with a #5 on the shirt.</p> <p>vii. On 8/19/15 at 9:08 a.m., DCS H bounced a long-armed and long-legged, gray and red stuffed animal toy in an up and down motion for Individual #7.</p> <p>viii. On 8/19/15 at 2:35 p.m., DCS K provided Individual #2 with the yellow, plastic lion mirror which he held as he sat on the swing in the backyard.</p> <p>An inventory of items located in the sensory bins was taken on 8/19/15 from 12:28 to 2:00 p.m. Items in the sensory bins included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A plastic caterpillar - A brown plastic milk jug with a hippopotamus picture on it - A 4-inch long green plastic frog - Numerous wooden blocks with numbers - A 7-inch long soft cloth green cat - An 18-inch long cloth reindeer with dangly legs and arms - A Fisher Price cell phone - Small rubber animals (a monkey, horse, bear and hippopotamus) - An Infantino elephant rattle - A Fisher Price computer - Infantino stuffed penguins with numbered shirts (#1, #2, #5 and #6) - A Sesame Street remote control 	MM162		

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MM162	<p>Continued From page 54</p> <ul style="list-style-type: none"> - A Playskool plastic guitar - A Little Tikes plastic camera - An Infantino cell phone - A HAP-P-KID plastic pig - A Fisher Price fishing pole - A Little Tikes screwdriver - A Sassy Baby's Sense-Ations book - A Nuby teething ring set <p>Age appropriate items were not noted to be available in the sensory bins in the living room.</p> <p>When asked during an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator said there were toys in the living room that were not age appropriate and most belonged to Individual #2 who was admitted from a sister facility with the toys. When asked about a program to encourage Individual #2 to use age appropriate items, the Treatment Coordinator stated no program had been developed.</p> <p>The facility failed to ensure age appropriate items were made available for the individuals.</p> <p>d. During observations completed on 8/18/15 and 8/19/15 it was noted the facility had two bathrooms, one off of the hallway with a shower, and one off of the bedroom shared by Individual #3 and Individual #7 with a bathtub. Observations were conducted on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes. During that time, individuals were noted to enter Individual #3 and Individual #7's bedroom to utilize the bathroom, as follows:</p> <p>i. During an observation on 8/18/15 at 5:05 p.m., Individual #2 was observed to go through Individual #3 and #7's bedroom with DCSA to use the bathroom. Individual #2 then left the</p>	MM162		

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MM162	<p>Continued From page 55</p> <p>bathroom at 5:10 p.m.</p> <p>ii. During an observation on 8/18/15 at 6:02 p.m., Individual #4 was observed to go through Individual #3 and #7's bedroom with DCS E to use the bathroom.</p> <p>iii. During an observation on 8/19/15 at 8:42 a.m., Individual #5 was observed to go with DCS J through Individual #3 and #7's bedroom to use the bathroom. Individual #3 was laying on her bed at the time. When asked, DCS A, who was present at the time, stated Individual #3 liked to rest before work. Individual #5 then left the bathroom at 8:49 a.m.</p> <p>During interviews conducted with 7 DCS on 8/24/15 and 8/25/15, the staff all stated when the bathroom off the hallway was occupied, individuals used the bathroom off Individual #3 and Individual #7's bedroom. The staff all stated they tried to be quiet when taking individuals into that bathroom in an attempt to not disturb Individual #3 and Individual #7.</p> <p>When asked how traffic in and out of the bathroom impacted Individual #3 and Individual #7, including their right to privacy, during an interview on 8/24/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated they had not even thought about the effects.</p> <p>The facility failed to ensure consideration was given to Individual #3 and Individual #7, necessary to ensure their right to privacy was respected and upheld.</p>	MM162		
MM169	16.03.11700 Physical Environment	MM169		

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MM169	<p>Continued From page 56</p> <p>The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA 's Life Safety Code and IDAPA 07.03.01, " Rules of Building Safety. "</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a sanitary environment to avoid sources and transmission of infections was provided for 4 of 7 individuals (Individuals #1, #2, #5 and #6) and had the potential to effect all individuals residing in the facility. This resulted in the potential for transmission of infections. The findings include:</p> <p>1. The facility's Nursing/Medical policy, dated 3/2015, documented "Hygiene and sanitation procedures will be implemented throughout the facility for control of communicable diseases..."</p> <p>During observations completed on 8/18/15 and 8/19/15 for a cumulative 5 hours and 44 minutes, items were noted to be kept in the living room in fabric bins.</p> <p>An inventory of items located in the fabric bins was taken on 8/19/15 from 12:28 to 2:00 p.m. Items in the fabric bins included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - A plastic caterpillar - A brown plastic milk jug with a hippopotamus picture on it - A 4-inch long green plastic frog - Numerous wooden blocks with numbers 	MM169	<p><i>refer to W454</i></p>	

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MM169	<p>Continued From page 57</p> <ul style="list-style-type: none"> - A Fisher Price cell phone - Small rubber animals (a monkey, horse, bear and hippopotamus) - An Infantino elephant rattle - A Fisher Price computer - A Sesame Street remote control - A Playskool plastic guitar - A Little Tikes plastic camera - An Infantino cell phone - A HAP-P-KID plastic pig - A Fisher Price fishing pole - A Little Tikes screwdriver - A Sassy Baby's Sense-Actions book - A Nuby teething ring set - A 7-inch long soft cloth green cat - An 18-inch long cloth reindeer with dangly legs and arms - Infantino stuffed penguins with numbered shirts (#1, #2, #5 and #6) <p>Individuals were observed to manipulate items from the bins, including placing the items in their mouths. Examples included, but were not limited to, the following:</p> <p>a. On 8/18/15 at 12:10 p.m., Individual #1 was laying in bed with a soft-sided toy approximately 5 inches long in his mouth.</p> <p>b. On 8/18/15 at 3:12 p.m. and 3:30 p.m., Individual #5 was chewing on plastic rings and carrying a second toy.</p> <p>c. On 8/18/15 at 4:43 p.m., DCS D handed Individual #2 a yellow plastic toy which he threw on the floor.</p> <p>d. On 8/18/15 at 5:10 p.m., Individual #2 looked through the fabric bins and picked out a plastic, yellow lion mirror with padding around the edges</p>	MM169		

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MM169	<p>Continued From page 58</p> <p>to manipulate:</p> <p>e. On 8/18/15 at 5:20 p.m. and 5:50 p.m., Individual #6 looked through the fabric bins, removed toys from the bins, and was on the floor playing with the toys.</p> <p>f. On 8/18/15 from 5:45 - 5:50 p.m., Individual #5 was holding two different plastic toys, one was a toy car which he periodically placed in his mouth.</p> <p>g. On 8/19/15 at 8:20 a.m., Individual #1 was taken to the bins where he chose a stuffed penguin with a #2 on the shirt to manipulate. On 8/19/15 at 8:25 a.m., Individual #1 was swinging around a stuffed penguin with a #5 on the shirt.</p> <p>At no point during the observations were DCS noted to sanitize the items after use.</p> <p>Interviews were conducted on 8/24/15 and 8/25/15 with 7 DCS. All of the DCS stated sanitizing the items was the responsibility of graveyard staff and they had never completed sanitization.</p> <p>However, information related to how staff were to sanitize the items, including the stuffed animals and the fabric bins, could not be found.</p> <p>During an interview on 8/26/15 from 1:58 - 3:40 p.m., the Treatment Coordinator stated an item should not be put back in the bins if an individual put it in their mouth. The Treatment Coordinator stated DCS should separate used items into a bucket if they do not want to immediately sanitize the item.</p> <p>The facility failed to ensure individuals were provided with a sanitary environment.</p>	MM169		

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MM215	<p>16.03.11711.01 Good Repair</p> <p>Each building used by the ICF/ID and its equipment must be in good repair.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 8/19/15 from 11:00 - 11:40 a.m. and 12:28 to 2:00 p.m. The Home Manager was present during both observations. During those times, the following was noted:</p> <ul style="list-style-type: none"> - There was an approximate 2-inch height difference between three sections of the driveway, resulting in uneven surface where the structures met. - The UV film on 1 of 3 living room windows had air bubbles throughout the entire window surface. - Individual #6's chest of drawers was missing a knob on 1 of 4 drawers. - The surface and finish on 1 of 2 wooden dining room tables was peeled and gouged. - There was a 12-inch tear in the upholstery of the living room couch. <p>During the observation, the Home Manager and the Maintenance Manager were made aware of the issues.</p>	MM215	<p>→ all items added to maintenance list to be addressed and fix by 9/30/15 maintenance Responsible</p> <p>→ HM to complete month House check and weekly walk throughs w/ needed items added to maintenance list HM Responsible</p> <p>→ PD to review HM walk through,</p>	

and maintenance list each month and address needed items to the action list PD responsible by 9/30/15

- PD to give action list to responsible maintenance each month PD BY 29/30/15

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MM215	Continued From page 60 The facility failed to ensure the environmental repairs were completed and maintained.	MM215		
MM218	16.03.11711.01(c) Clean and Sanitary The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all surfaces were kept clean and sanitary for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment not being kept clean. The findings include: 1. An environmental review was conducted at the facility on 8/19/15 from 11:00 - 11:40 a.m. and from 12:28 to 2:00 p.m. The Home Supervisor was present. During that time, the plywood beneath the kitchen counter facing the dining area was observed to be discolored and had numerous dried food debris build-up and horizontal scuff marks. When asked, the Home Manager stated that the plywood surface needed to be cleaned. The facility failed to maintain all surfaces in the facility in clean and sanitary condition.	MM218	<i>refer to MM215</i>	
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		

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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	<p>Continued From page 61</p> <p>This Rule is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individual dietetic needs were met for 2 of 7 individuals (Individuals #2 and #5) residing at the facility. This resulted in individuals not being provided with appropriate dining equipment and food modifications. The findings include:</p> <p>1. Individual #5's 5/8/15 IPP documented he was a 22 year old male whose diagnoses included profound mental retardation and epilepsy.</p> <p>Individual #5's 5/1/15 Dietary Evaluation documented he had hand tremors which made it difficult for him to keep food on a spoon and the intensity of the tremors varied from day to day. At times he required assistance holding his cup due to tremors and he was much more independent with eating when he ate at a raised table (chest height) where his arms could be supported.</p> <p>During observations conducted on 8/18/15 from 3:03 - 3:48 p.m. and 4:43 - 6:40 p.m., and on 8/19/15 from 8:12 - 9:15 a.m., Individual #5 was eating at the kitchen counter that separated the dining area from the kitchen. When Individual #5 was seated, the height of the counter was approximately at the top of his ribcage.</p> <p>On 8/18/15 at 6:25 p.m., DCS A assisted him to dine by holding his plate off the counter and under his chin.</p> <p>During an interview on 8/26/15 from 1:58 to 3:40 p.m., the Treatment Coordinator stated no efforts had been made to equip the dining table to meet Individual #5's needs. The QIDP, who was present during the interview, stated staff do not need to hold Individual #5's plate. The QIDP</p>	MM366	<p><i>Refer to W111 W460 W484</i></p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642
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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	<p>Continued From page 62</p> <p>stated at the day program, Individual #5 had a raised table, which allowed him to eat independently.</p> <p>The facility failed to ensure Individual #5's dining table was equipped with the use of adaptive equipment designed to meet his dining needs.</p> <p>2. Individual #2's 1/2/15 IPP documented he was a 24 year old male whose diagnoses included profound mental retardation. His IPP also stated he received a Dysphagia 2 mechanically altered diet with nectar thick liquids.</p> <p>Individual #2's 7/29/15 Physician's Orders stated his diet was Dysphagia 2 mechanical altered, nectar thick liquids, and dry bread moistened with liquid.</p> <p>When asked during an interview on 8/20/15 at 1:32 p.m., the facility's RD stated Individual #2's Dysphagia Level 2 solid food consistency should be between mechanically soft and pureed in texture.</p> <p>However, during observations on 8/18/15 from 4:43 - 6:40 p.m. and 8/19/15 from 8:12 - 10:35 a.m., staff were observed preparing, and Individual #2 was observed eating pureed foods.</p> <p>During follow-up interviews on 8/24/14 from 1:49 - 3:35 p.m. and on 8/25/15 from 12:50 - 1:20 p.m., 6 of 7 DCS stated Individual #2's food consistency was pureed.</p> <p>The facility failed to ensure Individual #2 was provided a modified diet as prescribed by the physician.</p>	MM366		