



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

October 2, 2015

Valentina Reudter, Administrator
Belmont Care Center
4806 Hawthorne Road
Chubbuck, ID 83202

RE: Belmont Care Center, Provider #13G046

Dear Ms. Reudter:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center, which was conducted on September 24, 2015.

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

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

Valentina Reudter, Administrator
October 2, 2015
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **October 14, 2015**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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

This request must be received by October 14, 2015. If a request for informal dispute resolution is received after October 14, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,


JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures



4806 Hawthorne Rd, Chubbuck, Idaho 83202 | Office – 208-238-5950 | Fax 208-238-5860

October 14, 2015

Jim Troutfetter
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

RECEIVED

OCT 14 2015

FACILITY STANDARDS

Dear Mr. Troutfetter

I would like to thank you and Ms. Karen Marshall for your patience during our carpet construction during our re-certification survey at Belmont Care Center – Provider # 13G046. There was so much going on that week, but once again you both made my team and our residents feel that you were here to teach us how to do our job better not to reprimand us. Again, thank you.

Please see the following plan of correction to the deficiencies found during our survey.

W125

1. Written Informed Consent has been gained from Individuals #1 and #4 and from HRC.
2. All individuals residing in the home currently have Written Informed Consents for restrictive components to programming.
3. Aspire Human Services has recently implemented chart reviews for all the homes. One part of the chart reviews includes verifying current consents are maintained.
4. Aspire Human Services in Pocatello is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Program Manager
6. Completion Date: November 20, 2015

W159

1. Incident/ Accident reports have been reviewed by the QIDP for Individuals #1-6 and #8-14 and signatures have been obtained as of October 1st, 2015.
2. All Incident/ Accident reports have been reviewed by the QIDP for all the individuals in the home and signatures have been obtained.
3. Aspire Human Services has recently implemented chart reviews for all the homes. One part of the chart reviews includes verifying all signatures have been obtained on the Incident/ Accident reports.
4. Aspire Human Services in Pocatello is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Program Manager
6. Completion Date: November 6, 2015

W239

1. Behavioral assessment has been updated to include replacement behaviors and the revised program has been implemented as of October 1, 2015.
2. All individual's behavioral assessments will be reviewed to ensure replacement behaviors are identified and implemented into programming.
3. Aspire Human Services has recently implemented chart reviews for all the homes. One part of the chart review is to verify behavioral programming included replacement behaviors.
4. Aspire Human Services in Pocatello is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Program Manager
6. Completion Date: November 20, 2015

W481

1. The food actually served log has been revised from a 4 page document to a single page document to consolidate paper and track persons responsible. Sheet is labeled food production sheet. This affects 15 out of 15 individuals in the home.
2. The food production sheet will be kept in the kitchen for the current week to ensure the food being prepared is the food being served. This affects 15 out of 15 individuals in the home.
3. The food production sheets will be completed during each meal preparation time. The documentation will be kept in the kitchen where it is accessible to individuals preparing meals.
4. The food production sheets will be gathered weekly and reviewed by the dietary manager to ensure accurate data and coordinate the correction of identified errors.

5. Person Responsible: Dietary Manager, Registered Dietician
6. Completion Date: November 6, 2015

MM134

Please see response to W125

MM155

Please see response to W159

MM159

Please see response to W239

MM181

1. Garbage and rubbish was cleared from the facility grounds by October 1, 2015.
2. The facility grounds will be maintained clear of garbage, rubbish and weeds.
3. Aspire Human Services in Pocatello currently has a monthly checklist which is completed by the home supervisor or lead worker. The checklist will include ensuring the grounds are maintained free of garbage, rubbish and weeds.
4. Each month the after the Program Supervisor or lead worker has completed their monthly checklist, the documentation will be turned into the Program Manager for verification that the inspection has occurred.
5. Person Responsible: Program Supervisor, Program Manager
6. Completion Date: November 6, 2015

MM215

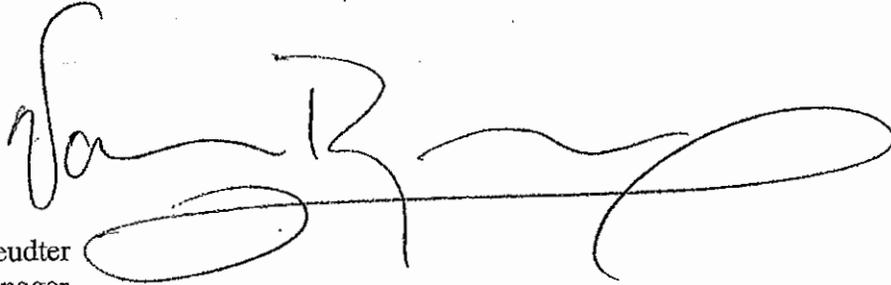
1. The vent cover for the air conditioner vent was replaced, toilet bolt covers were replaced, the light fixture in the phone room was replaced, the light fixture was replaced to the left of the phone room, and fridges were cleared of debris. Bids have been obtained for the new kitchen cabinets as well as the replacement stove.
2. Equipment used at the facility will be kept in good repair.
3. Aspire Human Services in Pocatello currently has a monthly checklist which is completed by the home supervisor or lead worker. The checklist will include ensuring all equipment is in good repair.
4. Each month the after the Program Supervisor or lead worker has completed their monthly checklist, the documentation will be turned into the Program Manager for verification that the inspection has occurred. The Program Manager will coordinate the correction of identified problems with equipment.
5. Person Responsible: Program Supervisor, Program Manager
6. Completion Date: November 6, 2015

MM366

Please see response to W481.

Please contact me if you have any questions regarding this Plan of Correction.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valentina Reudter', written in a cursive style. The signature is positioned to the right of the word 'Sincerely,' and above the printed name and contact information.

Valentina Reudter
Program Manager
Aspire Human Services
3625 Vaughn Ave, Pocatello, Idaho 83201
O - 208-233-0016 ext #25 | C - 208-223-5863

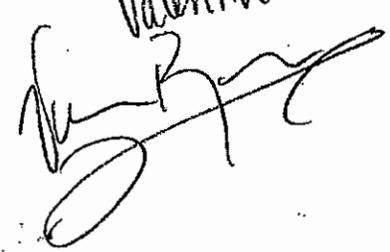
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

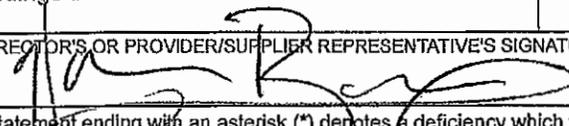
PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2015
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NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 9/21/15 to 9/24/15.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>BMP - Behavior Management Program DM - Dietary Manager HRC - Human Rights Committee IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional</p>	W 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">OCT 14 2015</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
W 125	<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 2 of 4 individuals (Individuals #1 and #4) 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>	W 125	<p>Please see attached letter for correction to deficiencies.</p> <p><i>Valentina Revdun</i></p> 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Manager	(X8) DATE 10/14/15
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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 125	Continued From page 1 1. During an observation on 9/21/15, from 3:15 - 4:49 p.m., the closet containing cleaning equipment and chemicals, the closet containing knives, and the snack room were noted to be locked. Individual #1 and Individual #4's records were reviewed. The records did not include consent or information related to the locked chemicals, knives or snack room. During an interview on 10/1/15 at 10:49 a.m., the Program Coordinator stated the chemicals and knives were locked because of the behaviors of the majority of the residents and Individuals #1 and #4 did not have maladaptive behaviors that would require the closets to be locked. During an additional follow up interview 10/1/15 at 11:52 a.m., the City Director stated the snack room was locked to prevent other individuals from taking snacks that did not belong to them.	W 125		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the	W 159		

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W 159	<p>Continued From page 2</p> <p>QIDP provided sufficient monitoring and oversight which impacted 14 of 15 individuals (Individuals #1 - #6 and Individuals #8 - #14) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:</p> <p>During an interview on 10/1/15 at 11:52 a.m., the City Director stated it was the facility's expectation that the QIDP reviewed all Incident/Accident reports was within five days.</p> <p>However, the facility's Incident/Accident reports, dated 3/12/15 - 9/11/15, did not include documentation that the QIDP had reviewed the Incident/Accident reports in a timely manner. Examples included, but were not limited to, the following:</p> <p>1. Individual #1's IPP, dated 5/6/15, documented a 34 year old male whose diagnoses included mild intellectual disability.</p> <p>- An Incident/Accident report, dated 8/7/15, did not contain evidence the QIDP had reviewed it.</p> <p>2. Individual #2's IPP, dated 1/14/15, documented a 44 year old male whose diagnoses included mild intellectual disability.</p> <p>- An Incident/Accident report, dated 7/22/15, did not contain evidence the QIDP had reviewed it.</p> <p>- An Incident/Accident report, dated 8/14/15, did not contain evidence the QIDP had reviewed it.</p> <p>3. Individual #3's IPP, dated 9/14/15, documented a 19 year old male whose diagnoses included mild intellectual disability.</p>	W 159			

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W 159	Continued From page 3 - An Incident/Accident report, dated 7/24/15, did not contain evidence the QIDP had reviewed it. - An Incident/Accident report, dated 8/2/15, did not contain evidence the QIDP had reviewed it. 4. Individual #4's IPP, dated 9/1/15, documented a 21 year old male whose diagnoses included mild intellectual disability. - An Incident/Accident report, dated 7/21/15, did not contain evidence the QIDP had reviewed it. 5. Individual #5's IPP, dated 12/17/15, documented a 22 year old male whose diagnoses included mild intellectual disability. - An Incident/Accident report, dated 7/23/15, did not contain evidence the QIDP had reviewed it. 6. Individual #6's IPP, dated 2/11/15, documented a 69 year old male whose diagnoses included mild intellectual disability. - An Incident/Accident report, dated 9/11/15, did not contain evidence the QIDP had reviewed it. 7. Individual #8's IPP, dated 4/8/15, documented a 28 year old male whose diagnoses included mild intellectual disability. - An Incident/Accident report, dated 7/8/15, did not contain evidence the QIDP had reviewed it. - An Incident/Accident report, dated 8/6/15, did not contain evidence the QIDP had reviewed it. 8. Individual #9's IPP, dated 2/4/15, documented	W 159			

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W 159	<p>Continued From page 4</p> <p>a 32 year old male whose diagnoses included mild intellectual disability.</p> <p>- An Incident/Accident report, dated 2/24/15, did not contain evidence the QIDP had reviewed it.</p> <p>- An Incident/Accident report, dated 4/19/15, was not signed by the QIDP until 7/7/15.</p> <p>- An Incident/Accident report, dated 5/6/15, was not signed by the QIDP until 7/7/15.</p> <p>9. Individual #10's IPP, dated 4/22/15, documented a 20 year old male whose diagnoses included mild intellectual disability.</p> <p>- An Incident/Accident report, dated 8/22/15, did not contain evidence the QIDP had reviewed it.</p> <p>10. Individual #11's IPP, dated 11/19/14, documented a 38 year old male whose diagnoses included mild intellectual disability.</p> <p>- An Incident/Accident report, dated 8/1/15, did not contain evidence the QIDP had reviewed it.</p> <p>- An Incident/Accident report, dated 8/16/15, did not contain evidence the QIDP had reviewed it.</p> <p>11. Individual #12's IPP, dated 5/11/15, documented a 21 year old male whose diagnoses included mild intellectual disability.</p> <p>- An Incident/Accident report, dated 7/28/15, did not contain evidence the QIDP had reviewed it.</p> <p>12. Individual #13's IPP, dated 2/25/15, documented a 32 year old male whose diagnoses included mild intellectual disability.</p>	W 159		

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W 159	Continued From page 5 - An Incident/Accident report, dated 7/21/15, did not contain evidence the QIDP had reviewed it. - An Incident/Accident report, dated 7/22/15, did not contain evidence the QIDP had reviewed it. - An Incident/Accident report, dated 8/14/15, did not contain evidence the QIDP had reviewed it. 13. Individual #14's IPP, dated 12/17/14, documented a 25 year old male whose diagnoses included mild intellectual disability. - An Incident/Accident report, dated 4/25/15, was not signed by the QIDP until 7/7/15. - An Incident/Accident report, dated 8/17/15, did not contain evidence the QIDP had reviewed it. 14. Individual #15's IPP, dated 7/15/15, documented a 31 year old male whose diagnoses included mild intellectual disability. - An Incident/Accident report, dated 3/12/15, did not contain evidence the QIDP had reviewed it. - An Incident/Accident report, dated 3/14/15, did not contain evidence the QIDP had reviewed it. During an interview on 9/24/15 from 10:35 - 11:08 a.m., the Program Coordinator stated there was a communication issue during a transition that caused an oversight. The facility failed to ensure the QIDP reviewed Incident/Accident reports in a timely manner.	W 159		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN	W 239		

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W 239	<p>Continued From page 6</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.</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 replacement behavior training was appropriate to address an individual's maladaptive behavior for 1 of 4 individuals (Individual #1) whose behavior assessments were reviewed. This resulted in an individual not receiving functional training to replace his maladaptive behavior. The findings include:</p> <p>1. Individual #1's IPP, dated 5/6/15, documented a 34 year old male whose diagnoses included mild intellectual disability.</p> <p>Individual #1's record contained a Behavior Assessment, dated 5/19/15, that did not document a replacement behavior for uncooperative behavior. During an interview on 9/24/15 from 10:35 - 11:08 a.m., the Program Coordinator stated the replacement behavior was on his BMP.</p> <p>However, the Appropriate Replacement Behaviors section of his BMP, dated 4/1/15, stated "... teaching him appropriate alternative behaviors for his negative uncooperative behavior." His BMP did not indicate what the appropriate replacement behavior was.</p>	W 239			

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W 239	Continued From page 7	W 239			
W 481	<p>When asked on 9/24/15 from 10:35 - 11:08 a.m., the Program Coordinator acknowledged there was no specific replacement behavior.</p> <p>The facility failed to ensure Individual #1's BMP included a replacement behavior for uncooperative behavior.</p> <p>483.480(c)(2) MENUS</p> <p>Menus for food actually served must be kept on file for 30 days.</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 a record of food served was kept for 30 days, which impacted 15 of 15 individuals (Individuals #1 - #15) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:</p> <p>1. An observation was conducted at the facility on 9/21/15 from 5:05 to 6:30 p.m. During that time, individuals were observed to eat the evening meal. The dinner menu consisted of beef enchiladas, cornbread, refried beans, peach slices, peas and carrots, salsa, and sour cream.</p> <p>However, the refried beans, peas and carrots, salsa, and sour cream were not served during the dinner meal.</p> <p>2. An observation was conducted at the facility on 9/22/15 from 6:55 - 8:50 a.m. During that time, individuals were observed to eat the breakfast meal. The breakfast menu consisted of grape</p>	W 481			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2015
NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204		
(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 481	<p>Continued From page 8 juice, cornflakes, milk, whole wheat pancakes, sausage links, margarine, and syrup.</p> <p>However, the grape juice was not served during the breakfast meal.</p> <p>When asked during an interview on 9/22/15 at 10:20 a.m., the DM stated the refried beans, peas and carrots, salsa, and sour cream were not served during the 9/21/15 dinner meal and the grape juice was not served during the 9/22/15 breakfast meal. The DM also stated the foods should have been served as the food items were available in the kitchen.</p> <p>The actual food served forms were reviewed. None of the forms documented the foods served for the 9/21/15 dinner or the 9/22/15 breakfast meals.</p> <p>When asked during a follow-up interview on 9/24/15 at 12:05 p.m., the DM stated the actual foods served forms should have been completed to reflect what foods were served for the above identified meals.</p> <p>The facility failed to ensure accurate documentation of food actually served was kept.</p>	W 481			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
BELMONT CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
**3625 VAUGHN AVENUE
POCATELLO, ID 83204**

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 9/21/15 - 9/24/15. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000	<p>RECEIVED</p> <p>OCT 14 2015</p> <p>FACILITY STANDARDS</p> <p><i>Please see attached response for correction to deficiencies.</i></p>	
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W125.	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: Refer to W159.	MM155		
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these	MM159		

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

[Signature]
TITLE **Program Manager**

(X6) DATE
10/14/15

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MM159	Continued From page 1 rules. This Rule is not met as evidenced by: Refer to W239.	MM159		
MM181	16.03.11702.05(a) Free From Weeds, Trash, and Rubbish The premises and all buildings must be kept free from accumulation of weeds, trash, and rubbish; This Rule is not met as evidenced by: Base on observation, it was determined the facility failed to ensure the facility's grounds were maintained free of trash for 15 of 15 individuals (Individuals #1 - #15) who resided at the facility. This resulted in the the facility's grounds being cluttered with cigarette butts and soda bottles. Findings include: 1. An environmental review was conducted at the facility on 9/22/15 from 11:30 - 11:55 a.m. During that time, the following was noted: - There were no less than 100 cigarette butts laying on the grounds from the lower level break area, along the sidewalk leading to the upper level break area, and adjacent to the upper break area and west end of the building. - Directly adjacent to the upper level break area concrete pad, there were no less than 50 round clay colored objects approximately 1/2 inch in diameter scattered on the ground which were identified as part of a water purification system for a pet lizard. - There were no less than 4 empty used soda bottles/cans on the ground by the lower break	MM181		

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MM181	Continued From page 2 area. The facility failed to ensure the facility's grounds were free of trash.	MM181		
MM215	16.03.11711.01 Good Repair Each building used by the ICF/ID and its equipment must be in good repair. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 15 of 15 individuals (Individuals #1 - #15) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 9/22/15 from 11:30 - 11:55 a.m. During that time, the following was noted: - The air conditioner vent cover was missing from the ceiling of the laundry room. - The toilet bolt covers were missing in upstairs bathrooms #1 and #2. - There was a missing ceiling light cover in the upstairs phone room. - The light on the wall to the left of the phone room was missing the cover. - The stainless steel kitchen stove had black/brown buildup on the left front of the stove where the knobs were located. The buildup measured 7 inches long and 2-3 inches wide.	MM215		

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MM215	<p>Continued From page 3</p> <ul style="list-style-type: none"> - Both the oven doors of the kitchen stove had black/brown buildup on the insides. - The lower oven door of the kitchen stove did not close completely on the right side resulting in the oven light being on. On 9/21/15 at 4:30 p.m., Individual #4 pressed his knee against the right side of the door and the oven light went out. - There was a missing cupboard drawer to the right of the kitchen stove. - The inside of both refrigerators in the kitchen contained an accumulation of debris. <p>During review of the facility's kitchen with the DM on 9/22/15 from 10:20 - 11:20 a.m., the DM acknowledged the above identified areas were in need of cleaning/repair.</p> <p>The facility failed to ensure the environment was kept clean and repairs were completed and maintained.</p>	MM215		
MM366	<p>16.03.11800 Dietetic Services</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to W481.</p>	MM366		