



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

October 5, 2015

Steve Young, Administrator  
Yellowstone Group Home #1 Springfield  
560 West Sunnyside  
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

On September 30, 2015, a follow-up visit of your facility, Yellowstone Group Home #1 Springfield, was conducted to verify corrections of deficiencies noted during the survey of August 3, 2015.

We were able to determine that the Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Client Protections (42 CFR 483.420)**, **Active Treatment Services (42 CFR 483.440)** and **Client Behavior and Facility Practices (42 CFR 483.450)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed, along with a full ICF/ID license. This license is effective September 30, 2015 through December 31, 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;

Steve Young, Administrator  
October 5, 2015  
Page 2 of 3

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 date 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 15, 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](http://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 15, 2015. If a request for informal dispute resolution is received after October 15, 2015 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Steve Young, Administrator  
October 5, 2015  
Page 3 of 3

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please feel free to call us at (208) 334-6626, option 4.

Sincerely,



ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pmt  
Enclosures



RECEIVED

OCT 16 2015

FACILITY STANDARDS

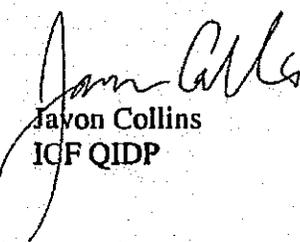
10/13/15

Ashley Henscheid, Health Facility Surveyor  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
PO Box 83720  
Boise, ID 83720

Dear Ashley Henscheid:

This is the Plan of Correction for the survey concluded at Aspire Human Services #1 Springfield Home, on September 28-30<sup>th</sup>, 2015. I would like to take the opportunity to thank you and Michael Case for the helpful information you always share. The survey process is always a learning experience, and you certainly made it helpful as well as pleasant. Thanks so much.

Please see the attached Plan of Correction for specific details on the actions taken by the facility to achieve compliance. If you have any further questions, please feel free to contact Javon Collins at 208-523-9839 ext. 12.

  
Javon Collins  
ICF QIDP

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

PRINTED: 10/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/30/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD IDAHO FALLS, ID 83404</b>		
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{W 000}	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the follow-up survey conducted from 9/28/15 to 9/30/15.</p> <p>The surveyors conducting your survey were:</p> <p>Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADHD - Attention Deficit Hyperactivity Disorder CFA - Comprehensive Functional Assessment DCS - Direct Care Staff FDA - Food and Drug Administration HRC - Human Rights Committee IPP - Individual Program Plan MAR - Medication Administration Record OCD - Obsessive Compulsive Disorder PECS - Picture Exchange Communication System QAM - Every morning QIDP - Qualified Intellectual Disability Professional</p>	{W 000}	<p><b>RECEIVED</b> <b>OCT 15 2015</b> <b>FACILITY STANDARDS</b></p>	
{W 111}	<p><b>483.410(c)(1) CLIENT RECORDS</b></p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate information for 1 of 3 individuals (Individual #3)</p>	{W 111}		

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

TITLE

(X6) DATE

*Jan Call*

**QIDP**

**10/14/15**

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

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{W 111}	<p>Continued From page 1</p> <p>whose records were reviewed. This resulted in a lack of accurate information being available regarding the individuals' experiences at the facility. The findings include:</p> <p>1. Individual #3's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound mental retardation. Individual #3's record did not include accurate information, as follows:</p> <p>a. Individual #3's Psychological Evaluation, dated 8/24/15, documented Individual #3's diagnoses included down syndrome, profound intellectual disability and major depressive disorder.</p> <p>However, Appendix A of Individual #3's record, undated, documented his diagnoses included down syndrome with profound intellectual disability, obsessive compulsive traits in the setting of down syndrome and disruptive behavior disorder.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Clinical Director stated the facility had just recently received the printed notes from the psychological appointment and Appendix A needed updated to match the diagnoses.</p> <p>b. Individual #3's record contained a Written Informed Consent, dated 9/17/15. The consent documented "Need: Prozac [an antidepressant drug] 40mg QAM."</p> <p>However, the Description and Justification for Plan of Treatment section documented information related to Paxil (an antidepressant drug).</p>	{W 111}			

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{W 111}	Continued From page 2 During an interview on 9/30/15 from 9:02 - 10:32 a.m., the QIDP stated the guardian and HRC were provided with separate, comprehensive information from the FDA related to Prozac. The QIDP stated the consent documentation was inaccurate in reference to Paxil.  The facility failed to ensure Individual #3's record contained accurate information.	{W 111}			
{W 124}	Repeat deficiency. 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 and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a guardian was provided with comprehensive information necessary to make informed decisions for 1 of 3 individuals (Individual #3) whose consents were reviewed. This resulted in insufficient information being provided to a guardian on which to base consent decisions. The findings include:  1. Individual #3's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound mental retardation.	{W 124}			

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{W 124}	<p>Continued From page 3</p> <p>Individual #3's record contained a consent for Therapeutic Options Supportive Restraints, dated 8/21/15, which documented Individual #3's "rights will be restricted with the use of a formal behavior management program, including the use of Therapeutic Options supportive restraints which consist of a block and restraints up to arm control to prevent him from hurting himself, staff, and/or property."</p> <p>The consent documented under the Risks vs. Benefits of the Plan of Treatment section, Individual #3's "rights are restricted with the use of a formal behavior management program, including the use of Therapeutic Options supportive restraints which consist of a block and restraints up to supportive escort prevent [sic] him from hurting himself, staff, and/or property. Though Staff [sic] at the homes have been properly trained to perform these restraints, there is always the risk of injury when performing them."</p> <p>The consent did not specify which of Individual #3's Behavior Intervention Plans (i.e. socially offensive, aggression, depressive symptoms, self-injurious behavior or property destruction) the consent was for. Further, the consents did not specify the situations in which physical restraint would be required.</p> <p>Individual #3's Behavior Intervention Plans, each dated 8/21/15, were reviewed. The plan for property destruction documented "When [Individual #3] demonstrates destructive behavior that presents with a serious risk of injury or serious damage, staff may use Body Control restraint to contain his unsafe destructive behavior. Staff may also direct [Individual #3] to</p>	{W 124}		

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{W 124}	<p>Continued From page 4</p> <p>use one of his coping skills at this time. If [Individual #3] continues to demonstrate destructive behavior that is not safety [sic] contained with Body Control restraint, staff my [sic] chose [sic] to use Arm Control restraint. If [Individual #3's] behavior remains unsafe, staff may use an additional person to support. The second person supporting the Arm control restrain [sic] will utilize the Body Control restraint."</p> <p>Individual #3's Behavior Intervention Plan for aggression also included instructions to staff regarding the use of a two-person restraint (one person utilizing Body Control, the second person utilizing Arm Control) when needed.</p> <p>However, information related to a two-person restraint was not included in the Written Informed Consent.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m. with the Positive Behavior Support Coordinator, QIDP and Clinical Director, the Positive Behavior Support Coordinator stated an Arm Control restraint was the most restrictive physical restraint Therapeutic Options used. The Positive Behavior Support Specialist stated the use of a Body Control would technically be covered in the consent with "...including the use of Therapeutic Options supportive restraints which consist of a block and restraints up to arm control."</p> <p>When asked if the guardian was fully informed of how and when the physical restraints were used, during the same interview, the Clinical Director stated guardians were not provided with details of Therapeutic Options restraints, such as pictures of the restraints or the order of restraints from</p>	{W 124}		

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{W 124}	Continued From page 5 least to most restrictive. The QIDP stated the information in the consent was all that was provided to the guardian.  The facility failed to ensure informed guardian consent was obtained for Individual #3's physical restraint use.	{W 124}		
{W 149}	Repeat deficiency. 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 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 developed. This failure had the potential to impact all individuals residing in the facility (Individuals #1 - #6). This failure resulted in the potential for incidents to not be immediately reported to the Administrator. The findings include:  1. The facility's Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source policy, revised 9/23/15, was reviewed. The policy stated "All Employees [sic] must notify the Administrator or the Administrator Designee immediately Monday through Friday 8am - 5 pm [sic], during evening or weekend hour's [sic] staff will immediately notify the Administrator on Duty, for the following circumstances:	{W 149}		

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{W 149}	<p>Continued From page 6</p> <p>(1) Actual or suspected Sexual [sic], physical, or verbal abuse (see 'Signs and Symptoms of Abuse' section of this policy)</p> <p>(2) Death</p> <p>(3) Serious physical injury or illness that jeopardizes a residents [sic] life, health or safety</p> <p>(4) Any incident which requires outside treatment such as hospitalization</p> <p>(5) Any unknown injury of suspicious nature</p> <p>(6) Any individual to individual physical altercation, regardless of whether or not there is notable injury</p> <p>(7) Any individual to individual incidents of abuse, neglect, or mistreatment as defined above in Definitions. [sic]</p> <p>(8) Any individual self-injurious behavior as defined above, this does not include self-stimulatory behavior</p> <p>(9) Any incident of individual suicide ideation."</p> <p>However, the policy did not instruct employees to report all types of abuse, neglect or mistreatment (e.g. staff neglect, financial exploitation, misuse of restraints, etc.) to the evening and weekend Administrator on Duty.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Clinical Director stated staff were trained to report all allegations of abuse, neglect and mistreatment to the Administrator on Duty and the policy would be revised.</p> <p>The facility failed to ensure the policy for abuse, neglect and mistreatment was sufficiently developed.</p> <p>Repeat deficiency.</p>	{W 149}		
{W 212}	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN	{W 212}		

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{W 212}	<p>Continued From page 7</p> <p>The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.</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 that evaluation data was available to support the diagnoses for 1 of 3 individuals (Individual #1) whose assessments were reviewed. This resulted in the potential for an individual to receive unnecessary interventions based on inaccurate diagnoses. The findings include:</p> <p>1. Individual #1's IPP, revised 8/27/15, stated he was a 28 year old male whose diagnoses included mild intellectual disability, schizoaffective disorder, bipolar disorder, ADHD, and OCD.</p> <p>Individual #1's record included a psychiatric evaluation, dated 7/5/06, which included an Axis I diagnosis of "Obsessive Compulsive Traits." His Medication Reduction Plan, dated 9/1/15, stated he received Paxil (an antidepressant drug) for OCD symptoms, and his IPP included an objective to track OCD symptoms.</p> <p>However, Individual #1's psychiatric notes, dated 12/9/13, stated "Paxil restarted [due to increase] in depressive [signs and symptoms with increased] agitation, anxiety." Additionally, Individual #1's MAR documented he received Paxil at bedtime "for depression."</p> <p>With the exception of the 7/5/06 psychiatric evaluation, Individual #1's record did not include</p>	{W 212}		

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{W 212}	Continued From page 8 information to support the diagnosis of OCD.  During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Positive Behavior Support Coordinator stated he utilized the diagnosis that was on the IPP, but did not know if there was supporting documentation related to the diagnosis of OCD. The Positive Behavior Support Coordinator stated Individual #1 did not exhibit signs and symptoms of depression and stated Paxil was used for OCD symptoms. The Clinical Director, who was present during the interview, stated Individual #1's diagnoses needed to be clarified with the psychiatrist.  The facility failed to ensure comprehensive evaluation data was present to support the diagnosis of OCD for Individual #1.	{W 212}			
{W 214}	Repeat deficiency. 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 3 individuals (Individuals #2 and #3) whose assessments were reviewed. This resulted in a lack of behavioral and developmental information on which to base program intervention decisions. The findings include:	{W 214}			

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{W 214}	<p>Continued From page 9</p> <p>1. Individual #2's 1/15/15 IPP stated he was a 39 year old male whose diagnoses included severe intellectual disability and autism.</p> <p>Individual #2's CFA, dated 8/26/15, was reviewed and contained multiple sections of tasks that were marked "refusal." Examples of areas marked "refusal" included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Money Management: 40 tasks</li> <li>- Community Integration: 71 tasks</li> <li>- Meal Planning: 52 tasks</li> </ul> <p>There was no additional information provided to explain how the task was assessed, if Individual #2 refused the do the task because he was unable to complete the task or simply did not want to, how many times the assessment was attempted, etc. During the recertification survey dated 8/3/15, the facility had been cited for marking sections of the CFA as "non-applicable" and providing no additional assessment information.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Clinical Director stated the assessment had been completed by a QIDP that was no longer employed by the facility. The Clinical Director stated marking tasks as "refusal" had been identified and addressed with the QIDP as it was believed he did not understand how the assessment was to be completed. The current QIDP, who was present during the interview, stated he was going back and redoing all the assessments, but had not made it through Individual #2's yet.</p> <p>The facility failed to ensure Individual #2's CFA</p>	{W 214}		

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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #1 SPRINGFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404		
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{W 214}	<p>Continued From page 10 included comprehensive information.</p> <p>2. Individual #3's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound mental retardation. Individual #3's assessments were reviewed, and did not include comprehensive information, as follows:</p> <p>a. Individual #3's CFA, dated 8/25/15, was reviewed and contained multiple sections of tasks that were marked "refusal." Examples of areas marked "refusal" included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Home Leisure: 14 tasks</li> <li>- Clothing Care: 15 tasks</li> <li>- Vocational/Retirement: 79 tasks</li> </ul> <p>There was no additional information provided to explain how the task was assessed, if Individual #3 refused the do the task because he was unable to complete the task or simply did not want to, how many times the assessment was attempted, etc.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Clinical Director stated the assessment had been completed by a QIDP that was no longer employed by the facility. The Clinical Director stated marking tasks as "refusal" had been identified and addressed with the QIDP as it was believed he did not understand how the assessment was to be completed. The current QIDP, who was present during the interview, stated he was going back and redoing all the assessments, but had not made it through Individual #3's yet.</p> <p>b. Individual #3's Functional Behavioral</p>	{W 214}		

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{W 214}	Continued From page 11 Assessment, revised 8/21/15, documented he engaged in self-injurious behavior. The assessment documented events that preceded the behavior, which included "going outside in yard."  However, during observations conducted at the facility on 9/28/15 and 9/29/15 for a cumulative 5 hours and 2 minutes, Individual #3 was noted to go outside in the yard multiple times without exhibiting self-injurious behavior.  During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Positive Behavior Support Coordinator stated Individual #3 would put dirt or grass in his eye as a sign of discomfort, but simply walking outside was not necessarily a preceding event. The Positive Behavior Support Coordinator stated the assessment would be revised.  The facility failed to ensure Individual #3's assessments included comprehensive information.	{W 214}			
{W 239}	Repeat deficiency. 483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN  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.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it	{W 239}			

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{W 239}	<p>Continued From page 12</p> <p>was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 1 of 3 individuals (Individual #3) whose behavior assessments were reviewed. This resulted in an individual not receiving functional training to replace his maladaptive behaviors. The findings include:</p> <p>1. Individual #3's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound mental retardation.</p> <p>Individual #3's Functional Behavioral Assessment, revised 8/21/15, documented he engaged in maladaptive behaviors including depressive symptoms, aggression, socially offensive behavior, self-injurious behavior and property destruction.</p> <p>The assessment stated Individual #3 engaged in aggression (defined as hitting, kicking, and/or pushing others) and property destruction (defined as grabbing others' eyeglasses, breaking others' eyeglasses, tipping objects over, pulling objects off walls or windows and/or ripping objects). The assessment documented Individual #3 engaged in both behaviors "To get attention from staff." The assessment documented Individual #3 had a skill deficit related to a "Lack of expressive and receptive communication skills."</p> <p>The assessment included a replacement behavior for both aggression and property destruction that stated Individual #3 would participate in a physical activity for at least 15 minutes, when provided with 3 options from staff.</p> <p>It was not clear how engaging in a physical</p>	{W 239}		

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{W 239}	Continued From page 13 activity was related to a lack of communication skills or gaining attention from staff.  During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Positive Behavior Support Coordinator stated the assessment would be revised.  The facility failed to ensure Individual #3's replacement behaviors were functionally related to his maladaptive behaviors.	{W 239}			
{W 289}	Repeat deficiency. 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 2 of 3 individuals (Individuals #1 and #3) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include:  1. Individual #3's IPP, dated 5/21/15, documented a 56 year old male whose diagnoses included profound mental retardation.	{W 289}			

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{W 289}	<p>Continued From page 14</p> <p>Individual #3's Functional Behavioral Assessment, revised 8/21/15, documented he engaged in maladaptive behaviors including depressive symptoms, aggression, socially offensive behavior, self-injurious behavior and property destruction. Individual #3's Behavior Intervention Plans for each assessed behavior, all dated 8/21/15, were reviewed. The plans did not include accurate, comprehensive instructions, as follows:</p> <p>a. Individual #3's Functional Behavioral Assessment stated Individual #3 engaged in property destruction, defined as grabbing others' eyeglasses, breaking others' eyeglasses, tipping objects over, pulling objects off walls or windows and/or ripping objects. The corresponding Behavior Intervention Plan documented "As soon as [Individual #3] begins to demonstrate property destruction behavior staff, [sic] will redirect him according to the type of property destruction behavior. To use his available sensory items (music, toys, ball, outside bench, banana chair), visual calendar, or other preferred leisure items."</p> <p>The plan documented if Individual #3 grabbed others' eyeglasses, staff were to block him. The plan also included if Individual #3 "demonstrates destructive behavior that presents with a serious risk of injury or serious damage, staff may use Body Control restraint to contain his unsafe destructive behavior."</p> <p>However, the plan did not include any instructions to staff for how to intervene if Individual #3 continued to engage in tipping objects over, pulling objects off walls or windows and/or ripping objects without a serious risk of injury or damage</p>	{W 289}		

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{W 289}	<p>Continued From page 15 if offering sensory or leisure items was ineffective.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Positive Behavior Support Coordinator confirmed the instructions were not present in the plan.</p> <p>b. Individual #3's Behavior Intervention Plan for depressive symptoms documented staff were to "Refer to his visual calendar or PECS for activities." The Behavior Intervention Plans for property destruction, socially offensive behavior and aggression each included similar instructions to staff regarding a visual calendar.</p> <p>However, during observations completed on 9/28/15 and 9/29/15 for a cumulative 5 hours and 2 minutes, Individual #3 was not observed to utilize a visual calendar.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the QIDP stated Individual #3 did not utilize a visual calendar and the programs needed revised.</p> <p>c. Individual #3's Behavior Intervention Plan for aggression documented Precursor Behaviors included socially offensive behavior and self-injurious behavior.</p> <p>However, the "Status" section of Individual #3's plan documented "Incidents of this behavior pattern are not preceded by precursor behaviors which is [sic] easily identifiable..."</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Positive Behavior Support Coordinator stated the information related to socially offensive behavior and self-injurious behavior needed</p>	{W 289}		

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{W 289}	<p>Continued From page 16 removed from the plan.</p> <p>The facility failed to ensure techniques to manage Individual #3's maladaptive behaviors were sufficiently incorporated into his behavior plans.</p> <p>2. Individual #1's IPP, revised 8/27/15, stated he was a 28 year old male whose diagnoses included mild intellectual disability, schizoaffective disorder, and bipolar disorder.</p> <p>Individual #1's record included three Behavior Intervention Plans, for schizoaffective symptoms, bipolar - mania, and OCD symptoms, each dated 8/27/15. The first two steps in the "Method" section of each plan stated staff were to redirect Individual #1 to "use his available sensory items" and then "engage in problem solving."</p> <p>However, Individual #1's record did not include assessment information related to sensory item needs or the effectiveness of problem solving.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Positive Behavior Support Coordinator stated he did not know what sensory items would be functional for Individual #1 as no sensory assessment had been completed. The Positive Behavior Support Coordinator stated problem solving as a intervention method had not been assessed for Individual #1 and the plans needed to be revised.</p> <p>The facility failed to ensure Individual #1's behavior plan included appropriate intervention techniques.</p> <p>Repeat deficiency.</p>	{W 289}		

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{W 312} {W 312}	<p>Continued From page 17</p> <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</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 behavior modifying drugs were used only as a comprehensive part of individuals' program plans that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 2 of 3 individuals (Individuals #1 and #2) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drug usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's IPP, revised 8/27/15, stated he was a 28 year old male whose diagnoses included mild intellectual disability, schizoaffective disorder, and bipolar disorder.</p> <p>His Medication Reduction Plan, dated 9/1/15, stated he received lithium (an antimanic drug) and Abilify (an antipsychotic drug) for bipolar disorder. The reduction criteria for both drugs stated they would be decreased or discontinued when Individual #1's objective for bipolar symptoms was met. However, the plan did not indicate which drug (lithium or Abilify) would be targeted for reduction first, or if both drugs would</p>	{W 312} {W 312}		

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{W 312}	<p>Continued From page 18 be reduced at the same time.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Clinical Director stated the plan needed to be revised, but they were waiting to address order of reduction with the psychiatrist.</p> <p>The facility failed to ensure Individual #1's lithium and Abilify were appropriately incorporated into a plan.</p> <p>2. Individual #2's 1/15/15 IPP stated he was a 39 year old male whose diagnoses included severe intellectual disability and autism.</p> <p>His Medication Reduction Plan, dated 8/31/15, stated he received Buspar (an antidepressant drug) and Risperdal (an antipsychotic drug) for aggression. The reduction criteria for both drugs stated they would be considered for reduction when incidents of aggression decreased to 45 or fewer per month for 3 consecutive months. However, the plan did not indicate which drug (Buspar or Risperdal) would be targeted for reduction first, or if both drugs would be reduced at the same time.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the Clinical Director stated the plan needed to be revised, but they were waiting to address order of reduction with the psychiatrist.</p> <p>The facility failed to ensure Individual #2's Buspar and Risperdal were appropriately incorporated into a plan.</p> <p>Repeat deficiency.</p>	{W 312}		
W 454	483.470(l)(1) INFECTION CONTROL	W 454		

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W 454	<p>Continued From page 19</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:</p> <p>1. Observations were conducted at the facility on 9/28/15 and 9/29/15 for 5 hours and 2 minutes. During those times, staff were not observed to practice appropriate infection control procedures. Examples included, but were not limited to, the following:</p> <p>a. During an observation on 9/28/15 from 2:35 - 4:00 p.m., the following was noted:</p> <p>At 3:10 p.m., DCS E began making macaroni salad for dinner. DCS E donned a pair of gloves, but was not noted to wash her hands first. After removing a pot from a cabinet, DCS E removed her right glove and obtained a box of pasta from the pantry. DCS E re-donned the same glove.</p> <p>After putting pasta and water in the pot, DCS E was observed to use her gloved hands to pull out a wooden cutting board, pick up a set of keys from the counter and hook them on her pants, then adjust her shirt over her pants. DCS E used her gloved hands to adjust her glasses no less</p>	W 454		

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W 454	<p>Continued From page 20 than three times during this process.</p> <p>At 3:20 p.m., DCS E placed raw carrots on the cutting board, washed the carrots, and began cutting the carrots on the wooden cutting board. DCS E was wearing the same gloves.</p> <p>At 3:35 p.m., DCS E was observed to adjust her glasses twice with her gloved hands and continue cutting carrots. At approximately 3:37 p.m., DCS E removed her left glove, picked up carrot pieces from the ground with her right gloved hand, and threw the carrot pieces and both gloves away. DCS E then picked up a cloth dishrag from the sink, wrung it out and wiped the wooden cutting board. She then washed the knife with the same cloth and set the dishrag back in the bottom of the sink.</p> <p>DCS E obtained celery from the fridge, placed it on the wooden cutting board and began separating the stalks with her bare hands. She then stopped, obtained and donned gloves, then began cutting the celery on the wooden cutting board. DCS E was not observed to wash her hands or the celery.</p> <p>After cutting the celery, DCS E used her gloved hand to remove pickles from a jar and cut them on the wooden cutting board. DCS E placed the celery and pickles in a bowl and removed her gloves. At 3:45, DCS E adjusted her bra straps, donned new gloves and began cutting more pickles. She was not observed to wash her hands.</p> <p>At 3:50 p.m., DCS E removed her gloves, obtained the cloth dishrag from the sink and wiped the wooden cutting board, placed the</p>	W 454		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/30/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD</b> <b>IDAHO FALLS, ID 83404</b>		
(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 454	<p>Continued From page 21</p> <p>dishrag back in the sink, then washed her hands and the knife. DCS E obtained a bag of shredded cheese, stuck her bare hand in the bag, stopped, donned gloves, then measured cheese into the bowl with the celery and pickles. She then obtained an onion, cut it on the wooden cutting board and placed the onion in the bowl with the other items. The observation ended at 4:00 p.m.</p> <p>During the 40 minute period, DCS E was only observed to wash her hands one time while preparing the raw vegetables for the macaroni salad. Additionally, DCS E was observed to use a wooden cutting board which she repeatedly wiped with a cloth dishrag that had been sitting in the bottom of the sink.</p> <p>b. During an observation on 9/29/15 from 8:18 - 9:00 a.m., the following was observed:</p> <p>At 8:30 a.m., DCS A was observed assisting Individual #2 prepare breakfast. Individual #2 coughed and DCS A removed her left glove to assist Individual #2 to cover his mouth. DCS A replaced her left glove with a new glove, but was not observed to wash her hand. She then assisted Individual #2 to butter his toast.</p> <p>DCS A cracked an egg into a pan, removed her gloves and threw them away with the egg shell, then donned a new pair of gloves. DCS A was not observed to wash her hands. DCS A provided hand over hand assistance to Individual #2 to cook the egg, wiped her nose with her gloved hand, then placed the cooked egg on a plate.</p> <p>At 8:35 a.m., DCS A removed her gloves and assisted Individual #2 to carry his items to the table. DCS A sat with Individual #2 and assisted</p>	W 454		

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

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NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD</b> <b>IDAHO FALLS, ID 83404</b>		
(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 454	<p>Continued From page 22</p> <p>him to cut his food and wipe his mouth. DCS A was not observed to wash her hands.</p> <p>DCS A was not observed to engage in proper hand washing practices.</p> <p>On 9/28/15 and 9/29/15, 6 DCS were interviewed about infection control procedures. All 6 DCS stated gloves were to be worn with cooking and when in contact with bodily fluids. However, only 2 of the 6 staff indicated hand washing should occur before and after glove use.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the City Director and Clinical Director both stated staff should be washing their hands between glove changes and should not be using wooden cutting boards.</p>	W 454		
W 474	<p>483.480(b)(2)(iii) MEAL SERVICES</p> <p>Food must be served in a form consistent with the developmental level of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure individuals received food in a form consistent with their developmental level for 1 of 3 individuals (Individual #6) who were observed to receive a modified diet texture. This resulted in an individual's food items being blended together. The findings include:</p> <p>1. Meal observations were conducted on 9/28/15</p>	W 474		

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NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD</b> <b>IDAHO FALLS, ID 83404</b>		
(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 474	<p>Continued From page 23 and 9/29/15. During those times, the following was observed:</p> <p>a. During an observation on 9/28/15 from 4:55 - 5:40 p.m., the evening meal was observed. The meal consisted of barbequed chicken, macaroni salad, corn, carrots, and mixed melon. Staff were observed to take the chicken, macaroni salad, corn, and carrots and blend it all together. The blended mixture was then placed in a high-sided plate and served to Individual #6.</p> <p>DCS G, who was present during the observation, stated if it seemed like the food items would go good together, they were blended together for Individual #6's pureed diet rather than pureeing each item separately.</p> <p>b. An observation was conducted on 9/29/15 from 6:15 - 7:15 a.m. During that time, DCS D was observed to assist Individual #6 prepare his breakfast. DCS D placed prepared instant oatmeal, prepared buttered toast, and a fried egg in a food processor and pureed the mixture. DCS D then placed the mixture in a high-sided plate and poured maple syrup over the top. DCS D then served the mixture to Individual #6.</p> <p>During an interview on 9/30/15 from 9:02 - 10:32 a.m., the City Director and Clinical Director both stated Individual #6 had the ability to determine which foods he wanted to eat, and in which order. The City Director and Clinical Director both stated Individual #6's food items should have been pureed and served to him as separate items, not blended together.</p> <p>The facility failed to ensure Individual #6's meals were served in a manner consistent with his</p>	W 474		

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NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD</b> <b>IDAHO FALLS, ID 83404</b>		
(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 474	Continued From page 24 developmental abilities.	W 474		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 09/30/2015
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NAME OF PROVIDER OR SUPPLIER  YELLOWSTONE GROUP HOME #1 SPRINGFIE	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	16.03.11 Initial Comments  The following deficiencies were cited during the follow-up survey conducted from 9/28/15 to 9/30/15.  The surveyors conducting your survey were:  Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP	{M 000}		
{MM080}	16.03.11100 Governing Body and Management  The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W111.	{MM080}	<p><b>RECEIVED</b></p> <p><b>OCT 15 2015</b></p> <p><b>FACILITY STANDARDS</b></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 W124 and W149.	{MM134}		
{MM159}	16.03.11400 Active Treatment Services  The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4),	{MM159}		

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

TITLE

(X6) DATE

*[Handwritten Signature]*

QIDP

10/14/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**YELLOWSTONE GROUP HOME #1 SPRINGFIE 3335 SPRINGFIELD IDAHO FALLS, ID 83404**

(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}	Continued From page 1  Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W212, W214 and W239.	{MM159}		
{MM162}	16.03.11500 Client Behavior and Facility Practices  The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W289 and W312.	{MM162}		
{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.  This Rule is not met as evidenced by: Refer to W454 and W474.	{MM366}		

RECEIVED

OCT 15 2015

FACILITY STANDARDS

W111

1.

1. Appendix A was revised for individual #3 to ensure that the diagnosis is reflected according to his psychological evaluation.
2. All individuals' Appendix A were reviewed and revised to ensure that the diagnoses reflected in appendix A reflects the diagnosis(es) identified within the psychological evaluation.
3. Individual #3 had information inserted explaining Paxil on his consent that was actually meant to be Prozac. Individual #3's written informed consent was revised to accurately reflect the information based on the individual's actual prescribed medication (Prozac).
4. All individuals' written informed consents were reviewed and revised, as necessary, for any informational inconsistencies.
5. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed, the Program Manager will coordinate the correction of any identified errors.
6. Person Responsible: Program Manager and QIDP
7. Completion Date: 11/1/15

W124

2.

1. A TO Information Guide was created for individual #3 to ensure that parents, guardians, and the HRC are adequately informed of the restraints and their least restrictive order. The information contained within the TO Information Guide will be presented to the guardian and HRC, and included with the written informed consent document when securing any signatures. Behavior Intervention Plans are discussed with guardians and included with the consents for Therapeutic Options when securing any required signatures; this is to provide clear information regarding which restrictive techniques are used, and how they are related to each targeted behavior.
2. For all individuals, TO Information Guides were included with all related consents to ensure that parents, guardians, and HRC are adequately informed of the restraints and their least restrictive order of implementation. Behavior Intervention Plans are also discussed with guardians and included with the consents for Therapeutic Options when securing any required signatures; this is to provide clear information regarding which restrictive techniques are used, and how they are related to each targeted behavior.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
4. Person Responsible: Program Manager and QIDP
5. Completion Date: 11/1/15

W149

3.

1. The facilities Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source Policy was reviewed and revised to inform employees to report any and all

situations of abuse, neglect, and mistreatment; which are comprehensively listed under the "Purpose" section.

2. Aspire Human Services Policy Committee will review policies when updates are necessary. After reviews are completed the Program Manager will coordinate the implementation of any new policies that are created or revised.
3. Person Responsible: Governing Body, Program Manager
4. Completion Date: 11/1/15

#### **W212**

4.

1. The Psychiatrist was contacted and an appointment set for individual #1 on 11/4/15 to clarify the most accurate diagnosis related to the individual's behavior. Following the appointment, the behavioral assessment for individual #1 will be revised, if necessary, to address the most current diagnosis.
2. All individuals' assessments and diagnoses will be reviewed and revised, as needed, to ensure that diagnoses are aligned with the behavior presented by the individual.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
4. Person Responsible: Program Manager and QIDP
5. Completion Date: 11/10/15

#### **W214**

5.

1. Individuals #2 and #3's CFA's are being revised to include comprehensive information. Sections that are N/A or Refusal will be revised and have comments to reflect why they are such. Individual #3's FBA will be revised to reflect accurate information related to the events that precede target behaviors, including the statement which previously stated simply "going outside".
2. All individuals' FBA's will be reviewed, and revised as needed, to ensure that any N/A's or Refusals are documented accurately and include comments to specify why such is the case.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
4. Person Responsible: Program Manager and QIDP
5. Completion Date: 11/1/15

#### **W239**

6.

1. Individuals #3's FBA is being revised to ensure the document accurately reflects the behavior-related skill deficits. Revisions to the FBA will ensure the functional relationship with related behavioral programming, as well as the alignment between individual #3's replacement behavior training programs and the FBA document.

2. All individuals' FBAs and related training programs are being reviewed, and revised if necessary; to ensure that replacement behaviors are functionally related to the targeted maladaptive behaviors.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. Staff trainings will take place to ensure that all staff are informed and are aware of the changes.
4. Person Responsible: Program Manager and QIDP
5. Completion Date: 11/10/15

**W289**

**7.**

1. Individuals #1 and #3's FBA/BIP will be revised to include specific staff instructions related to target behaviors and the associated intervention technique that should be used. Individuals #1 and #3's FBA/BIP will be reviewed, and revised to reflect the most current and accurate staff instructions, and to remove inaccurate and/or invalid information that is inconsistent with the FBA.
2. All individuals' FBA/BIPs will be reviewed, and revised if necessary, to include clear staff instructions related to behavior programming. All individuals' FBA/BIPs will be revised, if necessary, to ensure that any instructions are accurate and related only to the current programming that is aligned with the FBA; revisions will also ensure that inaccurate information is removed.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. Staff trainings will take place to ensure that all staff are informed and are aware of the changes.
4. Person Responsible: Program Manager and QIDP
5. Completion Date: 11/1/15

**W312**

**8.**

1. The Psychiatrist was contacted and an appointment set for individuals #1 and #2 on 11/4/15 for review and completion of the Med Reduction Plan; specifically, to assign which medications will be reduced first, upon meeting the identified criteria. Once completed, the Med Reduction Plan will reflect this information appropriately.
2. Medication reduction plans will be reviewed for all individuals. If necessary, an appointment will be set with the Psychiatrist for the review and completion of the Med Reduction Plan; specifically, this appointment will be used to assign which medications will be reduced first, upon meeting the identified criteria. Once completed, the Med Reduction Plans for all individuals will reflect this information appropriately.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
4. Person Responsible: Program Manager and QIDP

5. Completion Date: 11/10/15

**W454**

9.

1. Nursing will visit the home, for individuals 1-6, weekly during rounds and document infection control standards on their rounds observation forms. The program supervisor will complete active treatment observations bi-weekly and infection control will be assessed on the form.
2. Nursing will visit all homes weekly during rounds and document infection control standards on their rounds observation forms. The program supervisor will complete active treatment observations bi-weekly and infection control will be assessed on the form.
3. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. Staff trainings will take place to ensure that all staff are informed and are aware of the changes.
4. Person Responsible: Program Manager, QIDP, Program Supervisor, and Nursing
5. Completion Date: 11/1/15

**W474**

10.

1. We have scheduled (10/21/15) for the Registered Dietician to train in-service staff on how to prepare diets and foods correctly – specifically to address puree foods with individual #6. The dietician will begin making quarterly visits and observations to ensure standards are kept.
2. As needed, we will schedule for the Registered Dietician to train all in-service staff on how to prepare diets and foods correctly – specifically to address puree foods for all of the clients who have that in their dietary guidelines. The dietician will begin making quarterly visits and observations to ensure standards are kept.
3. Person Responsible: Program Manager, QIDP, Program Supervisor, and Nursing
4. Completion Date: 11/1/15

**MM080****1.**

1. Appendix A was revised for individual #3 to ensure that the diagnosis is reflected according to his psychological evaluation.
2. All individuals' Appendix A were reviewed and revised to ensure that the diagnoses reflected in appendix A reflects the diagnosis(es) identified within the psychological evaluation.
3. Individual #3 had information inserted explaining Paxil on his consent that was actually meant to be Prozac. Individual #3's written informed consent was revised to accurately reflect the information based on the individual's actual prescribed medication (Prozac).
4. All individuals' written informed consents were reviewed and revised, as necessary, for any informational inconsistencies.
5. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
6. Person Responsible: Program Manager and QIDP
7. Completion Date: 11/1/15

**MM134****2.**

1. A TO Information Guide was created for individual #3 to ensure that parents, guardians, and the HRC are adequately informed of the restraints and their least restrictive order. The information contained within the TO Information Guide will be presented to the guardian and HRC, and included with the written informed consent document when securing any signatures. Behavior Intervention Plans are discussed with guardians and included with the consents for Therapeutic Options when securing any required signatures; this is to provide clear information regarding which restrictive techniques are used, and how they are related to each targeted behavior.
2. For all individuals, TO Information Guides were included with all related consents to ensure that parents, guardians, and HRC are adequately informed of the restraints and their least restrictive order of implementation. Behavior Intervention Plans are also discussed with guardians and included with the consents for Therapeutic Options when securing any required signatures; this is to provide clear information regarding which restrictive techniques are used, and how they are related to each targeted behavior.
3. The facilities Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source Policy was reviewed and revised to inform employees to report any and all situations of abuse, neglect, and mistreatment; which are comprehensively listed under the "Purpose" section.
4. Aspire Human Services Policy Committee will review policies when updates are necessary. After reviews are completed the Program Manager will coordinate the implementation of any new policies that are created or revised.
5. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.

6. Person Responsible: Program Manager and QIDP
7. Completion Date: 11/1/15

### **MM159**

3.

1. The Psychiatrist was contacted and an appointment set for individual #1 on 11/4/15 to clarify the most accurate diagnosis related to the individual's behavior. Following the appointment, the behavioral assessment for individual #1 will be revised, if necessary, to address the most current diagnosis.
2. All individuals' assessments and diagnoses will be reviewed and revised, as needed, to ensure that diagnoses are aligned with the behavior presented by the individual.
3. Individuals #2 and #3's CFA's are being revised to include comprehensive information. Sections that are N/A or Refusal will be revised and have comments to reflect why they are such. Individual #3's FBA will be revised to reflect accurate information related to the events that precede target behaviors, including the statement which previously stated simply "going outside".
4. All individuals' FBA's will be reviewed, and revised as needed, to ensure that any N/A's or Refusals are documented accurately and include comments to specify why such is the case.
5. Individuals #3's FBA is being revised to ensure the document accurately reflects the behavior-related skill deficits. Revisions to the FBA will ensure the functional relationship with related behavioral programming, as well as the alignment between individual #3's replacement behavior training programs and the FBA document.
6. All individuals' FBAs and related training programs are being reviewed, and revised if necessary; to ensure that replacement behaviors are functionally related to the targeted maladaptive behaviors.
7. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. Staff trainings will take place to ensure that all staff are informed and are aware of the changes.
8. Person Responsible: Program Manager and QIDP
9. Completion Date: 11/10/15

### **MM162**

4.

1. Individuals #1 and #3's FBA/BIP will be revised to include specific staff instructions related to target behaviors and the associated intervention technique that should be used. Individuals #1 and #3's FBA/BIP will be reviewed, and revised to reflect the most current and accurate staff instructions, and to remove inaccurate and/or invalid information that is inconsistent with the FBA.
2. All individuals' FBA/BIPs will be reviewed, and revised if necessary, to include clear staff instructions related to behavior programming. All individuals' FBA/BIPs will be revised, if necessary, to ensure that any instructions are accurate and related only to the current programming that is aligned with the FBA; revisions will also ensure that inaccurate information is removed.

3. The Psychiatrist was contacted and an appointment set for individuals #1 and #2 on 11/4/15 for review and completion of the Med Reduction Plan; specifically, to assign which medications will be reduced first, upon meeting the identified criteria. Once completed, the Med Reduction Plan will reflect this information appropriately.
4. Medication reduction plans will be reviewed for all individuals. If necessary, an appointment will be set with the Psychiatrist for the review and completion of the Med Reduction Plan; specifically, this appointment will be used to assign which medications will be reduced first, upon meeting the identified criteria. Once completed, the Med Reduction Plans for all individuals will reflect this information appropriately.
5. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. Staff trainings will take place to ensure that all staff are informed and are aware of the changes.
6. Person Responsible: Program Manager and QIDP
7. Completion Date: 11/10/15

#### **MM366**

**5.**

1. Nursing will visit the home, for individuals 1-6, weekly during rounds and document infection control standards on their rounds observation forms. The program supervisor will complete active treatment observations bi-weekly and infection control will be assessed on the form.
2. Nursing will visit all homes weekly during rounds and document infection control standards on their rounds observation forms. The program supervisor will complete active treatment observations bi-weekly and infection control will be assessed on the form.
3. We are scheduling for the Registered Dietician to train in-service staff on how to prepare diets and foods correctly – specifically to address puree foods with individual #6. The dietician will begin making quarterly visits and observations to ensure standards are kept.
4. As needed, we will schedule for the Registered Dietician to train all in-service staff on how to prepare diets and foods correctly – specifically to address puree foods for all of the clients who have that in their dietary guidelines. The dietician will begin making quarterly visits and observations to ensure standards are kept.
5. Aspire Human Services in Idaho Falls has created a schedule for the completion of chart reviews. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors. Staff trainings will take place to ensure that all staff are informed and are aware of the changes.
6. Person Responsible: Program Manager, QIDP, Program Supervisor, and Nursing
7. Completion Date: 11/1/15