



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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Boise, Idaho 83720-0009
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October 15, 2015

Rex Redden, Administrator
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #1 Bellin, Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #1 Bellin, which was conducted on October 8, 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;

Rex Redden, Administrator
October 15, 2015
Page 2 of 2

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
6. Include dates when corrective action(s) will be completed. 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 28, 2015**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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

This request must be received by October 28, 2015. If a request for informal dispute resolution is received after October 28, 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

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

PRINTED: 10/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2015
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 1664 SOUTH BELLIN IDAHO FALLS, ID 83405
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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 10/5/15 to 10/8/15.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Trish O'Hara, RN</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 4 individuals (Individual #4) observed to take medications. This resulted in an individual's medication not being properly administered. The findings include:</p> <p>1. Individual #4's IPP, dated 6/18/15, documented a 34 year old female whose diagnoses included profound intellectual disability.</p>	W 369	<p>W 369</p> <p>1. A new MAR will be implemented for the omeprazole so that it is clear to staff that the medication is supposed to be crushed. All staff assisting the individual with their medications during the surveyors observation will be retrained on how to assist the individual with taking their omeprazole.</p> <p>2. All individuals have the potential to be affected by this practice. All MARs will be reviewed for accuracy to ensure that medications that are given are given according to the physicians orders. In addition, all staff in all facilities will be retrained on the Medication Administration Policy.</p>	

RECEIVED
OCT 29 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Max A. Redden</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/27/15</i>
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2015
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1664 SOUTH BELLIN IDAHO FALLS, ID 83405	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 1 Her Physician's Order, dated 9/25/15, stated she received omeprazole (an antiulcer drug) 40 mg three times a day. The physician's orders had a line through the words "do not crush inner pellets." Her Physician's Orders also documented "May crush all medications." Her MAR also had the words "do not crush inner pellets" that was lined through under the order for omeprazole. No other information regarding crushing the medication was listed on her MAR. During an observation conducted at the facility on 10/5/15 from 4:40 - 5:10 p.m., a direct care staff that was administering the medication was noted to open the omeprazole capsule and pour the contents into a medication cup and add apple juice to it. When asked on 10/6/15 from 9:55 - 10:18 a.m., the LPN stated there was a physician's order for crushing the omeprazole and that it should have been crushed and should not have been mixed in the apple juice. The facility failed to ensure Individual #4's omeprazole was administered correctly.	W 369	W 369 cont'd 3. The HCA and the LPN's will review all Physician's Orders and MARs to ensure they are accurate on a monthly basis. In addition, the Home Supervisor will review the Medication Administration Policy in every monthly staff meeting. 4. The QIDP will conduct quarterly chart reviews to ensure that the Physician's orders and the MARs are accurate. In addition, the QIDP will review all medication observation forms that are conducted by the Home Supervisor, QAM, and LPN to ensure staff are following the Medication Administration Policy. 5. The Home Supervisor, QAM, HCA, LPN's and QIDP will be responsible for implementing this plan of correction. 6. Target date for completion will be December 7, 2015.	

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 10/5/15 - 10/8/15. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Lead Trish O'Hara, RN	M 000		
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W369.	MM166	MM166 Refer to W 369	

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Alex A. Redden</i>	TITLE <i>Administrator</i>	(X6) DATE 10/27/15
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