



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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October 29, 2015

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

RE: Bitterroot Home, Provider #13G022

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Bitterroot Home, on October 22, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction 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;

Rene Stephens, Administrator
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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 **November 12, 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 November 12, 2015. If a request for informal dispute resolution is received after November 12, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
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NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301
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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>Bitterroot Home is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for the annual recertification survey conducted from 10/19/15 to 10/22/15.</p> <p>The survey was conducted by: Michael Case, LSW, QIDP</p>	W 000	<p style="text-align: center;">RECEIVED NOV - 6 2015 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kene Stephens</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/6/15</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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 10/19/15 to 10/22/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP	M 000	RECEIVED NOV - 6 2015 FACILITY STANDARDS	
MM243	16.03.11712.02(a) Shades or Drapes Suitable window shades or drapes must be provided to control lighting in the room. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure suitable window shades or drapes were provided for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in a lack of appropriate or functional blinds. The findings include: 1. An environmental review was conducted on 10/20/15 from 11:40 a.m. - 12:45 p.m. During that time, the following was noted: - The control rod for the louvered blinds in Individual #5's bedroom did not function properly, preventing the louvers from being adjusted. - The control rods for the louvered blinds in both Individual #6's bedroom, and the bedroom shared by Individual #1 and Individual #4, were missing preventing the louvers from being adjusted. - The louvered blinds in Individual #3's bedroom were broken and stuck in an open position. - There were no blinds or window coverings in Individual #2's bedroom.	MM243	MM243 All of the blinds now have control rods and can be adjusted. One set of blinds for individual #3 has been replaced with a heavy duty wardrobe rod and curtains with metal grommets to withstand the rough use they will receive. Individual #2 repeatedly tears down his blinds and curtains and even destroyed his entire window which required extensive repair and an entire window replacement. This individual was taken to a fabric store and chose a fabric he liked. Velcro is being sewn to this fabric and the other side of the Velcro is being stapled to the wall so when he pulls the covering down it can be easily reattached to the Velcro by staff each time. Allowing the individual to choose the covering he likes may dissuade him from pulling it down if he likes seeing it hanging in his room. We will work to find alternate panels to hang to encourage his participation in keeping them up in his room. Date of Correction: 11-09-2015 Responsible: Housekeeper/Cook, Facility Manager	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kene Stephens TITLE Administrator (X6) DATE 11/6/15

STATE FORM 6899 6B9M11 If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301		
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MM243	Continued From page 1 The Home Manager, who was present during the environmental review stated Individual #3's blinds had broken within the past 2 days and were to be replaced, and stated Individual #2's blinds had been replaced multiple times, but he continued to pull them down. The Home Manager stated she was not aware the other blinds were broken or missing adjustment rods. During an interview on 10/22/15 from 8:20 - 10:20 a.m., the Administrator stated she was not aware of the broken blinds, but was aware Individual #2 had repeatedly pulled his blinds down. The Administrator stated the facility was looking at alternative blinds for Individual #2 and Individual #3. The facility failed to ensure all individuals had suitable shades or drapes.	MM243		



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October 29, 2015

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

Provider #13G022

Dear Ms. Stephens:

An unannounced on-site complaint investigation was conducted from October 19, 2015 to October 22, 2015 at Bitterroot Home. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007157

Allegation #1: Behavioral interventions are insufficient to meet individuals' needs.

Findings #1: During the survey, observations were completed, individuals' records and behavioral data were reviewed, and staff and guardian interviews were conducted.

Observations were conducted at the facility on 10/19/15 and 10/20/15 for a cumulative 5 hours and 35 minutes. During that time, staff were observed to provide sufficient intervention for individuals' behavioral needs.

For example, one individual was observed to be assisting staff to set the table. The individual became agitated and attempted to strike his head on the table. The staff working with the individual blocked the head strike attempt and redirected the individual to a calming activity. Once calm, the individual resumed assisting to set the table.

Rene Stephens, Administrator
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Three individuals' records were selected for review. The individuals' behavior intervention plans were reviewed and documented appropriate interventions for identified maladaptive behaviors. Additionally, the individuals' behavioral data was reviewed, from 7/1/15 to 10/22/15, and documented interventions were implemented in accordance with the plans.

Three individuals' guardians were interviewed on 10/19/15 and 10/21/15. Two of the guardians stated they had no concerns with the behavioral interventions provided for individuals residing at the facility.

One individual's guardian stated she had been under the belief that the individual was being provided one-on-one staffing. The guardian stated she based this belief on the significance of the individual's maladaptive behavior while at home.

However, a review of the individual's record from admission documented he had never received one-on-one staffing. Additionally, the individual's documented maladaptive behaviors and interventions did not demonstrate one-on-one staff would be required for the individual.

The Qualified Intellectual Disabilities Professional {QIDP} and Administrator were interviewed on 10/22/15 from 8:20 - 10:20 a.m. Both stated they were not aware of incidents where individuals' behavioral interventions were not sufficient to meet their needs.

It could not be determined the facility was not providing behavioral interventions sufficient to meet individuals' needs. Therefore, the allegation was unsubstantiated due to insufficient evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Guardians are not notified of significant changes.

Findings #2: During the survey, observations were completed, the facility's investigations, incident/accident forms, and individual records were reviewed, and staff and guardian interviews were conducted.

Observations were conducted at the facility on 10/19/15 and 10/20/15 for a cumulative 5 hours and 35 minutes. During that time, no incidents that would require guardian notification were observed.

The facility's investigations from 11/1/14 - 10/19/15 were reviewed, as were incident/accident forms from 7/1/15 - 10/19/15. All significant incidents included documentation of guardian contact as requested in individuals' records.

Rene Stephens, Administrator
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Three individuals' guardians were interviewed on 10/19/15 and 10/21/15. Two of the guardians stated the facility always contacted them with information and changes as requested. Those two guardians stated they had no concerns with being provided information about changes by the facility.

One individual's guardian stated she had not been informed when the individual was removed from one-on-one staffing. However, a review of the individual's record since admission documented he had never received one-on-one staffing. When this information was discussed with the guardian, she stated she must have misunderstood.

The Qualified Intellectual Disabilities Professional {QIDP} and Administrator were interviewed on 10/22/15 from 8:20 - 10:20 a.m. Both stated the facility made every effort to contact guardians with all significant changes and information, as well as with general information as requested.

It could not be determined the facility was not notifying guardians of significant changes. Therefore, the allegation was unsubstantiated due to insufficient evidence.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt