



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
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November 24, 2015

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

RE: Belmont Care Center Crestview, Provider #13G050

Dear Ms. Reudter:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center Crestview, which was conducted on November 18, 2015.

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

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

Valentina Reudter, Administrator
November 24, 2015
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **December 7, 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 December 7, 2015. If a request for informal dispute resolution is received after December 7, 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

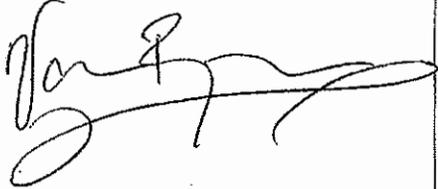


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 11/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER CRESTVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 4024 MOUNTAIN LOOP POCATELLO, ID 83204	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 11/16/15 to 11/18/15. The surveyor conducting your survey was: Michael Case, LSW, QIDP, Team Lead Common abbreviations used in this report are: CFA - Comprehensive Functional Assessment IPP - Individual Program Plan MAR - Medication Administration Record QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse WIC - Written Informed Consent	W 000	Please attached Plan of Correction 	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in implementation of restrictions not based on individual need and without assuring due process protections. The findings include: 1. An observation was conducted at the facility on	W 125	RECEIVED DEC - 8 2015 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Program Manager (X6) DATE 12/7/2015

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

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W 125	<p>Continued From page 1</p> <p>11/16/15 from 4:30 - 5:30 p.m. During that time, one of the kitchen cabinets and one of the kitchen drawers were noted to be locked.</p> <p>A direct care staff present during the observation stated, at 4:50 p.m., that the cabinet contained the sharp blades for the food processors and the drawer contained all sharp knives. The direct care staff stated she believed the facility had WICs in place for the locked knives and sharp blades, but stated there was no one she knew of residing in the facility that had issues with sharp knives or blades. The direct care staff stated none of the individuals had programing related to the use of knives and sharp blades.</p> <p>The records of Individuals #1 - #3 were reviewed and documented the following:</p> <ul style="list-style-type: none"> - Individual #1's WIC for locking knives, dated 10/26/14, stated he had a limited understanding of knives which would put him and his peers at risk of injury if he were to use a knife unsupervised. - Individual #2's WIC for locking knives, dated 10/26/14, stated he could handle knives safely, but several peers "struggle with this skill." - Individual #3's WIC for locking knives, dated 10/26/14, stated he had a limited understanding of knives which would put him and his peers at risk of injury if he were to use a knife unsupervised. <p>Individual #1 - #3's WICs all stated they could access knives by having staff unlock them. Additionally, Individual #1 - #3's CFAs were reviewed. None of the CFAs documented</p>	W 125			

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W 125	Continued From page 2 difficulty with handling sharp blades or knives. During an interview on 11/17/15 from 10:35 - 10:55 a.m., the Program Supervisor stated the knives and sharp blades had always been locked in the facility but she was not sure why. The Program Supervisor stated she was not aware of anyone in the facility that inappropriately used knives or sharp blades. Individual #5, who was present during the interview, stated knives were locked up because of an individual who lived at the facility years ago. During an interview on 11/18/15 from 9:30 - 10:45 a.m., the Program Coordinator and Program Manager both stated all 8 individuals residing at the facility had similar WICs in place. The Program Coordinator and the Program Manager both stated there was no current assessed need to have knives locked and the situation needed to be reevaluated.	W 125			
W 368	483.460(k)(1) DRUG ADMINISTRATION The facility failed to ensure individuals' rights to free access of knives was ensured. The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to administer drugs as ordered by the physician for 1 of 3 individuals (Individual #4) observed to take medications. This resulted in an individual receiving a medication in a manner which was	W 368			

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W 368	<p>Continued From page 3</p> <p>inconsistent with physician orders. The findings include:</p> <p>1. Individual #4's 9/23/15 IPP stated he was a 74 year old male whose diagnoses included profound intellectual disability, GERD (gastroesophageal reflux disease) and Barrett's Esophagus (a serious complication of GERD in which the tissue lining the esophagus is replaced by tissue similar to the intestinal lining).</p> <p>Individual #4's record included a physician's order, dated 9/17/12, which stated he was to receive metoclopramide (an antiemetic drug used in the treatment of GERD) 5mg 30 minutes before meals and at bedtime.</p> <p>During an observation on 11/17/15, Individual #4 was observed to receive 5ml of metoclopramide 5mg/5ml at 7:05 a.m. Individual #4 was then observed to be eating breakfast at 7:15 a.m.</p> <p>Individual #4's metoclopramide prescription label and MAR both stated to give "at least" 30 minutes prior to meals and at bedtime.</p> <p>During an interview on 11/17/15 from 10:35 - 10:55 a.m., the Program Supervisor, who had completed the medication administration program with Individual #4, stated Individual #4 should not have eaten until 30 minutes after the drug was received. The Program Supervisor stated there was no system in place to ensure other staff knew when Individual #4 received the drug and when he could receive food.</p> <p>During an interview on 11/18/15 from 9:30 - 10:45 a.m., the RN confirmed Individual #4 should not have eaten for 30 minutes after taking the</p>	W 368			

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W 368	Continued From page 4 metoclopramide.	W 368			
W 436	The facility failed to ensure Individual #4's order for metoclopramide was followed. 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure individuals' adaptive equipment was kept in good repair for 2 of 3 individuals (Individuals #4 and #7) who required adaptive equipment for mobility. This resulted in individuals' adaptive equipment being in disrepair. The findings include: 1. Three of the 8 individuals residing at the facility were noted to use wheelchairs for mobility. The following concerns with wheelchairs were noted: - During an observation on 11/16/15 from 4:30 - 5:30 p.m., Individual #7's wheelchair was noted to have rips on both armrests. The vinyl covering the left armrest was ripped up both sides exposing the foam along the inside and outside edges. The vinyl of the right armrest was ripped up both sides, and across the front section about 1 inch into the armrest center exposing the foam underneath.	W 436			

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W 436	Continued From page 5 - During an observation on 11/17/15 from 6:40 - 8:00 a.m., the zipper on the back of Individual #4's wheelchair seat cushion was noted to be broken exposing the foam cushion across the entire backside of the cushion. During an interview on 11/17/15 at approximately 2:00 p.m., the Program Supervisor stated she had been having difficulty with the medical equipment provider and the wheelchairs needed to be repaired.	W 436			
W 440	483.470(i)(1) EVACUATION DRILLS The facility failed to ensure Individual #4 and Individual #7's wheelchairs were maintained in good repair. The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. The facility's evacuation drills were reviewed and did not include documentation that evacuation drills had been completed for the day shift (6:30 a.m. - 2:30 p.m.) or graveyard shift (10:30 p.m. - 6:30 a.m.) during the second quarter (April - June) of 2015.	W 440			

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W 440	Continued From page 6	W 440			
W 484	<p>During an interview on 11/17/15 at 12:50 p.m., the Program Supervisor stated the drills had been missed due to a misunderstanding.</p> <p>The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.</p> <p>483.480(d)(3) DINING AREAS AND SERVICE</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each 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 all areas were equipped with eating utensils and dishes designed to meet the needs of 1 of 3 individuals (Individual #4) residing at the facility, who required adaptive eating equipment. This resulted in an individual not being provided with adaptive eating equipment during medication administration times. The findings include:</p> <p>1. An observation was conducted at the facility on 11/16/15 from 4:30 - 5:30 p.m. During that time, Individual #4 was noted to utilize a high-sided divided plate and built-up curved utensils during the evening meal.</p> <p>Individual #4 was also observed to participate in a medication administration program during the observation. During that time, the direct care staff assisting Individual #4 was observed to place metoclopramide (an antiemetic drug) 5mg/5ml into a disposable plastic cup with</p>	W 484			

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W 484	<p>Continued From page 7</p> <p>applesauce. The direct care staff then provided hand-over-hand assistance to Individual #4 to spoon the mixture into his mouth with a disposable plastic spoon.</p> <p>However, Individual #4 was observed to be able to feed himself during the evening meal with his adaptive spoon.</p> <p>During an interview on 11/17/15 from 10:35 - 10:55 a.m., the Program Supervisor stated Individual #4's adaptive equipment should have been utilized during the medication pass.</p> <p>During an interview on 11/18/15 from 9:30 - 10:45 a.m., the QIDP stated Individual #4's adaptive eating equipment should be utilized in all needed settings.</p> <p>The facility failed to ensure Individual #4 was provided with adaptive eating equipment necessary to promote independence during medication administration.</p>	W 484		

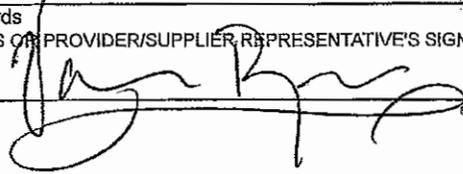
Bureau of Facility Standards

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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the licensure survey conducted from 11/16/15 to 11/18/15.</p> <p>The surveyor conducting your survey was: Michael Case, LSW, QIDP, Team Lead</p>	M 000	Please attached Plan of Correction	
MM080	<p>16.03.11100 Governing Body and Management</p> <p>The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W125.</p>	MM080	 <p>RECEIVED DEC - 8 2015 FACILITY STANDARDS</p>	
MM166	<p>16.03.11600 Health Care Services</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to W368.</p>	MM166		
MM169	<p>16.03.11700 Physical Environment</p> <p>The requirements of Sections 700 through 799 of</p>	MM169		

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



TITLE
Program Manager

(X6) DATE
12/7/2015

Bureau of Facility Standards

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MM169	Continued From page 1 these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W436 and W440.	MM169		
MM237	16.03.11711.10(a) Clean and in Good Repair All plumbing fixtures must be clean and in good repair. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure plumbing fixtures were maintained in good condition for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in a toilet being unsecured. The findings include: 1. An environmental review was conducted on 11/17/15 from 1:45 - 2:30 p.m. During that time, the toilet in the small bathroom was noted to rock significantly and swivel slightly side to side where the base attached to the floor. The maintenance staff, who was present during the review, was notified and stated the mounting needed to be secured. The facility failed to ensure plumbing fixtures were maintained in good repair.	MM237		

Bureau of Facility Standards

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MM366	<p>16.03.11800 Dietetic Services</p> <p>The requirements of Sections 800 through 899 of these rules are modifications and additions to the requirements of 42 CFR 483.480 - 483.480(d)(5), Condition of Participation: Dietetic Services incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W484.</p>	MM366		



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

December 7, 2015

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

RECEIVED
DEC - 8 2015
FACILITY STANDARDS

Dear Mr. Case,

I would like to thank you for a wonderful learning experience during the recent annual re-certification survey at Crestview Care Center – Provider # 13G050. Please see our responses below for each area of deficiency and please call me if you have any questions.

W125

1. All locks on cabinets and drawers were removed by November 20, 2015.
2. The need of knives/sharps being locked up has been re-evaluated and determined to be unnecessary.
3. Aspire Human Services will revise the comprehensive functional assessment to include the use of knives and other sharps. If a need is noted, it will be identified in the IPP and implemented with formal programming and/or service objectives.
4. Aspire Human Services in Pocatello is creating a schedule for the completion of the chart reviews. Chart reviews will include ensuring the use of knives and sharps. After chart reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Program Supervisor, QIDP, Program Manager
6. Completion Date: December 24, 2015.

W368

1. The medication time for individual #4 was changed to ensure the full prescribed time between taking the medication and meal time is observed.
2. All medications times will be reviewed monthly to ensure the medications are being passed at the prescribed time.
3. Aspire Human Services has recently implemented chart reviews for all the homes. One part of the chart reviews includes verifying all medications are passed at the prescribed time.
4. Aspire Human Services in Pocatello is creating a schedule for the completion of the chart reviews. After chart reviews are completed the RN will coordinate the correction of any identified errors.
5. Person Responsible: RN, Program Supervisor, Program Manager
6. Completion Date: December 24, 2015.

W436

1. [REDACTED] medical was called and replacement parts were ordered 11/19/2015. [REDACTED] medical replaced arm rests and seat cushions found to be in disrepair on 12/4/2015.
2. All mobility and adaptive equipment has been evaluated and repairs and replacements are being coordinated with occupational and physical therapists as well as our nursing team and the home supervisor.
3. Aspire Human Services will implement a durable medical checklist to be completed weekly which will include wheelchair checklists to ensure all parts are in good repair. Program Supervisor and nursing team will coordinate the correction of any identified needed repairs.
4. Person Responsible: Nursing, Program Supervisor, Program Manager
5. Completion Date: January 8th, 2016.

W440

1. The evacuation drills were completed as recommended in the 3rd and 4th quarters of the year.
2. Evacuation drill will be completed at least once per quarter for each shift of personnel. This affects all residents in the home for each shift.
3. Aspire Human Services in Pocatello will follow an evacuation drill schedule. The schedule will vary the time the drills are completed and the condition. The Program Supervisor will keep record of the completed drills. The drills will be reviewed monthly to ensure completion. The Program Manager will coordinate any errors noted after reviewing the documentation. Please see example schedule below.

2016

SHIFT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
AM Fire	█			█			█			█		
AM other	█			█			█			█		
PM Fire		█			█			█			█	
PM other		█			█			█			█	
GY Fire			█			█			█			█
GY other			█			█			█			█



- 4. Person Responsible: Program Supervisor, Program Manager.
- 5. Completion Date: December 24, 2015.

W484

- 1. Individual #4 is using his adaptive equipment across all settings to ensure the most independence as possible. Formal Program was also revised to reflect the use of adaptive equipment during medication passes.
- 2. A face sheet was added to all individuals who use adaptive equipment for eating in front of the MAR sheets to ensure adaptive equipment is used during medication passes.
- 3. Aspire Human Services has recently implemented chart reviews for all the homes. One part of the chart reviews will including ensuring all adaptive equipment used is listed including detailed description and when it should be used.
- 4. Person Responsible: Nursing, QIDP
- 5. Completion date: January 8th, 2016.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Valentina Reudter".

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



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

December 7, 2015

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

RECEIVED
DEC - 8 2015
FACILITY STANDARDS

Dear Mr. Case

I would like to thank you for your input during our annual re-certification survey for Crestview Care Center (Provider # 13G050). We learn so much during each survey and it is wonderful how annual re-certifications have become a time for growth.

Please see our responses below for each area of deficiency and please call me if you have any questions.

MM080

Please see response to W125

MM166

Please see response to W368

MM169

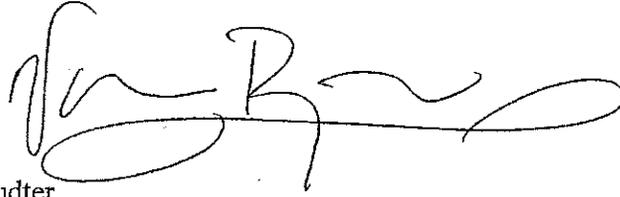
Please see response to W436 and W440

MM237

1. The toilet was removed, a new wax ring installed and secured by 11/20/2015.
2. The toilet was re-secured and this affects all 8 residents in the home.
3. Aspire Human Services in Pocatello currently has a monthly checklist which is completed by the Program Supervisor or lead worker. Each month after the checklist is completed, the documentation will be turned into the Program Manager verification. Program Manager will coordinated needed repairs.
4. Person Responsible: Program Supervisor, Program Manager
5. Completion Date: January 8th, 2016.

Please call me if you have any further questions about this plan of correction.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valentina Reudter', written in a cursive style.

Valentina Reudter
Program Manager
Aspire Human Services
3625 Vaughn Ave, Pocatello, Idaho 83201
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