



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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DIVISION OF LICENSING & CERTIFICATION
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December 10, 2015

Bridger Fly, Administrator
Communicare, Inc #9 Main
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #9 Main, Provider #13G059

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #9 Main, which was conducted on December 3, 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

Bridger Fly, Administrator
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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 23, 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 23, 2015. If a request for informal dispute resolution is received after December 23, 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 WASENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 12/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #9 MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 876 EAST MAIN JEROME, ID 83338	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 12/1/15 to 12/3/15.</p> <p>The surveyors conducting your survey were:</p> <p>Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADD - Attention Deficit Disorder ADL - Activities of Daily Living AQIDP - Assistant Qualified Intellectual Disabilities Professional BMP - Behavior Management Plan DCS - Direct Care Staff IDAPA - Idaho Administrative Procedures Act IPP - Individualized Program Plan LPN - Licensed Practical Nurse PRN - As needed QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse SE - Special Education</p>	W 000	<p><i>RECEIVED</i></p> <p><i>DEC 24 2015</i></p> <p><i>FACILITY STANDARDS</i></p>	
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</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 outside services met the needs for 4 of 4 individuals (Individuals #2, #3, #4, and #6) who</p>	W 120	<p><u>W120</u></p> <p>Corrective Actions & System Changes:</p> <p>Please note the following: 1) The Jerome School District has the responsibility of providing a "free public education" to the two individuals who attend the contracted school program.</p>	02/03/16

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

TITLE

(X6) DATE

Administrator *12/21/15*

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 120	<p>Continued From page 1</p> <p>attended public school programs. This resulted in a lack of coordination of services and communication with the school. The findings include:</p> <p>1. Two individuals attended a day program contracted by the school district. The services of the program were not sufficiently coordinated to ensure consistent training and staff responses across all settings, as follows:</p> <p>a. Individual #3's IPP, updated 10/13/15, stated he was a 19 year old male whose diagnoses included moderate intellectual disability and autism spectrum disorder. He attended a day program which was contracted by the school district.</p> <p>Individual #3 was observed at the day program on 12/1/15 from 11:25 a.m. - 12:10 p.m. During that time, he was observed to eat lunch, look at books, complete a letter tracing worksheet, complete a puzzle, use the restroom, and wash his hands. He was observed to have a designated staff working with him.</p> <p>The staff working with Individual #3 was interviewed during the observation and stated she did not have a specific schedule to follow, but followed a basic routine. When asked what programs were being implemented with Individual #3, the staff stated she only worked on behavioral objectives and did not have programs related to ADLs or academics. When asked about methods for addressing Individual #3's behavioral goals, the staff stated there were no formal methods and she simply addressed the maladaptive behaviors as she saw fit at any given moment.</p>	W 120	<p>2) This contract changed last year to another provider.</p> <p>3) The high school teacher is new to the Jerome School District and to the requirements of an ICF/ID. The observations she shared with the state surveyor had not been shared with the QIDP for this location.</p> <p>CCI will take the following corrective actions (these actions will be documented in the QIDP Log or Outside Services Log):</p> <p>1) The QIDP at this location will meet with the Special Services Administrator for the school district. Issues raised by the state surveyor will be reviewed and a plan will be developed for providing further training on expected coordination between CCI #9 as an ICF/ID and the newly hired high school teacher and the newly contracted developmental program.</p> <p>2) We have updated our operational policy related to Outside Services/Public Schools and will share this update with the Special Services Administrator, newly hired high school teacher and the newly contracted developmental program.</p> <p>3) Effective 01/15, CCI's QIDP will extend all school observations to 45 minutes and will conduct at least one per month with both the high school and the contracted developmental program. This information will be shared with school personnel as included in the plan developed with the Special Services Administrator.</p>	

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W 120	<p>Continued From page 2</p> <p>Individual #3's record for the day program was reviewed and documented 3 goals - to interact with others without tantrum behavior, to follow directives without behaviors, and to remain on an activity or task without yelling. A data sheet with a place for staff to circle a "+" or "-" for each goal was also present. However, no additional information related to how the objectives would be implemented could be found.</p> <p>Individual #3's IPP documented objectives including, but not limited to, hand washing, oral care, eating skills, dressing, communication, and toileting, as well as behavioral objectives for tantrum-like behavior and inappropriate social sexual conduct.</p> <p>b. Individual #6's IPP, updated 10/13/15, stated he was a 16 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. He attended a day program which was contracted by the school district.</p> <p>Individual #6 was observed at the day program on 12/1/15 from 11:25 a.m. - 12:10 p.m. During that time, he was observed to look at books, listen to a story, sort blocks, complete a puzzle, use the restroom, and wash his hands. He was observed to have a designated staff working with him.</p> <p>The staff working with Individual #6 was interviewed during the observation and stated she followed a routine, but did not have a specific schedule for Individual #6. The staff stated she only worked on behavioral objectives and did not have programs related to ADLs or academics. The staff stated there were no formal methods to address Individual #6's behavioral goals, and she simply addressed the maladaptive behaviors as</p>	W 120	<p>4) The QIDP will request clarification on who is the communication link between the contracted program and CCI related to educational issues. Communication related to schedules, attendance, medical issues, and behavioral issues will continue directly between CCI and the contracted program.</p> <p>5) CCI's QIDP will schedule a meeting with the communication leak after completing observations at both programs so any issues of concern can be discussed and documented.</p> <p>6) If issues of concern are not resolved, the QIDP and/or other CCI Administrative staff will request to meet the Special Services Administrator for further problem solving.</p> <p>Identifying Others Potentially Affected: Four individuals who attend school funded programs are affected.</p> <p>System Changes: Please refer to corrective actions.</p> <p>Monitoring: For the next six months, the QIDP Supervisor will review QIDP observations and communications with the school district as part of CCI's "Trending/Tracking" process. If needed, CCI Administrative staff will meet with the Special Services Administrator for further problem solving.</p>		

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W 120	<p>Continued From page 3 she saw fit at any given moment.</p> <p>Individual #6's record for the day program was reviewed and documented 3 goals - to stay by staff without running away, to interact with others without yelling or biting himself, and to interact with others without banging his head. A data sheet with a place for staff to circle a "+" or "-" for each goal was also present. However, no additional information related to how the objectives would be implemented could be found.</p> <p>During an interview on 12/2/15 from 9:00 - 9:45 a.m., the SE Teacher at the high school stated she was responsible for Individual #3 and Individual #6, and for providing oversight of the services provided at the contract day program. The SE Teacher stated she had been to the day program one time in order to see who the individuals were, but stated she was "at a loss" when it came to the individuals and their needs regarding ADLs and academics.</p> <p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the QIDP and QIDP Supervisor both stated there had been problems with communication with the school system. The QIDP stated she received quarterly reports for Individual #3 and Individual #6, and stated she had completed observations at the day program 2 or 3 times. However, the QIDP stated she had never looked at the programs for methods, and was not aware that there were no schedules or programs to address academics or ADLs.</p> <p>The AQIDP, who was present during the interview, stated she had provided Individual #3 and Individual #6's IPPs and BMPs to the day program when they first started to attend, but</p>	W 120			

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W 120	<p>Continued From page 4</p> <p>stated she had not followed up to ensure needs were being met.</p> <p>The facility failed to ensure services provided to Individual #3 and Individual #6 at the contracted day program were sufficiently coordinated to meet the individuals' needs.</p> <p>2. Two individuals attended a local high school. The services of the high school were not sufficiently coordinated to ensure consistent training and staff responses across all settings, as follows:</p> <p>a. Individual #4's IPP, updated 10/13/15, stated he was a 14 year old male whose diagnoses included moderate intellectual disability and autism spectrum disorder.</p> <p>Individual #4 was observed at the local high school on 12/2/15 from 9:00 - 9:45 a.m. During that time, Individual #4 was observed to be engaged in a craft task.</p> <p>The SE Teacher, who was present during the observation, was interviewed and stated communication with the facility was not good. The SE Teacher stated Individual #4 had a communication log, but stated she no longer reviewed the log as it did not contain valuable information. The SE Teacher stated her biggest concern with Individual #4 was in relation to a communication device that he was supposed to have, which was not sent by the facility on a regular basis. The SE Teacher stated Individual #4 had difficulty with the program on his own device and preferred to use a device the school had.</p>	W 120			

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W 120	<p>Continued From page 5</p> <p>When asked about IPPs and BMPs, the SE Teacher provided a copy of Individual #4's BMP that was kept in the back of a file cabinet. The SE Teacher stated she did not use the plan. Individual #4's communication log was also reviewed and documented communication between the facility staff and a Para Professional at the school related to snack needs and general observations of how Individual #4 had done on any given day.</p> <p>Individual #4's IPP documented objectives that included, but were not limited to, hand washing, oral care, eating skills, and communication.</p> <p>Additionally, Individual #4's communication evaluation, dated 10/1/15, was reviewed and did not include the use of a communication device, but stated he could communicate verbally.</p> <p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the QIDP stated Individual #4 did have a tablet communication device provided by his family upon admission, but stated it was not used as the program was too complex for Individual #4. The QIDP stated Individual #4 was encouraged to use his words as directed by the speech pathologist, because he was able to speak but chose not to do so unless encouraged. The QIDP could not confirm this information had been communicated to the school.</p> <p>b. Individual #2's IPP, updated 10/13/15, stated he was a 16 year old male whose diagnoses included profound intellectual disability, autism spectrum disorder, and ADD. He attended the local high school.</p> <p>Individual #2 was observed at the local high</p>	W 120			

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W 120	Continued From page 6 school on 12/2/15 from 9:00 - 9:45 a.m. During that time, Individual #2 was observed to be engaged in reading comprehension tasks. The SE Teacher, who was present during the observation, was interviewed and stated she did not have copies of Individual #2's IPP or BMP. She stated they may have been provided to the previous teacher and misplaced. The SE Teacher stated communication with the facility was not good, and that phone calls to the QIDP and AQIDP were not always returned. Individual #2's IPP documented objectives that included, but were not limited to, hand washing, eating skills, dressing skills, general grooming skills, and communication. During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the QIDP and QIDP Supervisor both stated there had been problems with communication with the school. Both the QIDP and the AQIDP, who was also present during the interview, stated they had been to the school to complete observations, but stated they did not look at paperwork when present. The AQIDP stated she had been to the school once for an observation, and the QIDP stated she had been 2 or 3 times. The QIDP stated coordination with the school program needed to be improved. The facility failed to ensure outside services were adequately coordinated for Individual #2 and Individual #4.	W 120			
W 159	483.430(a) QIDP	W 159	<u>W159</u> 1. Please refer to W120. 2. Please refer to W239 3. Please refer to W474	02/03/16	

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W 159	Continued From page 7 Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which impacted 5 of 9 individuals (Individuals #2 - #6) residing at the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include: 1. Refer to W120 as it relates to the facility's failure to ensure the QIDP ensured outside services were sufficiently monitored and coordinated to meet individuals' needs. 2. Refer to W239 as it relates to the facility's failure to ensure the QIDP ensured functional replacement behavior training was created for an individual's maladaptive behaviors. 3. Refer to W474 as it relates to the facility's failure to ensure the QIDP ensured an individual's food was served in a form consistent with his developmental level.	W 159			
W 239	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.	W 239	<u>W239</u> Corrective Actions: Generally when individuals are newly admitted to a CCI location, an initial Behavior Management/Support Plan (BMP) is developed and then requires modification within a few months. Revisions to Individual #4's BMP were not needed and therefore the QIDP Supervisor who processes and	02/03/16	

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W 239	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 1 of 4 individuals (Individual #4) whose behavior plans were reviewed. This resulted in an individual not receiving functional training to replace his maladaptive behaviors. The findings include:</p> <p>1. Individual #4's IPP, updated 10/13/15, stated he was a 14 year old male whose diagnoses included moderate intellectual disability and autism spectrum disorder. He was admitted to the facility on 7/8/15.</p> <p>Individual #4's BMP, dated 7/8/15, stated he engaged in non-compliance (defined as refusing to comply with staff requests relative to participation in his active treatment program), physical aggression (defined as harming or attempting to harm other individuals), self-injurious behavior (defined as hitting his head), food hoarding (defined as taking food from cabinets or refrigerators, reaching/grabbing for food off counters/tables and attempting to grab food/drinks from others during meal times), placing non-food items in mouth, and elopement (defined as leaving the premises without staff).</p> <p>Under the Alternate Behavior Training section, the plan stated "This will be determined at his 30 day post admission staffing." However, no additional information related to alternative behavior training could be found in the IPP or record.</p> <p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the QIDP Supervisor stated</p>	W 239	<p>reprocesses these plans failed to remember that this alternative behavior program needed to be added. A program will be developed and implemented 01/16 with a BMP update completed.</p> <p>Identifying Others Potentially Affected: There are no other alternative behavior plans missing from the other eight individual's BMPs who live at this location.</p> <p>System Changes: This was an oversight and no systems changes are indicated.</p> <p>Monitoring: Since the QIDP Supervisor who typically monitors these types of situations was the person responsible for this issue we will make it a part of the QIDP's responsibility to monitor BMPs developed for newly admitted individuals at the 30 day post admission staffing and this will be discussed at the next scheduled Trending and Tracking meeting.</p>		

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W 239	Continued From page 9 alternative behavior training objectives and plans had not been developed due to an oversight.	W 239		
W 331	<p>The facility failed to ensure appropriate replacement behaviors were developed to address Individual #4's identified maladaptive behaviors.</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</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 adequate nursing services were provided, which directly impacted 3 of 3 individuals (Individuals #4, #6 and #7) who experienced head injuries, and had the potential to impact all individuals (Individuals #1 - #9) residing at the facility. This resulted in the potential for a lack of sufficient monitoring and follow-up necessary to meet individuals' health needs. The findings include:</p> <p>1. The facility utilized a Head Injury Check form, which stated staff were to complete the form when instructed by a nurse and attach it to an Accident/Injury (A/I) Report form. The form included a section to document the frequency and duration of the head checks, and a section for staff to document their initials and time, a section to circle status information (e.g., alert, able to move arms/legs, awake, no vomiting), and narrative information.</p> <p>The facility's A/Is were reviewed from 5/1/15 - 11/30/15. The review showed Head Injury Check</p>	W 331	<p><u>W331</u></p> <p>Please refer to the memo from the QIDP Supervisor to the CCI Administrator which is attached for an analysis of the development of this issue. (Attachment A)</p> <p>Corrective Actions: Based on surveyor input we have redesigned our "Head Check" form (Attachment B). After this plan of correction is accepted we will in-service staff at this location and will start using this form.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to "Corrective Actions".</p> <p>Monitoring: LPNs will review completed documents and provide any supplemental training necessary. The RN Supervisor will look at completed "Head Check" forms during scheduled reviews routinely for the next six months and intermittently thereafter.</p>	02/03/16

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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #9 MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 876 EAST MAIN JEROME, ID 83338		
(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 331	<p>Continued From page 10</p> <p>forms had been completed for Individuals #4, #6, and #7. The forms documented the LPN had provided direction to staff on frequency and duration of monitoring for head injury. However, the forms did not provide information as to how those determinations were made. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - An A/I form, dated 5/3/15 at 4:00 p.m., stated Individual #6 "fell to the floor and started hitting his head on the floor..." Staff documented the LPN instructed staff to complete head checks every hour until bedtime. The form documented head checks were completed hourly from 4:15 - 7:15 p.m. - An A/I form, dated 5/28/15 at 7:00 p.m., stated Individual #6 dropped to the floor and "hit his head two times before I got the pillow under his head..." Staff documented the LPN instructed staff to complete a head check at 7:00 p.m. and before bed. The form documented head checks were competed at 7:00 p.m. and 8:00 p.m. - An A/I form, dated 6/16/15 with no time indicated, stated Individual #7 "banged his head on a corner of the wall and made a small cut on his right above [sic] eye-brow." Staff documented the LPN was contacted at 10:38 a.m. and instructed staff to complete head checks at 10:38 a.m., 12:00 p.m., and 2:00 p.m. - An A/I form, dated 7/23/15 at 8:20 a.m., stated Individual #7 "was banging his head against the table really hard." Staff documented the LPN instructed staff to complete head checks every hour until 2:00 p.m. - An A/I form, dated 8/7/15 at 1:30 p.m., stated 	W 331			

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W 331	<p>Continued From page 11</p> <p>Individual #4 "banged his head really hard on the mirror" in the bathroom. Staff documented the LPN instructed staff to complete head checks every hour for a total of 4 hours.</p> <p>It was not clear how frequency and duration of the head checks was being determined, or that the frequency of the checks was sufficient to ensure individuals had not suffered latent injuries.</p> <p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the LPN stated she would gather information from direct care staff related to how hard the individual hit their head, how many times, if there was an injury or not, if the individual was wearing a helmet or not, etc. The LPN stated she then made a determination of frequency and duration of head checks based on the information provided by the direct care staff.</p> <p>However, Idaho Administrative Code section 23.01.01, Rules of the Board of Nursing, in section 23.01.01460, states "Licensed practical nurses function in dependent roles. Licensed practical nurses, also referred to as LPNs, provide nursing care at the delegation of a licensed registered nurse, licensed physician, or licensed dentist pursuant to rules established by the Board." Section 23.01.01460.02(a) states the function of the LPN includes contributing "to the assessment of health status by collecting, reporting and recording objective and subjective data."</p> <p>The Rules allow LPNs to gather information, but not to make assessment decisions (such as frequency and duration of head checks after injury).</p>	W 331			

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W 331	Continued From page 12 During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the LPN stated there were no written parameters or guidelines used when she determined frequency and duration of head checks. The RN, who was present during the interview, stated she was not aware the LPN could not make assessment decisions related to head checks and confirmed no protocols or guidelines for making the determinations were in place. The RN stated it would not be appropriate to allow a person to go to bed one hour following a head injury without waking the person to assess for injury.	W 331		
W 336	The facility failed to ensure individuals were provided appropriate nursing services in relation to their needs related to head injury. 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews were completed on a quarterly basis for 2 of 4 individuals (Individuals #1 and #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: 1. Individual #1 and #3's medical records were reviewed. The records included nursing reviews	W 336	<u>W336</u> Corrective Actions: This issue was identified by the RN Supervisor prior to this survey and disciplinary action occurred with the LPN assigned to this location. Additionally, major revisions have occurred related to the design of the "Quarterly Nursing" screening form. Identifying Others Potentially Affected: All individuals at this location are potentially affected. System Changes: Please refer to "Corrective Actions". Monitoring: The RN Supervisor reviewing records on a regular basis and is meeting with the Administrator	02/03/16

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W 336	Continued From page 13 that were completed on 5/25/15, 8/24/15, and 11/30/15. The medical records did not include a completed review for the first quarter (January, February, March) of 2015.	W 336	to discuss issues of concern and so that he can supervisor her review of nursing systems.		
W 345	<p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the LPN and RN both stated the reviews had been missed due to an oversight, and no make-up review had been completed.</p> <p>The facility failed to ensure nursing reviews were completed on a quarterly basis.</p> <p>483.460(d)(3) NURSING STAFF</p> <p>The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.</p> <p>This STANDARD is not met as evidenced by: Based on review of Board of Nursing Rules and Regulations, observation, record review and staff interviews, it was determined the facility failed to ensure their RN was utilized as required by State law. This directly impacted 7 of 9 individuals (Individuals #3 - #9), and had the potential to impact all individuals (Individuals #1 - #9) residing at the facility. This resulted in the potential for individuals to experience negative impacts to their health. The findings include:</p> <p>1. The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state at IDAPA 23.01.01401.02(f) that the RN is responsible to maintain "safe and effective nursing care..." by "Acting as a patient's advocate" (as stated in IDAPA 23.01.01401.02(f)(iii) and by collaborating with other health professionals (as stated in</p>	W 345	<p><u>W345</u></p> <p>Please note: no individuals at this location experienced any negative impact to their health related to this issue.</p> <p>1. Please refer to W331. 2. Please refer to W368.</p> <p>Monitoring: The RN Supervisor reviewing records on a regular basis and is meeting with the Administrator to discuss issues of concern and so that he can supervisor her review of nursing systems.</p>	02/03/16	

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W 345	Continued From page 14 IDAPA 23.01.01401.02(h)). IDAPA 23.01.01401 states that in addition to providing hands on care, licensed RNs are responsible for "delegation, management, administration, teaching and case management... [and]...are expected to exercise competency in judgment, decision making, implementation of nursing interventions, delegation of function or responsibilities, and administering of medications and treatments prescribed by legally authorized persons." During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the RN stated she provided oversight to the facility, as well as providing on-call coverage when the LPN was not on duty or on-call. However, observation and record review did not indicate the oversight and monitoring provided by the RN was sufficient to meet the individual's needs, as follows: 1. Refer to W331 as it relates to the RN's failure to provide sufficient monitoring and oversight to ensure individuals received nursing services in accordance with their needs. 2. Refer to W368 as it relates to the RN's failure to ensure individuals' drugs were administered in accordance with physician orders.	W 345		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368	<u>W368</u> Please refer to the memo from the QIDP Supervisor to the CCI Administrator which is attached for an analysis of the development of this issue. The current RN had no	02/03/16

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W 368	<p>Continued From page 15</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 administer drugs as ordered by the physician for 6 of 9 individuals (Individuals #3- #5 and #7 - #9) whose physician's orders were reviewed. This resulted in individuals receiving medications without a physician's order. The findings include:</p> <p>1. An environmental review was conducted on 12/2/15 from 10:55 - 11:55 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> - Individual #4's grooming kit contained a can of Lotrimin foot spray. The Nursing 2015 Drug Handbook stated Lotrimin was an antifungal drug and stated potential adverse reactions included, but were not limited to, headache, allergic contact dermatitis, burning, irritation, maceration (the softening or breaking down of the skin), pain, and edema. However, Individual #4's Physician's Recap Orders, dated 9/21/15, did not include the use of the drug. - Individual #7's grooming kit contained a bottle of Oxy medicate face wash (a benzoyl peroxide drug), and a bottle of Clean and Clear astringent (a salicylic acid drug). Drugs.com stated potential side effects for benzoyl peroxide drugs included, but were not limited to, painful irritation of the skin, burning, blistering, difficulty breathing, hives, swelling of the eyes, face lips, or tongue, and tightness in the throat. Potential side effects for salicylic acid drugs included, but were not limited to, skin irritation, difficulty breathing, hives, swelling of the eyes, face, lips, or tongue, tightness in the throat, confusion, dizziness, headache, nausea, and headache. However, 	W 368	<p>responsibility for the initial development and implementation of our ADL system which has not been cited as problematic by surveyors since its implementation in 2010. (Attachment A)</p> <p>Corrective Actions: We have redesigned our Physician's Order Recap form (Attachment C), page 2 of our Nursing Summary form (Attachment D), and our documentation system for non-prescription treatments (Attachment E). We have also designed a staff certification record for delegated ADL duties Attachment F1-F3. After this plan of correction is accepted we will reprocess medication and treatment information.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to "Corrective Actions".</p> <p>Monitoring: The RN Supervisor reviewing records on a regular basis and is meeting with the Administrator to discuss issues of concern and so that he can supervisor her review of nursing systems.</p>	

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W 368	<p>Continued From page 16</p> <p>Individual #7's Physician's Recap Orders, dated 12/1/15, did not include the use of the drugs.</p> <p>- Individual #8's grooming kit contained a tube of Zapzyt acne gel 10% (a salicylic acid drug). However, Individual #8's Physician's Recap Orders, dated 12/1/15, did not include the use of the drug.</p> <p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the RN stated over-the-counter topical treatments were not necessarily on the physician's orders, but were included on the Nursing Summaries as Nurses Orders.</p> <p>Idaho Administrative Code section 23.01.01, Rules of the Board of Nursing, states at section 23.01.01101.04(e) "The nurse shall not obtain, possess, furnish or administer prescription drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs." The Rules state, at section 23.01.01315.04, that Advanced Practice Registered Nurses "may prescribe and dispense pharmacologic and non-pharmacologic agents pursuant to applicable state and federal laws."</p> <p>During an interview on 12.3.15 from 11:25 a.m. - 12:40 p.m., the RN stated she was not an Advanced Practice Registered Nurse.</p> <p>Individuals' Nurses Orders were reviewed and documented the following:</p> <p>- Individual #3's Nurses Orders, undated, included the use of hydrocortisone cream 1% PRN to red/irritated skin. The Nursing 2015 Drug Handbook stated hydrocortisone was a corticosteroidal drug, and stated potential side</p>	W 368		

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W 368	<p>Continued From page 17</p> <p>effects included, but were not limited to, glycosuria, burning, hypertrichosis (excessive hair growth), allergic contact dermatitis, maceration, and hypothalamic-pituitary-adrenal (HPA) axis suppression (suppression of immune and inflammatory reactions). However, Individual #3's Physician's Recap Orders, dated 9/21/15, did not include the use of the drug.</p> <p>- Individual #5's Nurses Orders, undated, included the use of Oxy face wash (a benzoyl peroxide drug). Individual #5's Physician's Recap Orders, dated 9/21/15, did not include the use of the drug.</p> <p>- Individual #8's Nurses Orders, undated, included the use hydrocortisone cream 1%. However, Individual #8's Physician's Recap Orders, dated 12/2015, did not include the use of the drugs.</p> <p>- Individual #9's Nurses Orders, undated, included the use of Clean and Clear to face, product unspecified (e.g., astringent, gel, etc.). Drugs.com stated Clean and Clear products are benzoyl peroxide drugs. However, Individual #9's Physician's Recap Orders, dated 12/2015, did not include the use of the drug.</p> <p>During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the LPN confirmed the individuals were receiving the topical treatments as indicated on their Nurses Orders. The RN and LPN both stated they were not aware they could not create nurses orders for individuals' topical drugs.</p> <p>The facility failed to ensure medications were administered in accordance with physicians' orders.</p>	W 368		

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W 382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</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 drugs and biologicals were maintained under locked conditions, which had the potential to impact 9 of 9 individuals (Individuals #1 - #9) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:</p> <p>1. An environmental review was conducted on 12/2/15 from 10:55 - 11:55 a.m. During that time, the following unlocked drugs and biologicals were observed in individuals' grooming kits:</p> <ul style="list-style-type: none"> - Individual #4's grooming kit contained a can of Lotrimin foot spray. The Nursing 2015 Drug Handbook stated Lotrimin was an antifungal drug and stated potential adverse reactions included, but were not limited to, headache, allergic contact dermatitis, burning, irritation, maceration (the softening or breaking down of the skin), pain, and edema. - Individual #5's grooming kit contained a bottle of Clean and Clear Persa-gel 10 (a benzoyl peroxide drug). Drugs.com stated potential side effects for benzoyl peroxide drugs included, but were not limited to, painful irritation of the skin, burning, blistering, difficulty breathing, hives, swelling of the eyes, face lips, or tongue, and tightness in the throat. 	W 382	<p>W382</p> <p>Corrective Actions: All biologicals and medicated treatments will be locked up. We believe that we got confused between changes in State Regulations related to unlocking chemicals and the federal regulations related to locking biological and medicated products. Additionally, there were no adverse effects to this issue although we understand the potential for adverse consequences is always possible.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to "Corrective Actions".</p> <p>Monitoring: The RN Supervisor reviewing system on a regular basis and will do a monthly check on locking of these medications for the next six months and intermittently thereafter.</p>	02/03/16	

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W 382	Continued From page 19 - Individual #7's grooming kit contained a bottle of Oxy medicate face wash (a benzoyl peroxide drug), and a bottle of Clean and Clear astringent (a salicylic acid drug). Drugs.com stated potential side effects for benzoyl peroxide drugs included, but were not limited to, painful irritation of the skin, burning, blistering, difficulty breathing, hives, swelling of the eyes, face lips, or tongue, and tightness in the throat. Potential side effects for salicylic acid drugs included, but were not limited to, skin irritation, difficulty breathing, hives, swelling of the eyes, face, lips, or tongue, tightness in the throat, confusion, dizziness, headache, nausea, and headache. - Individual #8's grooming kit contained a tube of Zapzyt acne gel 10% (a salicylic acid drug). During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the LPN stated she did not know medicated lotions and acne treatments needed to be locked. The facility failed to ensure all drugs and biologicals were maintained under locked conditions.	W 382			
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. 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.	W 454	<u>W454</u> Corrective Actions: Checking grooming kits for safety and sanitation is ultimately an Assistant QIDP responsibility in our system. This AQIDP will receive a formal written counseling related to this issue. Further failures to monitor these items sufficiently will result in disciplinary actions.	02/03/16	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #9 MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 876 EAST MAIN JEROME, ID 83338		
(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 20</p> <p>That failure directly impacted 8 of 9 individuals (Individuals #1 - #8) residing at the facility, and had the potential to impact all individuals (Individuals #1 - #9). That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:</p> <p>1. An environmental review was conducted on 12/2/15 from 10:55 - 11:55 a.m. During that time, the following concerns were observed with individuals' grooming kits:</p> <ul style="list-style-type: none"> - Individual #1's grooming kit contained an uncovered tooth brush, a can of shaving cream, 2 cans of body spray, 2 bottles of deodorant, a bottle of hair spray, a bottle of apricot facial scrub, and a small unmarked bottle with a clear liquid. - Individual #2's grooming kit contained an uncovered tooth brush, a container with bar soap, a brush, and a bottle of deodorant. - Individual #3's grooming kit contained 2 uncovered tooth brushes, 2 bottles of apricot face scrub, a small unmarked bottle containing a clear liquid, a safety razor, a can of shave cream, nail clippers, and a comb. - Individual #4's grooming kit contained 2 uncovered tooth brushes, a can of shaving cream, 2 bottles of deodorant, nail clippers, 2 combs, a can of Lotrimin antifungal foot spray, and a bottle of body wash. - Individual #5's grooming kit contained an uncovered tooth brush, a container with bar soap, a bottle of apricot face scrub, a bottle of deodorant, a bottle of Clean and Clear Persa-gel 	W 454	<p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to "Corrective Actions."</p> <p>Monitoring: QIDP will do a random monthly "spot check" related to grooming kit sanitation monthly and will document this on a CCI "Narrative Observation" form. Further issues related to AQIDP performance will be discussed with the Administrator.</p>		

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W 454	Continued From page 21 10, a bottle of hair spray, a can of body spray, a bottle of mouth wash, a nail clipper and a comb. - Individual #6's grooming kit contained an uncovered toothbrush, a bottle of hair spray, 2 containers of deodorant, a can of shaving cream, 2 safety razors, 2 tubes of Equate diaper rash ointment, 2 combs, and a dental mirror. - Individual #7's grooming kit contained an uncovered toothbrush, a bottle of Gold Bond medicated powder, a hair brush, a can of shaving cream, a bottle of deodorant, a can of body spray, a bottle of body wash, a bottle of Oxy medicate face wash, 2 combs, and a bottle of Clean and Clear astringent. - Individual #8's grooming kit contained 3 uncovered tooth brushes, a can of shave cream, a brush, a bottle of lotion, a tube of Zapzyt acne gel 10%, a bottle of deodorant, nail clippers, an electric razor, and a small unmarked bottle of blue liquid. During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the AQIDP stated grooming kits should be kept clean and all tooth brushes should be covered. The AQIDP stated the kits should be checked each shift, but stated she has not been ensuring the checks were being completed. When asked about he unmarked bottles, the AQIDP stated she believed they contained mouthwash and should be labeled. The facility failed to ensure appropriate infection control procedures were implemented.	W 454			
W 474	483.480(b)(2)(iii) MEAL SERVICES	W 474	<u>W474</u>	02/03/16	

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W 474	<p>Continued From page 22</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, record review, and staff interview, it was determined the facility failed to ensure each individual's diet order was followed as prescribed for 1 of 9 individuals (Individual #5) who were observed eating dinner. This resulted in the potential for an individual to experience swallowing difficulties and possible aspiration. The findings include:</p> <p>1. Individual #5's IPP, dated 3/26/15, documented a 24 year old male whose diagnoses included severe intellectual disability.</p> <p>His record contained a Quarterly Nutrition Assessment, dated 10/29/15, which documented he was to receive a mechanical soft diet.</p> <p>Additionally, his Physician's Recap Orders, dated 9/21/15, documented his diet texture was mechanical soft and his Special Diet Instructions documented his meat was to be ground.</p> <p>However, during an observation on 12/1/15 from 4:35 - 5:46 p.m., staff was noted to spoon feed Individual #5 a piece of pot roast approximately one half inch by one half inch which he had a difficult time chewing.</p> <p>When the DCS assisting Individual #5 was asked about his diet texture, she stated it was mechanical soft. However, the pot roast on his plate ranged from approximately one inch by one inch to approximately one inch by one and one half inches.</p>	W 474	<p>Corrective Actions: The menu which was prepared by the dietician indicated that roast beef was to be chopped. The information on instruction for preparation of meat on the "Special Diet Instructions" indicated to staff that meats were to be ground. This inconsistency was not identified by employees at any level. The dietician has been contacted about make changes to the menu so that it is consistent with the "Special Diet Instructions." We will do an inservice training with staff to inform them to bring such inconsistencies in instructions to the attention of management staff so that corrections can be made.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: Please refer to "Corrective Actions."</p> <p>Monitoring: The RN Supervisor will do a random monthly "spot check" related to menus and will note any issues in her documentation of review to the Administrator so that necessary corrective actions can occur.</p>		

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W 474	Continued From page 23 The DCS was then noted to cut Individual #5's pot roast into pieces consistent with his dietary requirements. During an interview on 12/3/15 from 11:25 a.m. - 12:40 p.m., the RN and QIDP both stated Individual #5's pot roast should have been finely chopped or ground. The facility failed to ensure Individual #5 received an appropriate dietary texture.	W 474			

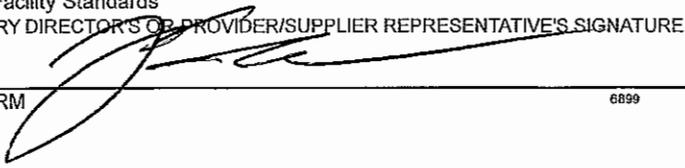
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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the licensure survey conducted from 12/1/15 to 12/3/15.</p> <p>The surveyors conducting your survey were:</p> <p>Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>AQIDP - Assistant Qualified Intellectual Disabilities Professional</p>	M 000	<p style="text-align: center;">RECEIVED DEC 24 2015 FACILITY STANDARDS</p>	
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 W120.</p>	MM080	<p><u>MM080</u> Please refer to W120</p>	02/03/16
MM155	<p>16.03.11300 Facility Staffing</p> <p>The requirements of Sections 300 through 399 of these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules</p> <p>This Rule is not met as evidenced by:</p>	MM155	<p><u>MM155</u> Please refer to W159</p>	02/03/16

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



TITLE

Administrator

(X6) DATE

12/21/15

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MM155	Continued From page 1 Refer to W159.	MM155		
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W239.	MM159	<u>MM159</u> Please refer to W239	02/03/16
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 W331, W336, W345, W368 and W382.	MM166	<u>MM166</u> Please refer to W331, W336, W345, W368, and W382	02/03/16
MM169	16.03.11700 Physical Environment The requirements of Sections 700 through 799 of 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	MM169	<u>MM169</u> Please refer to W454	02/03/16

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MM169	Continued From page 2 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W454.	MM169		
MM190	16.03.11703.02 Chemical Storage All toxic chemicals must be properly labeled and stored according to the manufacturer's instructions. Toxic chemicals must not be stored in individual areas, with drugs, or in any area where food is stored, prepared, or served. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all chemicals were properly labeled for 9 of 9 individuals (Individuals #1 - #9) residing at the facility. This resulted in chemicals being without labels that identified their contents. The findings include: 1. An environmental review was conducted on 12/2/15 from 10:55 - 11:55 a.m. During that time, the following was observed: - There was an orange liquid in an unmarked spray bottle under the kitchen sink on the young adult side of the facility. The AQIDP, who was present during the review, stated the bottle contained Lysol and should have been labeled. The facility failed to ensure all chemicals were properly labeled.	MM190	<u>MM190</u> Corrective Actions: It is the practice of this facility to label and store all chemicals in accordance to current rules and regulations. The unlabeled chemical found in this survey has been labeled. The AQIDP conducts monthly checks of the exterior and interior of the facility and documents these findings on a "Preventative Maintenance Checklist." Making sure chemicals are properly stored and labeled has been added to this list to be monitored by AQIDP (See Attachment G). Identifying Others Potentially Affected: All individuals at this location were potentially affected. System Changes: Please refer to "Corrective Actions" section. Monitoring: Chemicals will be checked on an ongoing basis and findings recorded on the "Preventative Maintenance Checklist." This is completed by the AQIDP and reviewed by the Administrator every month. The Administrator has reviewed this process with the AQIDP to improve monitoring of these types of issues.	02/03/16

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MM215	Continued From page 3	MM215	<u>MM215</u>	02/03/16
MM215	<p>16.03.11711.01 Good Repair</p> <p>Each building used by the ICF/ID and its equipment must be in good repair.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 9 of 9 individuals (Individuals #1 - #9) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 12/2/15 from 10:55 - 11:55 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> - There was an approximately one and one half by two and one half inch section of exposed chip board in the hall outside the shower room on the east side. - There was a patch approximately one foot by one foot by the light switch in the laundry room that was unpainted on the east side. - There was a section of calking approximately five feet long along the back of the tub room sink counter that was cracked and peeling on the east side. - There was a patched area approximately two and a half feet by eight inches between the two closets in Individual #1's room that was not painted. - The dresser in Individual #2's room was missing two of the eight handles. 	MM215	<p>Corrective Actions: This facility is a home to individuals with significant maladaptive behaviors. While efforts are made to make sure this facility is in good order at times it is difficult to complete maintenance needs.</p> <p>The following issues will be repaired:</p> <ol style="list-style-type: none"> 1. A section of exposed chip board in the hall outside the shower room on the east side. 2. An unpainted patch by the light switch in the laundry room on the east side. 3. Cracking caulk line along the back of the tub room sink on the east side. 4. An unpainted area in Individual #1's room. 5. Missing handles on Individual #2's dresser. 6. Section of base board under window of Individual #2's bedroom window. 7. The couch with rips will be repaired or replaced on the east side. 8. The love seat will be repaired or replaced on the east side. 9. The microwave has been cleaned. 10. The section of window seal in Individual #5 and #7's room. 11. Unpainted patches on the west side entry. 12. Missing two top knobs on #3's dresser. 13. Caulking around the shower room sink on the west side. 	

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MM215	Continued From page 4 <ul style="list-style-type: none"> - There was a section of base board approximately one foot long missing under the window of Individual #2's bedroom window. - The couch on the east side had a rip on the back cushion approximately two by four inches and a rip approximately six inches long on the arm. - The love seat on the east side had a rip approximately six by four inches long. - The microwave on the east side had food stains and splatters. - The window sill in Individual #5 and #7's room had a section of plaster approximately one inch by four inches and had exposed metal. - The west side entry way had three patched areas that were approximately four inches by four inches, eight inches by six inches, and one and a half foot by one foot that were unpainted. - The dresser in Individual #3's room was missing the two top knobs. - The calking around the shower room sink counter was peeled, cracked, and missing up the right side and the back on the west side. <p>The facility failed to ensure environmental repairs were completed and maintained.</p>	MM215	Identifying Others Potentially Affected: All individuals at this location are potentially affected. System Changes: No changes are needed upon repair of the list of items. Monitoring: Exterior and Interior repair issues are handled through a "Preventative Maintenance Checklist." This is completed by the AQIDP and reviewed by the Administrator every month. The Administrator has reviewed this process with the AQIDP to improve monitoring of these types of issues.	
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),	MM366	<u>MM366</u> Please refer to W474	02/03/16

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MM366	<p>Continued From page 5</p> <p>Condition of Participation: Dietetic Services incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W474.</p>	MM366		