



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 15, 2016

Tami Malone, Administrator
Independent Living Services Five Mile
P.O. Box 6395
Boise, ID 83711

RE: Independent Living Services Five Mile, Provider #13G006

Dear Ms. Malone:

This is to advise you of the findings of the Medicaid/Licensure survey of Independent Living Services Five Mile, which was conducted on January 13, 2016.

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;

Tami Malone, Administrator
January 15, 2016
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **January 27, 2016**, 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:

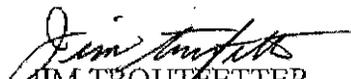
www.icfmr.dhw.idaho.gov

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 January 27, 2016. If a request for informal dispute resolution is received after January 27, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,


JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures

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

PRINTED: 01/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2016
NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING SERVICES FIVE MILE			STREET ADDRESS, CITY, STATE, ZIP CODE 1736 NORTH FIVE MILE ROAD BOISE, ID 83704	
(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 1/11/16 - 1/13/16. The surveyors conducting your survey were: Jim Trouffetter, QIDP, Team Lead Michael Case, LSW, QIDP Common abbreviations used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record	W 000		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate general and preventative medical care was provided for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in a lack of follow-through with a dietary recommendation. The findings include: 1. Individual #1's IPP, dated 12/17/15, documented a 20 year old male whose diagnoses included severe intellectual disability and seizure disorder. Individual #1's record contained a Nutritional Assessment and Evaluation, dated 11/19/12, which stated long term Depakote (an	W 322	<p>10 322 -</p> <p>1. THE PRIMARY AND NEUROLOGICAL PHYSICIANS FOR INDIVIDUAL #1 WILL BE CONTACTED TO REVIEW THE RECOMMENDATIONS AND DETERMINE THE APPROPRIATE COURSE FOR THIS INDIVIDUAL AND THOSE RECOMMENDATIONS WILL BE IMPLEMENTED BY 2/26/16 BY THE NURSE AND MONITORED BY PROGRAM ADMINISTRATOR.</p> <p>2. ALL INDIVIDUAL RECORDS WILL BE REVIEWED TO IDENTIFY INDIVIDUALS W/ NUTRITIONAL RECOMMENDATIONS ARE BEING FOLLOWED BY FACILITY BY 2/5/16 BY PROGRAM ADMINISTRATOR.</p> <p>3. INDIVIDUALS WILL BE REVIEWED FOR DIETARY RECOMMENDATIONS</p>	

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

TITLE

(X6) DATE

Amara Malone

Program Administrator

1/25/16

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 322	Continued From page 1 anticonvulsant drug) use can deplete folicin and vitamin D and recommended a vitamin supplement containing folicin (a B vitamin) and vitamin D. His record also contained a physician's order, dated 11/17/15, which documented he received Depakote Sprinkles (an anticonvulsant drug) 375 mg twice a day. The physician's order did not contain an order for the recommended vitamin supplement. During an interview on 1/13/16 from 1:20 - 2:00 p.m., the Administrator stated she was unable to provide documentation of a follow up related to the dietician's recommendation.	W 322	3. (cont) - AT TIME OF ANNUAL ITPP MEETING AND AGAIN WHEN INDIVIDUAL CHARTS ARE RENEWED FOR COMPLETENESS BY PROGRAM ADMINISTRATOR	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual medication administration record was maintained for 1 of 5 individuals (Individual #5) whose medication administration records were reviewed. This resulted in a lack of documentation of an individual's drug administration. The findings include: 1. Individual #5's record documented a 17 year old female whose diagnoses included profound intellectual disability.	W 365	w-365 1. ALL CURRENT MARX FOR INDIVIDUAL #5 WILL BE RENEWED BY NURSE FOR ACCURATE DOCUMENTATION. ADDITIONAL TRAINING AND OBSERVATION FOR STAFF RESPONSIBLE FOR OBSERVED DISCREPANCY W/ INDIVIDUAL #5 MEDICATION WILL BE COMPLETED BY 1/28/16. IN ADDITION, ALL SHIFTS WILL BE OBSERVED DELIVERING MEDICATIONS BY NURSE AND/OR HOME SUPERVISOR BY 2/26/16. 2. CURRENT INDIVIDUAL MARX WILL BE RENEWED FOR ACCURATE DELIVERY AND DOCUMENTATION BY NURSE AND/OR HOME SUPERVISOR BY 1/26/16	

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W 365	Continued From page 2 Individual #5's record contained a Behavior Log which documented Xanax (an anxiolytic drug) had been administered on 1/11/16 at 1:30 a.m. However, her MAR, dated 1/2016, did not contain documentation the drug had been administered. During an interview on 1/13/16 from 1:20 - 2:00 p.m., the Administrator stated the Xanax should have been documented on Individual #5's MAR. The facility failed to ensure Individual #5's medication administration record was accurately maintained.	W 365	2) CONT. - ANY ADDITIONAL DEFICIT WILL RESULT IN ADDITIONAL TRAINING ETC AS STATED ABOVE AND MONITORED BY PROGRAM ADMINISTRATOR 3) ALL STAFF CERTIFIED TO DELIVER MEDICATION WILL BE PERIODICALLY OBSERVED BY NURSE ANTHONIE SUPERVISOR TO ENSURE MAINTENANCE OF ACCURATE DELIVERY AND DOCUMENTATION. TO BE MONITORED BY PROGRAM ADMINISTRATOR ON A MONTHLY BASIS BASED ON MONTHLY SUPERVISOR OBSERVATION REPORTS.	
W 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain records of the receipt and disposition of all controlled drugs for 1 of 1 individuals (Individual #5) whose controlled drug records were reviewed. This resulted in potential mismanagement of controlled substances by the facility. The findings include: 1. Individual #5's record documented a 17 year old female whose diagnoses included profound intellectual disability. Individual #5's record included a Behavior Log form which documented she had received Xanax	W 385	W 385 - 1) THE PHARMACY PROVIDED THE FACILITY WITH THE "CONTROLLED DRUG ADMINISTRATION RECORD" (CDAR) FOR INDIVIDUAL # 5 THIS RECORD HAS BEEN ADDED TO TRACK CONTROLLED MEDICATIONS AS OF 1/25/16. THE NURSE WILL PERIODICALLY RECONCILE THE FORM WHILE IT IS IN USE AND AGAIN WHEN FORM IS COMPLETED IN ADDITION TO ADDING TO MEDICATION DONE ZYADAY IN FACILITY. THE COMPLETED RECORD WILL THEN BE KEPT IN A PERMANENT FILE FOR INDIVIDUAL #5 TO BE MAINTAINED BY THE NURSE AND MONITORED BY	

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W 385	<p>Continued From page 3 (an anxiolytic drug) on 1/11/16 at 1:30 a.m. However, the drug administration was not documented on the MAR.</p> <p>During an interview on 1/13/16 at approximately 1:15 p.m., the Home Supervisor was asked how controlled drugs were tracked. The Home Supervisor stated direct care staff would initial and date the blister pack when a controlled drug was administered. When asked to see the blister pack, the Home Supervisor stated it had been disposed of because the dose given on 1/11/16 was the last dose in the blister pack. The Home Supervisor was not aware of any other way controlled drugs were tracked.</p> <p>During an interview on 1/13/16 from 1:20 - 2:00 p.m., the LPN stated she signed a form for the pharmacy when she took possession of a controlled drug for the facility, and then placed the blister pack with the drug in the medication cabinet at the facility when it was needed. The LPN stated direct care staff were to initial and date the blister pack when a controlled drug was given and document the administration on the MAR. The facility then had a process to check the blister packs against the MAR twice a day to ensure the documentation matched.</p> <p>When asked about controlled drug tracking sheets, the LPN stated the facility had none. When asked how the facility maintained records of the receipt and disposition of the controlled drugs, the LPN stated there was no process other than comparing blister packs with the MAR. The LPN confirmed blister packs were not maintained after they were empty.</p> <p>The facility failed to ensure a system to track</p>	W 385	<p>1) cont - THE PROGRAM ADMINISTRATOR DURING ROUTINE CHART REVIEWS</p> <p>2) ALL INDIVIDUALS TAKING CONTROLLED MEDICATIONS WILL BEGIN USING THE ABOVE MENTIONED RECORD SPECIFIC TO THAT INDIVIDUAL BY 2/1/16 AND WILL BE MONITORED AS STATED ABOVE.</p> <p>3) ANY INDIVIDUAL PRESCRIBED A CONTROLLED MEDICATION WILL BE NOTIFIED BY PHARMACY AT TIME AND WILL SEND THE "COAR" FOR NURSE TO IMPLEMENT AND MONITOR AS STATED ABOVE</p>	

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W 385	Continued From page 4 receipt and disposition of all controlled drugs was developed and maintained.	W 385			

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 state licensure survey conducted from 1/11/16 - 1/13/16.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Michael Case, LSW, QIDP</p>	M 000	<p style="text-align: center;">RECEIVED JAN 26 2016 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 W322, W365 and W385.</p>	MM166		<p><i>see plan of correction for federal tag</i></p>

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrative</i>	(X6) DATE 1/29/16
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