



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
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February 1, 2016

Russell McCoy, Administrator
Rulon House
415 South Arthur
Pocatello, ID 83204

RE: Rulon House, Provider #13G020

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of Rulon House, which was conducted on January 28, 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;

Russell McCoy, Administrator
February 1, 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 **February 11, 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 February 11, 2016. If a request for informal dispute resolution is received after February 11, 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



Promoting Functional Independence Through Person Centered Services

February 10, 2016

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FACILITY STANDARDS

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the survey completed January 28, 2016. On the Statement of Deficiencies / Plan of Correction, Form CMS-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed below.

Sincerely,

Russell C. McCoy, M.A., Ed.
Executive Director

Enclosures

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

PRINTED: 01/29/2016
FORM APPROVED
OMB NO. 0938-0391

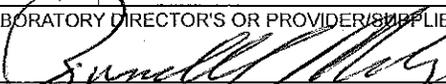
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER RULON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 1/25/16 - 1/28/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP Common abbreviations used in this report are: ATS - Active Treatment Specialist HRC - Human Rights Committee IPP - Individual Program Plan	W 000		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the human rights committee sufficiently monitored the facility's practices related to control of inappropriate behavior and protection of individuals' rights for 1 of 4 individuals (Individual #1) residing in the facility. This resulted in restrictive interventions being implemented without prior review or approval. The findings include:	W 264	W264 483.440(f)(3)(iii) For Individual #1, a current HRC document will be presented to the committee for approval. All other individuals' HRC documents will be reviewed for accuracy and appropriate approval documentation. To ensure this deficient practice does not occur again, a schedule will be developed for when each resident's HRC Document is due for renewal. The Residential Program Director will follow this schedule for committee meeting content. Corrective Action Completion Date: March 10, 2016 Person Responsible: Jamie L. Anthony, Residential Program Director	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 02/10/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 264	Continued From page 1 Individual #1's IPP, dated 8/4/15, documented a 46 year old male whose diagnoses included mild intellectual disability. His record was reviewed and did not contain current approvals for the use of video monitoring, Luvox and Invega. During an observation on 1/25/16 from 2:10 - 3:35 p.m. video cameras were noted to be installed in common areas both upstairs and downstairs and were monitored on a screen in the downstairs pantry area. His record also contained a Physician's Orders form, dated 11/13/15, which documented he received Invega (an antipsychotic drug) 9 mg daily and Luvox (an antidepressant drug) 150 mg in the morning and 250 mg in the evening. During an interview on 1/28/16 from 9:40 - 10:05 a.m., the Program Director stated current HRC approvals had not been obtained due to an oversight.	W 264		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.	W 426	W426 483.470(d)(3) For Individual #4 and #5, as well as all other individuals in the facility who are unable to self-regulate temperatures, the Physical Facilities Manager has obtained a new thermometer that can be calibrated. This will ensure an accurate reading on the thermometer. He will also calibrate his thermometer	

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W 426	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 2 of 7 individuals (Individuals #4 and #5) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include:</p> <p>1. An environmental review was conducted on 1/27/16 from 9:38 - 10:05 a.m. During that time, water temperatures were as follows:</p> <ul style="list-style-type: none"> - Bathroom in Individuals #4 and #5's bedroom - 116.4 degrees Fahrenheit - Upstairs hall bathroom - 116.4 degrees Fahrenheit - Downstairs hall bathroom - 116.7 degrees Fahrenheit <p>The ATS, who was present during the environmental review, stated Individuals #4 and #5 were unable to independently regulate the water temperatures.</p> <p>During an interview on 1/28/16 from 9:08 - 9:40 a.m., the ATS stated Individuals #4 and #5 did not have a training program to teach them to self regulate water temperatures.</p> <p>The facility failed to ensure water temperatures were maintained at 110 degrees Fahrenheit or below for Individuals #4 and #5.</p> <p>Note: Water temperatures were re-checked on 1/28/16 at 8:00 a.m. and found to be within an acceptable range.</p>	W 426	<p>once a quarter and test the water temperatures once a month to ensure each faucet's hot water does not exceed 110 degrees Fahrenheit.</p> <p>Corrective Action Completion Date: February 12, 2016</p> <p>Person Responsible: Jesse Atwell, Physical Facilities Manager</p>		

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W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</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 evacuation drills were conducted quarterly for each shift of personnel for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas in the event of an emergency. The findings include:</p> <p>1. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the swing shift (3:00 - 11:00 p.m.) during the first quarter (January - March) of 2015.</p> <p>During an interview on 1/28/16 from 9:40 - 10:05 a.m., the Program Director stated the evacuation drill for the swing shift had not been completed due to an oversight.</p> <p>The facility failed to ensure an evacuation drill was completed for the swing shift during the first quarter of 2015.</p>	W 440	<p>W440 483.470(i)(1)</p> <p>The Residential Program Director will revise the tracking form to ensure a day shift, swing shift, and graveyard evacuation drill is completed each quarter.</p> <p>Corrective Action Completion Date: March 1, 2016</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>		

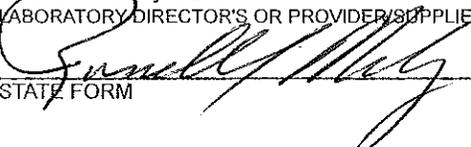
Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 1/25/16 - 1/28/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP	M 000		
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 W264.	MM159	MM159 16.03.11400 Refer to W264	
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 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W426 and W440.	MM169	MM169 16.03.11700 Refer to W426 and W440	

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