



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  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 19, 2016

Rex Redden, Administrator  
Idaho Falls Group Home #2 Wanda  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #2 Wanda, Provider #13G029

Dear Mr. Redden:

This is to advise you of the findings of the Complaint survey, which was conducted at your facility, Idaho Falls Group Home #2 Wanda, on April 14, 2016.

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

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

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

Rex Redden, Administrator  
April 19, 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 the 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 **May 2, 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](http://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 May 2, 2016. If a request for informal dispute resolution is received after May 2, 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,

  
MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 04/14/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  
**IDAHO FALLS GROUP HOME #2 WANDA**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**4360 WANDA STREET  
AMMON, ID 83406**

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

M 000	16.03.11 Initial Comments  The following deficiencies were cited during the complaint survey conducted from 4/13/16 - 4/14/16.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Autumn Bernal, RN, BSN  Common abbreviations used in this report include:  QIDP - Qualified Intellectual Disability Professional	M 000		
MM342	16.03.11741.02 Report of Fire  Each ICF/ID must submit to the Department a separate report of each fire incident that occurs within the facility within thirty (30) days of the occurrence. The facility must use the Department's reporting form, "Facility Fire Incident Report," available online at: <a href="http://www.facilitystandards.idaho.gov">http://www.facilitystandards.idaho.gov</a> . The facility must provide all specific data concerning the fire including the date, origin, extent of damage, method of extinguishment, and injuries, if any, for each fire incident. A reportable fire incident is when a facility has an incident:  This Rule is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a report for each fire incident was submitted to the Department within 30 days for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This failure resulted in a lack of required data being reported to the Department. The findings include:	MM342	MM342  1. A fire incident report has been submitted to the Department. The staff of the Wanda Home will be trained on how to document an evacuation report in case this happens again in the future.  2. All individuals at all facilities have the potential to be affected by this practice. All staff in all facilities will be trained on how to document an evacuation report in the event a fire occurs in the facility. All management staff will be trained on how to submit a fire incident report to the Department within 30 days of the fire occurring according to the regulation.  3. The QIDP will train all members of management on the regulation regarding submitting the fire incident report to the department within 30 days of a fire occurring in a facility. The QAM's and Home Supervisors will train staff on how to complete an evacuation drill in the event a fire occurs and a member of management is not present in the home.	

RECEIVED  
MAY 02 2016  
FACILITY STANDARDS

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

TITLE

(X8) DATE

*Key A Redden*

administrator

5/2/16

## Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/14/2016
NAME OF PROVIDER OR SUPPLIER  IDAHO FALLS GROUP HOME #2 WANDA		STREET ADDRESS, CITY, STATE, ZIP CODE 4360 WANDA STREET AMMON, ID 83406		
(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) COMPLETE DATE
MM342	<p>Continued From page 1</p> <p>1. During an interview on 4/14/16 at 11:23 a.m., a direct care staff stated a fire had started in the facility's oven sometime during the second or third week of January 2016. The direct care staff stated individuals were evacuated and the fire department responded. The facility staff had extinguished the fire prior to the arrival of the fire department.</p> <p>On 4/14/16 at 3:30 p.m., the facility's fire reports were requested for review. The QIDP and Finance and Personnel Coordinator both stated a fire had occurred on 1/19/16 at 6:39 p.m. However, the QIDP stated a report had not been completed and the Department had not been notified.</p> <p>The facility failed to ensure a fire incident report was submitted to the Department within 30 days.</p>	MM342	<p>MM342 cont'd</p> <p>4. The QIDP/QAM will be notified if a fire occurs in a facility. The QAM will be responsible for completing the fire incident report, and submit it to the QIDP for review. All evacuation drills will be submitted to the QIDP for review.</p> <p>5. The QIDP, QAM, and Home Supervisor will be responsible for ensuring that staff are trained on how to complete an evacuation drill, and how to complete a fire incident report in the event a fire occurs in one of the facilities.</p> <p>6. Target date for completion will be June 20, 2016.</p>	



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  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 19, 2016

Rex Redden, Administrator  
Idaho Falls Group Home #2 Wanda  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

Provider #13G029

Dear Mr. Redden:

An unannounced on-site complaint investigation was conducted from April 13, 2016 to April 14, 2016 at Idaho Falls Group Home #2 Wanda. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007278**

**Allegation #1:** Individuals are subjected to abuse and the facility does not address the concerns.

**Findings #1:** During the investigation, observations, record review, and staff interviews were conducted with the following results:

The facility's accident and injury forms from 1/1/16 - 4/13/16 were reviewed. None of the forms documented concerns of abuse taking place. The facility's investigations from 10/8/15 - 4/13/16 were reviewed. Two investigations had been completed.

One investigation, dated 11/5/15, documented a direct care staff had used an inappropriate tone of voice and "slapped" an individual's hand away from her plate. A second investigation, dated 3/8/16, documented a direct care staff had yelled at an individual causing maladaptive behavior. In both incidents, the direct care staff accused were immediately suspended, and both were subsequently terminated as a result of the investigations.

Rex Redden, Administrator  
April 19, 2016  
Page 2 of 4

Observations were conducted at the facility on 4/13/16 from 4:10 - 5:00 p.m., and on 4/14/16 from 8:15 - 9:00 a.m. During those times, no individuals were observed to be subjected to abuse, neglect, or mistreatment. Additionally, none of the individuals demonstrated fear or concern around any of the direct care staff present.

Six direct care staff were interviewed across shifts, on 4/14/16 from 11:23 a.m. - 12:10 p.m. and 2:28 - 3:06 p.m. All 6 direct care staff were able to describe the facility's process for identifying and reporting allegations of abuse, neglect, and mistreatment. All 6 direct care staff stated they were unaware of any situations of abuse other than the allegations investigated by the facility (dated 11/5/15 and 3/8/16).

The facility appropriately addressed allegations of abuse, neglect, and mistreatment. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The facility failed to adequately address environmental safety concerns.

**Findings #2:** During the investigation, observations, record review, and staff interviews were conducted with the following results:

Observations were conducted at the facility on 4/13/16 from 4:10 - 5:00 p.m., and on 4/14/16 from 8:15 - 9:00 a.m. During those times, no environmental safety concerns were noted.

Six direct care staff were interviewed across shifts, on 4/14/16 from 11:23 a.m. - 12:10 p.m. and 2:28 - 3:06 p.m. All 6 direct care staff were able to describe the facility's process for identifying and reporting environmental safety concerns. Four of the 6 direct care staff stated a fire had occurred in the oven sometime in January 2016. The 4 direct care staff stated, individuals were evacuated and a direct care extinguished the fire. All 4 direct care staff stated the oven was replaced the next day.

The Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance Manager (QAM) were interviewed on 4/14/16 at 3:30 p.m. Both the QIDP and the QAM stated a fire had occurred on 1/19/16 at 6:39 p.m. Both stated the fire had been contained in the oven, and all individuals were evacuated. Both stated monthly staff meetings were held and a Standing Agenda was utilized for the meetings. The Standing Agenda was reviewed and noted to include environmental issues such as cleaning, infection control, and emergency evacuation procedures. The QAM stated fire safety had been addressed at a recent meeting.

Rex Redden, Administrator  
April 19, 2016  
Page 3 of 4

It could not be determined the facility failed to address environmental safety concerns. Therefore, the allegation was unsubstantiated and no deficient practice was identified. A related deficient practice was identified for a failure to report the fire incident to the Department and the facility was cited at M342.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** Individuals' needs are not met due to a lack of communication between staff.

**Findings #3:** During the investigation, observations, record review, and staff interviews were conducted with the following results:

The facility's accident and injury forms from 1/1/16 - 4/13/16 were reviewed. None of the forms documented concerns that would indicate individuals' needs were not being met.

Observations were conducted at the facility on 4/13/16 from 4:10 - 5:00 p.m., and on 4/14/16 from 8:15 - 9:00 a.m. During those times, direct care staff were observed to communicate with one another to ensure individuals' needs were met, including but not limited to sensory, physical therapy, toileting and grooming needs.

For example, at the completion of the morning meal, on 4/14/16 at 8:30 a.m., one direct care staff began assisting an individual with washing dishes. The direct care staff communicated to her coworkers what she was doing, and requested their assistance with other individuals to complete grooming tasks.

Six direct care staff were interviewed across shifts, on 4/14/16 from 11:23 a.m. - 12:10 p.m. and 2:28 - 3:06 p.m. All 6 direct care staff stated communication between staff was sufficient to meet individuals' needs. Two of the direct care staff stated there had been a direct care staff that did not communicate well with coworkers, but that staff no longer worked for the facility.

The Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance Manager (QAM) were interviewed on 4/14/16 at 3:30 p.m. Both the QIDP and the QAM stated monthly staff meetings were held and a Standing Agenda was reviewed along with any new issues. The Standing Agenda was reviewed and included information related to individuals' care needs, active treatment, documentation, dignity and respect, sensory training, etc.

It could not be determined that individuals' needs were not being met due to a lack of communication between staff. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

**Conclusion #3:** Unsubstantiated. Lack of sufficient evidence.

Rex Redden, Administrator  
April 19, 2016  
Page 4 of 4

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

Sincerely,

Handwritten signature of Michael Case in black ink.

MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care

Handwritten signature of Nicole Wisenor in black ink.

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt