



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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April 21, 2016

Rex Redden, Administrator  
Idaho Falls Group Home #4 Summit  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #4 Summit, Provider #13G071

Dear Mr. Redden:

This is to advise you of the findings of the complaint survey of Idaho Falls Group Home #4 Summit, which was conducted on April 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Rex Redden, Administrator  
April 21, 2016  
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 **May 4, 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 4, 2016. If a request for informal dispute resolution is received after May 4, 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

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

PRINTED: 04/20/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/13/2016
NAME OF PROVIDER OR SUPPLIER  IDAHO FALLS GROUP HOME #4 SUMMIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3612 SUMMIT TRAIL IDAHO FALLS, ID 83402		
(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 complaint survey conducted from 4/11/16 - 4/13/16.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Autumn Bernal, RN, BSN  Common abbreviations used in this report are: QAM - Quality Assurance Manager QIDP - Qualified Intellectual Disabilities Professional	W 000			
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 for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. That failure had the potential to provide opportunities for food borne illness to occur and negatively impact individuals' health. The findings include:  1. Observations were conducted on 4/11/16 from 2:25 - 3:10 p.m., and 4/12/16 from 2:55 - 4:55 p.m. During those times, issues related to safe and sanitary food handling practices were identified, as follows:  a. During an observation on 4/11/16 at 2:52 p.m.,	W 454	W 454  1. The staff at the Summit Home will be retrained on how to handle and store food in a safe and sanitary manner.  2. All individuals at all facilities have the potential to be affected by this practice. All staff in all facilities will be retrained on how to handle and store food in a safe and sanitary manner.  3. Proper food handling and storage practices will be added to the standing agenda for staff meetings, and will be reviewed every month. In addition, the QIDP, QAM, and Home Supervisor will check to ensure that appropriate food handling and storage practices are occurring every time they are in the home.		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.

*Ray A. Redden* Administrator 5/2/16  
FDRM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3GH611 Facility ID: 13G071 If continuation sheet Page 1 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>IDAHO FALLS GROUP HOME #4 SUMMIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3612 SUMMIT TRAIL IDAHO FALLS, ID 83402</b>		
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W 454	<p>Continued From page 1</p> <p>the following food items were found to be stored on the floor of the pantry located in the laundry room:</p> <ul style="list-style-type: none"> <li>- One 25-pound paper bag of flour, open and half empty</li> <li>- Three plastic-mesh bags of potatoes</li> <li>- Two 25-pound paper bags of flour, unopened</li> <li>- Two 25-pound paper bags of rice, unopened</li> </ul> <p>b. During an observation on 4/12/16 at 2:55 p.m., a plastic zip-lock bag containing approximately 2 pounds of frozen ground beef was observed in the kitchen sink under hot running water. A direct care staff, who was present during the observation, stated the meat was being thawed for dinner.</p> <p>When asked about safe thawing practices, the direct care staff indicated he had worked in fast food service. The direct care staff then placed the plastic bag in a bowl under cool running water.</p> <p>c. During an observation on 4/12/16 at 3:15 p.m., a large cylindrical object wrapped in a bath towel was observed in the refrigerator on top of a cardboard box containing 5 dozen eggs. The box was sitting directly over the produce drawer. A direct care staff, who was present during the observation, stated that it was a frozen "meat-log" that was placed in the refrigerator to thaw.</p> <p>When asked where the fluids from the thawing meat would go, the direct care staff rearranged the refrigerator and placed the frozen meat on a metal tray.</p> <p>During an interview on 4/13/16 from 1:10 - 1:30</p>	W 454	<p>W 454 cont'd</p> <p>4. The QIDP/QAM will attend staff meetings to ensure staff are being trained appropriately. In addition, the QIDP, QAM, and Home Supervisor will check to ensure that appropriate food handling and storage practices are occurring every time they are in the home.</p> <p>5. The QIDP, QAM, and Home Supervisor will be responsible for ensuring safe food handling and storage practices are occurring in all facilities.</p> <p>6. Target date for completion will be June 20, 2016.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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W 454	Continued From page 2 p.m., the QAM stated food items were not to be stored on the floor. When asked, the QAM stated the meat thawing practices observed should not have happened.  The facility failed to ensure food was handled in a safe and sanitary manner to prevent potential food borne illness.	W 454			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the complaint survey conducted from 4/11/16 - 4/13/16.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Autumn Bernal, RN, BSN  Common abbreviations used in this report are:  QIDP - Qualified Intellectual Disabilities Professional QAM- Quality Assurance Manager	M 000		
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 W454.	MM169	MM169  Refer to W 454	
MM183	16.03.11702.05(c) Refuse Storage Containers  All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and must not leak. Containers must be provided with tight fitting lids unless stored in a vermin-proof room or	MM183	MM183  1. A new garbage can with a lid has been purchased for the kitchen.	

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ray A Redden</i>	TITLE Administrator	(X6) DATE 5/2/16
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## Bureau of Facility Standards

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MM183	Continued From page 1 enclosure;  This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all containers used for storage of garbage were provided with tight-fitting lids for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for individuals to be exposed to contaminated items. The findings include:  1. Observations were conducted at the facility on 4/11/16 from 2:25 - 3:10 p.m and on 4/12/16 from 8:15 - 10:11 a.m and 2:55 - 3:45 p.m. During those times, it was noted that the garbage can in the kitchen did not have a lid.  During an interview conducted on 4/13/16 from 1:10 - 1:30 p.m., the QAM stated she was aware of the need for garbage containers to have lids and was also aware that the lid was missing from the kitchen garbage can.  The facility failed to ensure all garbage containers had tight fitting lids.	MM183	MM183 cont'd  2. All individuals in all facilities have the potential to be affected by this practice. All staff in all homes will be retrained on the importance of filling out damage reports immediately when an item is damaged, broken, or missing.  3. The Home Supervisor and QAM will review the damage reports daily and submit them to the Administrator for review and purchase of the item(s).  4. The QAM's and Home Supervisors will review and date each of the damage reports before submitting them to the Administrator to ensure that items are being purchased in a timely manner.  5. The QAM's, Home Supervisors, and the Administrator will be responsible for ensuring that all needed items are purchased in a timely manner for the facilities.  6. Target date for completion will be June 20, 2016.	
MM194	16.03.11704.01(b) Handling  Be handled, processed, and stored in an appropriate manner that prevents contamination.  This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure linens and clothing were stored in an appropriate manner to prevent contamination for 7 of 7 individuals	MM194	MM194  1. All staff will be retrained on how to store linens to prevent potential contamination.	

Bureau of Facility Standards

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MM194	<p>Continued From page 2</p> <p>(Individuals #1 - #7) residing at the facility. This resulted in potential for individuals to be exposed to contaminated linens and clothing. The findings include:</p> <p>1. Observations were conducted at the facility on 4/11/16 and 4/12/16 for a total of 3 hours and 21 minutes. During those times, linens were not observed to be stored in a manner to prevent potential contamination. Examples included, but were not limited to, the following:</p> <p>a. On 4/11/16 from 2:25 - 3:09 p.m. and on 4/12/16 from 8:15 - 11:25 a.m., the downstairs linen closet had no less than 7 folded blankets and one pillow on the floor.</p> <p>b. On 4/11/16 at 2:40 p.m., the upstairs linen closet had two towels, a pillowcase, and sheets on the floor.</p> <p>c. On 4/11/16 at 2:52 p.m., there were folded clothes (2 pants and 4 shirts) sitting on the floor outside of the bedroom shared by Individual #5 and Individual #6.</p> <p>During an interview conducted on 4/13/16 from 1:10 - 1:30 p.m., the QAM stated she was not aware the clean linen was being stored on the floor. The QAM stated linens and clothing should not be stored on the floor.</p> <p>The facility failed to ensure linens were stored in a manner to prevent potential contamination.</p>	MM194	<p>MM194 cont'd</p> <p>2. All individuals at all facilities have the potential to be affected by this practice. All staff in all facilities will be retrained on how to store linens to prevent potential contamination.</p> <p>3. Linen storage practices will be added to the standing agenda for staff meetings, and will be reviewed every month. In addition, the QIDP, QAM, and Home Supervisor will check to ensure that linens are being stored correctly every time they are in the home.</p> <p>4. The QIDP/QAM will attend staff meetings to ensure staff are being trained appropriately. In addition, the QIDP, QAM, and Home Supervisor will check to ensure that linens are being stored appropriately every time they are in the home.</p> <p>5. The QIDP, QAM, and Home Supervisor will be responsible for ensuring lines are being stored correctly in all facilities.</p> <p>6. Target date for completion will be June 20, 2016.</p>	
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>	MM215		

Bureau of Facility Standards

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MM215	Continued From page 3  This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the building was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An observation was conducted at the facility on 4/11/16 from 2:25 - 3:10 p.m. During that time, the following was noted:  - A lamp in the downstairs play room had exposed wires at the socket and was missing the cover.  - The downstairs playroom had a hole in the drywall behind the door, approximately 1 inch in diameter.  - The corner cabinet in the kitchen was missing the door.  - The drawer to the left of the refrigerator was missing.  - The right cabinet door was missing in the upstairs bathroom.  - The ceiling fan in the living room was missing a shade cover on 1 of 4 compact fluorescent light bulbs.  The QAM, who was present during the observation, stated repairs needed to be completed. The QAM removed the lamp with the exposed wires from the facility.	MM215	MM215  1. Damage reports have been submitted for the items that were noted during the survey that were in need of repair or replacement.  2. All individuals in all facilities have the potential to be affected by this practice. All staff in all homes will be retrained on the importance of filling out damage reports immediately when an item is damaged, broken, or missing.  3. The Home Supervisor and QAM will review the damage reports daily and submit them to the Administrator for review and purchase of the item(s). The Administrator will forward all damage reports to maintenance for all items that need repaired.  4. The QAM's and Home Supervisors will review and date each of the damage reports before submitting them to the Administrator to ensure that items are being purchased in a timely manner. The maintenance personnel will date the damage report upon completion and submit it to the Administrator. <i>Implementation of a Home Inspection form to be completed by QAM &amp; Home Supervisor weekly to ensure damage reports are completed on all issues.</i>  5. The QAM's, Home Supervisors, maintenance personnel, and the Administrator will be responsible for ensuring that all needed items are purchased or repaired in a timely manner for the facilities.  6. Target date for completion will be June 20, 2016.  <i>per. QISP by m. Coe, LSA, AS 5.9.16</i>	

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MM216	Continued From page 4 The facility failed to ensure environmental repairs were completed and maintained.	MM216		
MM218	16.03.11711.01(c) Clean and Sanitary  The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.  This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the building was maintained clean and sanitary for 7 of 7 individuals (Individual #1 - #7) residing at the facility. This resulted in individuals being exposed to unsanitary conditions. The findings include:  1. An observation was conducted at the facility on 4/11/16 from 2:25 - 3:10 p.m. During that time, the following was noted:  - There was black mold on the downstairs bathroom wall to the lower right side of shower stall.  - There was cereal and debris on the floor throughout the upstairs and downstairs living areas.  - Three windows downstairs had missing screens.  - There was a liquid spill under the table, approximately 1 foot by 2 feet, that was present throughout the forty-four minute observation.  - There were no fewer than 5 laundry hampers located in the laundry room that contained soiled	MM218	MM218  1. The staff at the Summit Home will be retrained on how to keep the facility clean and sanitary at all times to prevent the entrance of insects and rodents.  2. All individuals at all facilities have the potential to be affected by this practice. All staff in all facilities will be retrained on the importance of keeping the facility clean and sanitary at all times.  3. Keeping the facility clean and sanitary at all times will be added to the standing agenda for staff meetings, and will be reviewed every month. In addition, the QIDP, QAM, and Home Supervisor will check to ensure that the facility is clean and sanitary every time they are in the home. The QIDP and Administrator will conduct a minimum of one weekly home inspections to ensure the homes are being kept clean and sanitary.  4. The QIDP/QAM will attend staff meetings to ensure staff are being trained appropriately. In addition, the QIDP, QAM, and Home Supervisor will check to ensure that the homes are clean and sanitary every time they are in the home.  5. The QIDP, QAM, Home Supervisor, and Administrator will be responsible for ensuring all facilities are clean and sanitary.  6. Target date for completion will be June 20, 2016.	

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MM218	<p>Continued From page 5</p> <p>clothing and no less than 3 sets of bedding, which were overflowing onto the floor.</p> <p>The QAM, who was present during the observation, stated cleaning needed to take place.</p> <p>The facility failed to ensure the facility was maintained in a clean and sanitary manner.</p>	MM218		



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April 21, 2016

Rex Redden, Administrator  
Idaho Falls Group Home #4 Summit  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

Provider #13G071

Dear Mr. Redden:

An unannounced on-site complaint investigation was conducted from April 11, 2016 to April 13, 2016 at Idaho Falls Group Home #4 Summit. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007261**

**Allegation #1:** Individuals are unable to participate in family visits and community outings due to facility staffing issues.

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

Observations were conducted on 4/11/16 and 4/12/16 for a total of 3 hours and 31 minutes. During that time, individuals were observed leaving the facility for community outings. A community outings schedule was posted in the living room, which included activities such as a visit to a family member's home, local food establishments, a recreation center, and a purchase outing.

Eight direct care staff were interviewed across shifts on 4/12/16 from 8:15 - 10:11 a.m. and 4/12/16 from 2:55 - 3:45 p.m. All 8 direct care staff stated they accompanied individuals on community outings on a regular basis. Five of the 8 staff stated there had been a problem with getting individuals into the community in the past, but the issue had been resolved.

Rex Redden, Administrator  
April 21, 2016  
Page 2 of 4

Four individuals were selected for review, and their community outing records, from 1/01/16 - 4/12/16, were reviewed. All four individuals' records documented a variety of community outings and visits to family members' homes. However, no information for March 2016 could be found.

During an interview on 4/13/16 from 11:05 - 11:25 a.m., the QAM stated the designated community staff position had been eliminated in February 2016. The QAM stated issues with community outings were identified in March and a new community outings system was implemented in April to rectify the situation. The QAM stated one individual typically had weekly visits to a family member's home. The QAM stated the visits to a family member's home were missed for two weeks due to an error. However, the situation had been resolved.

Three individuals' guardians were interviewed on 4/12/16 from 4:05 - 5:30 p.m. Two of the guardians stated they had no concerns regarding community outings or family visitations. One individual's guardian stated the individual had missed several visits to a family member's home, and the facility had not contacted her prior to the missed visits. However, she had spoken with the Quality Assurance Manager (QAM) and visitations had resumed in April 2016.

The facility failed to ensure appropriate community outings took place during the month of March 2016. Additionally, one individual did miss visits to a family member's home on a consistent basis. However, the facility identified the issue and implemented corrective action prior to the survey. Therefore, the allegation was substantiated, but, no deficient practice was identified.

**Conclusion #1:** Substantiated. No deficiencies related to the allegation are cited.

**Allegation #2:** Individuals do not have access to personal funds.

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

Eight direct care staff were interviewed across shifts on 4/12/16 from 8:15 - 10:11 a.m. and 4/12/16 from 2:55 - 3:45 p.m. All 8 staff stated money for individuals' outings was provided by the Quality Assurance Manager (QAM).

Four individuals were selected for review. All four individuals' community outing records, dated 1/1/16 - 4/12/16, documented a variety of community outings. The records also documented personal activities such as haircuts.

Three individuals' guardians were interviewed on 4/12/16 from 4:05 - 5:30 p.m. All three guardians stated they had no concerns regarding individuals' ability to access personal funds.

Rex Redden, Administrator

April 21, 2016

Page 3 of 4

During an interview on 4/13/16 from 11:05 - 11:25 a.m., the QAM and Qualified Intellectual Disabilities Professional (QIDP) both stated the facility provided funds for community outings, and individuals' personal funds were used for personal belonging purchases and haircuts. The QAM stated each individual had a minimum of thirty dollars secured at the office for immediate access. Larger amounts of cash were accessed through a requisition. Those requests were completed monthly, but could be completed within one day if needed.

It could not be determined individuals could not access personal funds. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

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

**Allegation #3:** Individuals are late to medical appointments.

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

Observations were conducted on 4/11/16 and 4/12/16 for a total of 3 hours and 31 minutes. On 4/11/16 at 2:25 p.m., six individuals were noted to be present at the facility. When asked, a direct care staff present stated one individual was at a medical appointment. The direct care staff stated nursing staff had taken the individual to the appointment. No other medical appointments took place during the observation times.

Eight direct care staff were interviewed across shifts on 4/12/16. All 8 direct care staff stated individuals were regularly taken to medical appointments by nursing staff. All 8 direct care staff stated they were not aware of any incidents where individuals were late or missed appointments.

Three individuals' guardians were interviewed on 4/12/16 from 4:05 - 5:30 p.m. All three guardians stated they had no concerns regarding individuals being late to medical appointments.

During an interview on 4/13/16 from 11:05 - 11:25 a.m., the Quality Assurance Manager (QAM) and Qualified Intellectual Disabilities Professional (QIDP) both stated nursing staff took individuals to their appointments. Both stated they were not aware of any incident where individuals were late to medical appointments.

It could not be determined individuals were late for medical appointments. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

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

Rex Redden, Administrator

April 21, 2016

Page 4 of 4

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISEÑOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt