



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  
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April 21, 2016

Steve Young, Administrator  
Yellowstone Group Home #3 Hoopes  
560 West Sunnyside  
Idaho Falls, ID 83402

RE: Yellowstone Group Home #3 Hoopes, Provider #13G065

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #3 Hoopes, which was conducted on April 18, 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

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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,



KAREN MARSHALL  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

KM/pmt  
Enclosures



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MAY - 2 2016

FACILITY STANDARDS

4/28/16

Karen Marshall, Health Facility Surveyor  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
PO Box 83720  
Boise, ID 83720

Dear Karen Marshall:

This is the Plan of Correction for the survey concluded at Aspire Human Services #3 Hoopes Home, on April 11<sup>th</sup>-15<sup>th</sup>, 2016. I would like to take the opportunity to thank you and Jim Troutfetter for the helpful information you always share. The survey process is always a learning experience, and you certainly made it helpful as well as pleasant. Thank you so much.

Please see the attached Plan of Correction for specific details on the actions taken by the facility to achieve compliance. If you have any further questions, please feel free to contact Javon Collins at 208-523-9839 ext. 12.

Javon Collins  
ICF QIDP

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:  <b>13G065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/18/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #3 HOOPES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1949 HOOPES IDAHO FALLS, ID 83404</b>		
(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 4/11/16 to 4/18/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD, Team Leader Jim Troutfetter, QIDP  Common abbreviations used in this report are:  CFA - Comprehensive Functional Assessment DCS - Direct Care Staff IDT - Interdisciplinary Team IPP - Individual Program Plan Pt - Patient QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian SIB - Self Injurious Behavior	W 000			
W 159	483.430(a) QIDP  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, policy review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:  1. Refer to W207 as it relates to the facility's failure to ensure the QIDP ensured appropriate	W 159			

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE **QIDP** (X6) DATE **4/29/16**

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 159	Continued From page 1 facility staff participated in interdisciplinary team meetings.  2. Refer to W210 as it relates to the facility's failure to ensure the QIDP ensured assessments were completed within 30 days of an admission.  3. Refer to W226 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP was completed within 30 days of admission.  4. Refer to W252 as it relates to the facility's failure to ensure the QIDP ensured sufficient data was collected to determine the efficacy of an individual's intervention strategies.  5. Refer to W351 as it relates to the facility's failure to ensure the QIDP ensured a complete dental examination was completed for an individual within 30 days of admission.  6. Refer to W454 as it relates to the facility's failure to ensure the QIDP ensured infection control procedures were adhered to by all staff.  7. Refer to W481 as it relates to the facility's failure to ensure the QIDP ensured menus were maintained for foods actually served.	W 159			
W 207	483.440(c)(2) INDIVIDUAL PROGRAM PLAN  Appropriate facility staff must participate in interdisciplinary team meetings.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate facility staff participated in the IDT	W 207			

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W 207	<p>Continued From page 2</p> <p>meeting for 1 of 1 individuals (Individual #1) recently admitted to the facility. This resulted in the lack of comprehensive information being provided and a lack of opportunities for the IDT members to consult with one another and to exchange information. The findings include:</p> <p>1. Individual #1's 12/17/15 IPP documented she was a 55 year old female whose diagnoses included moderate intellectual disability, major recurrent depression moderate, dementia, disruptive mood behavior disorder, and seizure disorder.</p> <p>Individual #1's record was reviewed. She was admitted to the facility on 3/4/16 from a sister facility within the same company.</p> <p>There was a signature page attached to her IPP that documented the last IDT meeting date was 12/17/15.</p> <p>There was no documentation in Individual #1's record that an IDT meeting was held after she was admitted to the facility on 3/4/16 and which IDT members attended the meeting.</p> <p>During an interview on 4/14/16 from 11:00 -11:30 a.m., the QIDP stated an IDT meeting was held after Individual #1 was admitted but there was no documentation of when the meeting occurred and which IDT members attended the meeting. He confirmed it was not possible to determine who had been at the meeting.</p> <p>The facility failed to ensure appropriate facility staff participated in an IDT meeting after Individual #1 was admitted to the facility.</p>	W 207			

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W 210 W 210	Continued From page 3 483.440(c)(3) INDIVIDUAL PROGRAM PLAN  Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.  This STANDARD is not met as evidenced by: Based on policy and record review and staff interview, it was determined the facility failed to ensure appropriate assessments were conducted within 30 days for 1 of 1 individuals (Individual #1) who was recently admitted to the facility. This resulted in a lack of information being available on which to base program intervention decisions. The findings include:  1. The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "When a new individual moves into one of the group homes, a team of professionals (Physician, Social Worker, QIDP, Dietician, Guardian, etc.) spends the first 30 days assessing the strengths and needs of the individual."  The policy was not implemented, as follows:  1. Individual #1's 12/17/15 IPP documented she was a 55 year old female whose diagnoses included moderate intellectual disability, major recurrent depression moderate, dementia, disruptive mood behavior disorder, and seizure disorder.  Individual #1's record was reviewed. She was admitted to the facility on 3/4/16 from a sister	W 210 W 210			

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W 210	Continued From page 4 facility within the same company.  Individual #1's 12/7/15 CFA contained the current QIDP's signature. However, the CFA did not reflect the date when the QIDP reviewed the CFA.  In addition, there was no documentation that the IDT had reviewed the CFA and the assessments to determine Individual #1's current needs and strengths.  When asked during an interview on 4/14/16 from 11:00 - 11:30 a.m., the QIDP stated Individual #1 was admitted from a sister facility and a review of the CFA including assessments by the IDT had been completed. When asked for documentation of the IDT review of the CFA and assessments, the QIDP stated there was no documentation of when the IDT reviews had been completed.  The facility failed to ensure comprehensive assessments were conducted within 30 days of Individual #1's admission.	W 210			
W 226	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the IDT prepared an IPP within 30 days of admission for 1 of 1 individual (Individual #1) who was recently admitted to the facility. This resulted in an IPP being utilized that had been developed at	W 226			

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W 226	Continued From page 5 a sister facility, and had the potential to result in delays in identifying, prioritizing, and addressing Individual #1's needs. The findings include:  1. Individual #1's 12/17/15 IPP documented she was a 55 year old female whose diagnoses included moderate intellectual disability, major recurrent depression moderate, dementia, disruptive mood behavior disorder, and seizure disorder.  Individual #1 was admitted to the facility on 3/4/16 from a sister facility within the same company. However, the IPP in her record was completed on 12/17/15 prior to her admission.  When asked during an interview on 4/14/16 from 11:00 - 11:30 a.m., the QIDP stated Individual #1's IPP was developed by the IDT after her admission, however there was no documentation of when the IDT meeting was conducted and which IDT members provided input for the meeting.  The facility failed to ensure Individual #1's IPP and programs were prepared within 30 days after admission.	W 226			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 252			

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W 252	<p>Continued From page 6</p> <p>was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 1 of 3 individuals (Individual #4) whose behavioral data was reviewed. That failure had the potential to impede the ability of the treatment team in evaluating the effectiveness of programmatic techniques. The findings include:</p> <p>1. Individual #4's IPP, dated 7/16/15, documented a 22 year old female whose diagnoses included severe intellectual disability and autism.</p> <p>Her record documented she had one-to-one staffing to prevent injuries secondary to a seizure disorder, to prevent aggression to other individuals, and to block SIB.</p> <p>Her record also contained a QIDP Monthly Summary, dated January 2016, which documented Individual #4's attempts at aggression to others and SIB were no longer going to be tracked and that only actual SIB or aggressive contact with others would be tracked.</p> <p>The QIDP Monthly Summary, dated January 2016, further stated "I want to focus on what's being followed through with (behaviorally) before what's simply being attempted."</p> <p>However, without tracking attempts to assault others or tracking attempts to engage in SIB, the facility would only have data related to how well the DCS were doing to prevent Individual #4 from engaging in actual SIB or actually assaulting other individuals.</p> <p>During an interview on 4/14/16 at 8:40 a.m., the QIDP stated he was no longer tracking attempts</p>	W 252			

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W 252	Continued From page 7 to assault or attempts to engage in SIB as he did not believe the information would be useful.	W 252			
W 351	The facility failed to ensure Individual #4's behavioral data provided sufficient information to evaluate the efficacy of her programs. <b>483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE</b>  Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission).  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a comprehensive dental evaluation was completed within 30 days of admission for 1 of 1 individual (Individual #1) who was recently admitted to the facility. This resulted in the potential for an individual's dental problems to be unidentified and untreated in a timely manner. The findings include:  1. Individual #1's 12/17/15 IPP documented she was a 55 year old female whose diagnoses included moderate intellectual disability, major recurrent depression moderate, dementia, disruptive mood behavior disorder, and seizure disorder.  Individual #1's record was reviewed with the	W 351			

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W 351	Continued From page 8 following results:  - She was admitted to the facility on 3/4/16 from a sister facility within the company.  - A 4/16/15 dental patient note which documented, "...it took 2 caregivers plus myself and we still didn't get great pictures..."  - A 10/22/15 dental patient note which documented, "...attempted an ant pa [anterior panoramic x-ray], pt was not okay with it. We tried having caretaker help, was unable to obtain one..."  However, Individual #1's record did not contain documentation related to the IDT evaluating her dental status after admission, when the next dental visit was scheduled, or that a plan to obtain x-rays had been developed.  When asked during an interview on 4/18/16 from 1:00 - 1:32 p.m., the QIDP stated at her next dental appointment scheduled in May 2016, one more attempt would be made to obtain dental x-rays. He also said if Individual #1 still resisted to have x-rays obtained, a plan would then be developed to address her dental needs.	W 351			
W 454	483.470(l)(1) INFECTION CONTROL  The facility failed to ensure a dental examination was completed for Individual #1 within 30 days of her admission.  The facility must provide a sanitary environment to avoid sources and transmission of infections.	W 454			

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W 454	<p>Continued From page 9</p> <p>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. This directly impacted 2 of 6 individuals (Individuals #4 and #5) observed. This had the potential to provide opportunities for cross-contamination to occur and negatively impact the individuals' health. The findings include:</p> <p>1. An observation was conducted at the facility on 4/12/16 from 11:15 a.m. - 12:20 p.m. During that time the following was noted:</p> <ul style="list-style-type: none"> <li>- At 11:18 a.m., Individual #4's one-to-one staff had a black rattail comb in her mouth between her upper and lower jaws as she accompanied Individual #4 from her bedroom to the couch in the living room. When Individual #4 sat on the couch, the staff removed the rattail comb from her mouth and placed it beside a hairbrush on the table next to the couch.</li> <li>- At 11:22 a.m., the staff combed and styled Individual #4's hair using the same black rattail comb that she had previously held in her mouth between her upper and lower jaws.</li> <li>- At 11:27 a.m., the staff was observed providing cares to Individual #4 with the same rattail comb in her mouth between her upper and lower jaws.</li> <li>- At 11:36 a.m., the staff had completed cares for Individual #4 and then assisted Individual #5 to get a glass of water in the kitchen.</li> </ul> <p>During the above observations, the staff was not</p>	W 454		

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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	
W 454	Continued From page 10 observed to sanitize the comb prior to combing and styling Individual #4's hair. In addition, the staff was not observed to wash her hands before assisting Individual #5 to get a glass of water from the kitchen faucet.  When asked during an interview about infection control procedures on 4/13/16 from 11:10 - 11:28 a.m., the Program Supervisor verified the infection control procedures were not followed when the staff had the rattail comb in her mouth when providing cares to Individual #4.  The facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases.	W 454			
W 481	483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:  1. An observation was conducted at the facility on 4/11/16 from 4:40 - 7:15 p.m. During that time, Individuals #2 - #6 were observed eating dinner. The menu consisted of country fried steak with gravy, fresh mashed potatoes with gravy, green beans, a baked roll, and chocolate sour cream cake.	W 481			

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

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

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W 481	<p>Continued From page 11</p> <p>However, the staff prepared and served Individuals #2 - #6 instant boxed mashed potatoes, not fresh mashed potatoes.</p> <p>At 7:02 p.m., Individual #1 entered the dining room and was served the same instant boxed mashed potatoes, not fresh mashed potatoes.</p> <p>2. An observation was conducted at the facility on 4/12/16 from 11:15 a.m. - 12:20 p.m. During that time, Individuals #1 - #6 were observed eating lunch. The menu consisted of Beef and Bean Stew, mandarin oranges, green salad, and parmesan bread sticks.</p> <p>The individuals were served macaroni instead of green salad.</p> <p>During the environmental review on 4/13/16 from 10:28 - 11:28 a.m., russet and red potatoes were observed in the kitchen pantry. The substitution spreadsheets for each individual were observed in a plastic binder. However, the substitution spreadsheets for each individual were blank.</p> <p>When asked, during the environmental review, the Lead Worker stated none of the individuals at the facility would eat green salad as they did not like green salad. The Lead Worker stated that fresh mashed potatoes should have been made for the evening meal on 4/11/16. The Lead Worker verified the foods actually served to each individual were not documented on the individuals' spreadsheets.</p> <p>When asked during a follow-up interview on 4/14/16 from 1:35 - 1:55 p.m., the RD stated she would review the menus with the facility to ensure the food items on the menu were foods that the</p>	W 481			

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W 481	Continued From page 12 individuals would actually eat. She confirmed the individuals should have been served fresh mashed potatoes for the dinner meal on 4/11/16, not instant boxed potatoes. She also confirmed the foods that were not listed on the menus and were consumed by the individuals should be documented.  The facility failed to ensure accurate documentation of food actually served was kept.	W 481			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2016</b>
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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the state licensure survey conducted from 4/11/16 to 4/18/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD, Team Leader Jim Troutfetter, QIDP	M 000		
MM155	16.03.11300 Facility Staffing  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  This Rule is not met as evidenced by: 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 W207, W210, W226, and W252.	MM159		
MM166	16.03.11600 Health Care Services  The requirements of Sections 600 through 699 of these rules are for modifications and additions to	MM166		

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

TITLE

(X6) DATE

*Jim Call*

*QIDP*

*4/29/16*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2016</b>
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MM166	Continued From page 1  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 W351.	MM166		
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		
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), Condition of Participation: Dietetic Services incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W481.	MM366		

**W226****4.**

1. Per W207, the IDT meeting was held and Individual #1's IPP has been reviewed/updated to reflect the appropriate admission and IPP implementation dates.
2. For all new admits, the IDT team will spend the first 30 days assessing the strengths and needs of the individual and ensure implementation of a new IPP within the specified time frame.
3. Aspire Human Services has revised the admission and pre-admission policy to include a checklist. The checklist will have the Program Supervisor, QIDP, facility Nurse, and Program Manager reviewing current evaluations prior admission indicating the facility can meet their needs. Further, the checklist will help ensure that individuals have received assessment and review of those assessments in the 30-day time period.
4. Aspire Human Services has created a schedule for the completion of internal reviews. After internal reviews are completed the Program Manager will coordinate the correction of any identified errors.
5. Person Responsible: Governing Body, Program Manager and QIDP
6. Completion Date: 4/21/16

**W252****5.**

1. Individual #4's Functional Behavioral Assessment and Behavioral Management Plans will be reviewed and revised to include "attempts" which had previously been removed from tracking. Training will take place for the home to ensure that reimplementation is conducted and recorded properly.
2. All individuals' FBA's and BMP's will be reviewed, and revised as needed, to ensure that any "attempts" are being recorded and analyzed as a part of documentation.
3. Aspire Human Services has created a schedule for the completion of internal reviews. After internal reviews are completed the Program Manager will coordinate the correction of any identified errors.
4. Person Responsible: Program Manager and QIDP
5. Completion Date: 5/31/16

**W351****6.**

1. Per W207, the IDT meeting was held and Individual #1's dental status was discussed. A dental appointment is set for 5/5/16. If unsuccessful, programming will be created to address this need and a desensitization plan will be put in place.
2. For all new admits, the IDT team will spend the first 30 days assessing the strengths and needs of the individual and nursing will ensure dental appointments are set within the time period to address the individual's dental needs.
3. Aspire Human Services has revised the admission and pre-admission policy to include a checklist. The checklist will have the Program Supervisor, QIDP, facility

**MM155**

**1.**

1. Please see response given under W159 – Facility Staffing

**MM159**

**2.**

1. Please see response given under W207, W210, W226, and W252 – Active Treatment Services.

**MM166**

**3.**

1. Please see response given under W351 – Health Care Services

**MM169**

**4.**

1. Please see response given under W454 – Physical Environment

**MM366**

**5.**

1. Please see response given under W481 – Dietetic Services