



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
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FAX: (208) 364-1888
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CERTIFIED MAIL: 7012 3050 0001 2125 5693

July 28, 2016

Valentina Reudter, Administrator
Belmont Care Center Crestview
Aspire Human Services
444 Hospital Way Suite 701
Pocatello, ID 83201-2744

RE: Belmont Care Center Crestview, Provider #13G050

Dear Ms. Reudter:

Based on the Complaint survey completed at Belmont Care Center Crestview on July 15, 2016, we have determined that Belmont Care Center Crestview is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/ID) Condition of Participation of **Health Care Services (42 CFR 483.460)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Belmont Care Center Crestview to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

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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
6. Include dates when corrective action(s) will be completed.

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

Such corrections must be achieved and compliance verified by this office, before August 29, 2016. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than August 21, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **August 10, 2016.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Belmont Care Center Crestview ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective July 15, 2016, through November 12, 2016. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

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Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **August 25, 2016**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT
Licensing and Certification Administration, DHW
PO Box 83720
Boise, ID 83720-0009
Phone: (208)334-6626
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 August 10, 2016. If a request for informal dispute resolution is received after August 10, 2016 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately.

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Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care 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

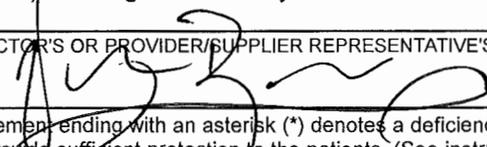
PRINTED: 07/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/15/2016
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NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER CRESTVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 4024 MOUNTAIN LOOP POCATELLO, ID 83204
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint survey conducted from 7/12/16 to 7/15/16.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD Autumn Bernal, RN, BSN</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment DCS - Direct Care Staff IPP - Individualized Program Plan MAR - Medication Administration Record OT - Occupational Therapy/Therapist QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse</p>	W 000	<p><i>Please see attached POC for corrections.</i></p> <p>RECEIVED AUG 15 2016 FACILITY STANDARDS</p>	
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, policy review, record review and staff interview, it was determined the facility's Governing Body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. This failure directly impacted 1 of 4 individuals (Individual #2) whose records were reviewed and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This failure</p>	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Manager	(X6) DATE 8/10/16
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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 104	Continued From page 1 resulted in the Governing Body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include: 1. Refer to W120 as it relates to the Governing Body's failure to ensure an outside service met an individual's needs. 2. Refer to W159 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight for individuals residing in the facility. The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet an individual's health, safety, and active treatment needs.	W 104			
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure outside services were sufficiently coordinated and monitored for 1 of 1 individual (Individual #2) who received outside home health services. This resulted in a lack of monitoring, communication, and comprehensive information being available to all team members on which to base individualized care and programming decisions. The findings include: 1. Individual #2's 10/23/15 IPP documented a 74	W 120			

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W 120	<p>Continued From page 2</p> <p>year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility.</p> <p>Individual #2's 4/18/16 physician note documented a stage I pressure ulcer on the right side of his coccyx that developed during a 10-day hospital stay in April 2016. However, communication between the home health agency and the facility was not sufficient to effectively coordinate care, ensure consistency of care, or ensure Individual #2's needs were being met as follows:</p> <p>During record review, on 7/13/16 at 11:00 a.m., no documentation was found in the facility's records of the home health agency's "Start or Resumption of Care," or wound assessments, instructions for wound care, or related interventions to treat the wound.</p> <p>During an interview, on 7/13/16 at 11:08 a.m., RN B confirmed there was no wound assessment, wound care instructions or related interventions for the pressure ulcer in the facility's records. Registered Nurse B stated a home health agency was being utilized and the facility was relying on the agency to treat and assess the wound.</p> <p>RN A joined the interview on 7/13/16 shortly after 11:08 a.m., by phone. When asked if position change schedules were being implemented, RN A stated that Individual #2 had an air-mattress, therefore, it was her understanding position rotation schedules were not necessary. In addition, RN A stated Individual #2 was no longer receiving wound care, Individual #2's physician had "signed off," on his wound, his wound had</p>	W 120		

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W 120	<p>Continued From page 3 healed and no longer needed treatment.</p> <p>However, the facility had not previously obtained records from the home health agency in order to effectively manage Individual #2's coordination of care and ensure the outside service was meeting his needs.</p> <p>The home health agency provided the following documents that were requested by the survey team:</p> <p>A 4/21/16 document titled, Start or Resumption of Care, stated Individual #2 was admitted to home health services in order to assist with increasing mobility, alleviate pressure to bony prominences, and treatment of the decubitus ulcer including application of Calmoseptine cream (an analgesic and protectant) and dressing changes.</p> <p>A 6/15/16 document titled, Recertification or Other Follow-Up, stated the following: "SN [Skilled Nursing] will also continue to encourage patient and staff to change body positions and keep pressure off of r [right] buttocks and hip to facilitate healing. Due to patients lack of mobility + cerebral palsy the patient has a difficult time keeping pressure off of ulcers."</p> <p>During a follow-up interview, on 7/13/16 at 2:10 p.m., RN A stated she had learned there were some miscommunications with the home health agency and a lack of monitoring and safeguards on the facility's part. Registered Nurse A stated she had learned that Individual #2 still had a pressure ulcer and was still receiving wound care from home health every other day. In addition, after reviewing documentation from the home health agency, she learned pressure relief and</p>	W 120		

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W 120	Continued From page 4 rotation schedules were recommended in addition to the air-mattress.	W 120		
W 159	<p>The facility failed to ensure Individual #2's outside home health services were sufficiently coordinated and monitored.</p> <p>483.430(a) QIDP</p> <p>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 record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight of individuals' needs. This directly impacted 2 of 4 individuals (Individuals #1 and #2) reviewed, and had the potential to impact all individuals (Individuals #1 - #8) residing in the facility. This resulted in a lack of QIDP monitoring and oversight necessary to ensure individuals' needs were comprehensively addressed. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W234 it relates to the facility's failure to ensure the QIDP ensured clear, consistent directions were specified in each individual's written training programs. 2. Refer to W250 it relates to the facility's failure to ensure the QIDP ensured active treatment schedules were developed to reflect an individual's needs. 3. Refer to W259 it relates to the facility's failure to ensure the QIDP ensured an individual's assessments were accurate and comprehensive. 	W 159		

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W 159	Continued From page 5 4. Refer to W260 it relates to the facility's failure to ensure the QIDP ensured an IPP was revised to accurately reflect and respond to an individual's current needs. 5. Refer to W318 Condition of Participation: Health Care Services and associated standard level deficiencies as they relate to the facility's failure to ensure the QIDP ensured individuals were provided with preventive and general medical care necessary to meet their needs. 6. Refer to W436 as it relates to the facility's failure to ensure the QIDP ensured an individual's adaptive equipment was appropriately maintained, provided or replaced to meet his needs. The cumulative effect of these failures resulted in a lack of advocacy and appropriate treatment being provided to an individual in relation to his pressure ulcer wounds.	W 159		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clear, consistent directions were specified in each written training program for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program. The findings include:	W 234		

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W 234	<p>Continued From page 6</p> <p>1. Individual #1's 9/9/15 IPP documented a 78 year old male, whose diagnoses included mild intellectual disability and major depressive disorder.</p> <p>The PM Shift Change Report, dated 6/28/16, documented "[Individual #1] has a very bad rash that is bleeding. it [sic] is by his groin area from not showering and all his incontinence."</p> <p>Individual #1's Shower Logs for June 2016 documented he had received a shower on the following days, just prior to 6/28/16:</p> <ul style="list-style-type: none"> - 6/23/16 on AM shift - 6/25/16 on AM and PM shift - 6/27/16 on AM shift <p>However, Individual #1 did not receive a shower for 4 consecutive days from 6/1/16 - 6/4/16 and for 7 consecutive days from 6/12/16 - 6/18/16.</p> <p>Additionally, his May Shower Log documented he had not received a shower for 6 consecutive days from 5/1/16 - 5/6/16.</p> <p>Individual #1's Showering Social Story program, dated 2/2016, did not include instructions for staff on what to do if he refused showering for an extensive period of time.</p> <p>During an interview on 7/13/16 at 11:50 a.m., the QIDP stated she did not believe there was a protocol that provided direction to staff related to refusals and that the showering program did not contain information related to what staff were to do if Individual #1 refused to shower.</p> <p>The facility failed to ensure program instructions</p>	W 234		

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W 234	Continued From page 7 included specific information for staff to implement in order to meet Individual #1's hygiene needs.	W 234			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop active treatment schedules which were consistent and reflective of an individual's needs for 1 of 4 individuals (Individual #2) whose active treatment schedules were reviewed. This resulted in the lack of supports and necessary services being provided to Individual #2 to meet his needs. The findings include: 1. Individual #2's 10/23/15 IPP documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility. Individual #2's 4/18/16 physician note documented a stage I pressure ulcer on the right side of his coccyx that developed during a 10-day hospital stay in April 2016. However, his record did not include documentation that his Active Treatment Schedule had been adjusted to assist him in relieving pressure, as follows: A 4/21/16 document titled, Start or Resumption of	W 250			

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W 250	Continued From page 8 Care, stated Individual #2 was admitted to home health services in order to assist with increasing mobility, alleviate pressure to bony prominences, and treatment of the decubitus ulcer including application of Calmoseptine cream (an analgesic and protectant) and dressing changes. A 6/15/16 document titled, Recertification or Other Follow-Up, stated "SN [skilled nursing] will also continue to encourage patient and staff to change body positions and keep pressure off of r [right] buttocks and hip to facilitate healing. Due to patients lack of mobility + cerebral palsy the patient has a difficult time keeping pressure off of ulcers." However, Individual #2's Active Treatment Schedule was not revised or updated to include the recommendations to keep pressure off of his right buttocks and hip. During an interview on 7/15/16 from 09:10 - 10:15 a.m., the QIDP stated Individual #2's Active Treatment Schedules had not been revised since his health needs had changed in April 2016. The facility failed to ensure Individual #2's Active Treatment Schedule was updated to include his positioning needs.	W 250		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by:	W 259		

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W 259	<p>Continued From page 9</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure assessments were accurate and comprehensive for 1 of 4 individuals (Individual #2) whose assessments were reviewed. This resulted in a lack of assessment information on which to base program decisions. The findings include:</p> <p>1. Individual #2's 10/23/15 IPP documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility.</p> <p>Individual #2's 4/18/16 physician note documented a stage I pressure ulcer on the right side of his coccyx that developed during a 10-day hospital stay in April 2016. However, his record did not include documentation that his CFA was updated to meet his change in needs. Examples included, but were not limited to the following:</p> <p>a. During an observation on 7/13/16 at 9:05 a.m. Individual #2 was observed with a urine drain bag in use.</p> <p>Individual #2's physician's orders, dated 6/2/16, documented continuous condom catheters and down drain bags.</p> <p>Individual #2's CFA, dated 10/22/15, included a toileting section which stated he remained unsoiled during the night, remained dry during the night, and indicated discomfort when pants were wet or soiled independently.</p> <p>However, there was no documentation in the CFA to reflect the need for, or use of condom</p>	W 259		
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NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER CRESTVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 4024 MOUNTAIN LOOP POCATELLO, ID 83204		
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W 259	<p>Continued From page 10 catheters or drain bags.</p> <p>During an interview on 7/15/16 at 09:10 -10:15 a.m. the Program Supervisor stated Individual #2 wore a condom catheter 24 hours a day Monday thru Friday. On weekends, he only wore it at night, in order to prevent skin breakdown from extended use. The QIDP, who was also present during the interview, stated the CFA had not been updated.</p> <p>b. Individual #2's records included a 4/18/16 physician note, that documented a decubitus stage 1 skin breakdown on coccyx and instructions to keep him off his right side as much as possible.</p> <p>The home health agency documented the following:</p> <p>A 4/21/16 document titled, Start or Resumption of Care, stated Individual #2 was admitted to home health services in order to assist with increasing mobility, alleviate pressure to bony prominences, and treatment of the decubitus ulcer including application of Calmoseptine cream (an analgesic and protectant) and dressing changes.</p> <p>A 6/15/16 document titled, Recertification or Other Follow-Up, stated the following: "SN [Skilled Nursing] will also continue to encourage patient and staff to change body positions and keep pressure off of r [right] buttocks and hip to facilitate healing. Due to patients lack of mobility + cerebral palsy the patient has a difficult time keeping pressure off of ulcers."</p> <p>However, Individual #2's 10/22/15 CFA did not include any information about the skin breakdown</p>	W 259		

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W 259	<p>Continued From page 11</p> <p>care needs, (e.g., how long to keep him in his wheelchair, bed, or position him off his right side).</p> <p>During an interview on 7/15/16 from 09:10 - 10:15 a.m., the QIDP stated the pressure ulcer care and position changes were not updated in Individual #2's CFA.</p> <p>c. Individual #2's 9/23/15 nutritional assessment documented a weight of 139 pounds, and reported "weight maintenance with repletion (avoid weight loss)."</p> <p>Individual #2's recorded weights from January through July 2016 were as follows:</p> <ul style="list-style-type: none"> - January: 137.5 lbs - February: 135 lbs - March: 134 lbs - April: 131 lbs - May: 128 lbs - June 7th: 126 lbs - June 28th: 124 lbs - July 12th: 123.2 lbs <p>Individual #2's weight, from April to July 12, 2016, represented a 7.8 pound or 5.95% weight loss in 4 months.</p> <p>During an interview on 7/15/16 from 9:10 - 10:15 a.m., the Dietary Manager was asked if a nutrition assessment was updated following Individual #2's hospitalization, his pressure ulcer, or his recorded weight loss. The Dietary Manager stated, "I cannot say." The Nurse's Aide, who was also present during the interview, stated she had seen the weight loss and was concerned, so she called and had the DCS re-weigh him. The Nurse's Aide also stated when there was a difference</p>	W 259		

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W 259	Continued From page 12 greater than 3 pounds, they were supposed to notify someone. RN A, who was also present during the interview, stated Individual #2's physician was notified of the weight change when he saw Individual #2 on 7/14/16, but did not seem concerned. However, the physician ordered laboratory work to be done.	W 259		
W 260	<p>The facility failed to ensure Individual #2's CFA was updated as his status and needs changed.</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure an IPP was revised to accurately reflect and respond to an individual's current needs for 1 of 4 individuals (Individual #2) whose records were reviewed. This failure resulted in an individual's IPP not reflecting his current status or needs. The findings include:</p> <p>1. Individual #2's 10/23/15 IPP documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility.</p> <p>Individual #2's medical record documented a stage I pressure ulcer on the right side of coccyx that developed during a 10-day hospital stay in April 2016. However, his record did not include</p>	W 260		

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W 260	<p>Continued From page 13</p> <p>documentation that his IPP was updated to meet his changing needs. Examples included, but were not limited to, the following:</p> <p>a. A 4/18/16 physician note documented a decubitus stage 1 skin breakdown on coccyx and instructions to keep him off his right side as much as possible.</p> <p>A 4/21/16 home health document titled, Start or Resumption of Care, stated Individual #2 was admitted to home health services in order to assist with increasing mobility, alleviate pressure to bony prominences, and treatment of the decubitus ulcer including application of Calmoseptine cream (an analgesic and protectant) and dressing changes.</p> <p>A 6/15/16 home health document titled, Recertification or Other Follow-Up, stated "SN [skilled nursing] will also continue to encourage patient and staff to change body positions and keep pressure off of r [right] buttocks and hip to facilitate healing. Due to patients lack of mobility + cerebral palsy the patient has a difficult time keeping pressure off of ulcers."</p> <p>However, Individual #2's IPP did not include any instructions about keeping him off his right side, documentation related to his current skin care needs, and there were no directions to staff regarding how long Individual #2 should be positioned in his wheelchair, bed, or on his side or back.</p> <p>During an interview on 7/15/16 from 09:10 - 10:15 a.m., the QIDP stated the pressure ulcer care or position changes were not updated in his IPP. RNA, who was also present during the interview,</p>	W 260		

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W 260	<p>Continued From page 14</p> <p>stated they have been trying to change his position, but he often moved himself onto the pressure ulcer. The QIDP also stated they had not included any written instructions to staff related to Individual #2's positioning requirements.</p> <p>b. During an observation on 7/13/16 at 9:05 a.m. Individual #2 was observed with a urine drain bag in use.</p> <p>Individual #2's 4/12/16 physician's orders documented continuous condom catheters and down drain bags.</p> <p>The toileting section of the IPP stated Individual #2 needed reminders to use the restroom and required assistance to use the toilet.</p> <p>However, the IPP did not include an objective, program, or instructions for the use of condom catheters in his toileting program. Further, there were no specific instructions on the application, removal, cleaning or time frames for use in order to provide necessary care.</p> <p>During an interview on 7/15/16 at 09:10 -10:15 a.m. the Program Supervisor stated Individual #2 wore a condom catheter 24 hours a day Monday thru Friday. On weekends, he only wore it at night, in order to prevent skin breakdown from extended use. The QIDP, who was also present during the interview, stated the IPP had not been updated to reflect the use of condom catheters.</p> <p>The facility failed to ensure Individual #2's IPP was updated reflect his current status and needs.</p>	W 260		
W 318	483.460 HEALTH CARE SERVICES	W 318		

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W 318	Continued From page 15 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure necessary health care assessments, monitoring and timely follow-up occurred. This resulted in a lack of recommended interventions and coordination of care necessary to meet an individual's health care needs. The findings include: 1. Refer to W331 as it relates to the facility's failure to ensure an individual received nursing services in accordance with his needs. 2. Refer to W334 as it relates to the facility's failure to ensure an individual received comprehensive quarterly exams completed by direct physical examination. 3. Refer to W339 as it relates to the facility's failure to ensure an individual received nursing interventions as indicated by his needs.	W 318			
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided for 1 of	W 331			

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W 331	<p>Continued From page 16</p> <p>4 individuals (Individual #2) whose records were reviewed. This resulted in a lack of clear direction related to interventions and a lack of monitoring necessary to meet an individual's health needs. The findings include:</p> <p>1. The facility's standing orders included a statement, which stated, noncomplicated wound care as determined by the nurse. The standing orders did not contain specific information of what noncomplicated wound care was.</p> <p>When asked during an interview, on 7/14/16 at 3:02 p.m., the Program Manager and Nurse's Aide stated there were no further instructions or protocols for the treatment of noncomplicated wound care.</p> <p>During an interview on 7/13/16 at 11:08 a.m., RN B described noncomplicated wound care, as superficial abrasions or rashes that the nurse treats with bandages or over-the-counter ointments such as Neosporin (an antibiotic) or hydrocortisone (relieves itching for minor skin irritations). Registered Nurse B stated those ointments were previously on the standing orders, but were no longer specified and considered a part of the order for noncomplicated wound care provided by the nurse.</p> <p>The facility failed to ensure nursing services clarified unclear orders with a physician.</p> <p>2. Individual #2's IPP, dated 10/23/15, documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility.</p>	W 331		

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W 331	Continued From page 17 Individual #2's record contained a physician's order, dated 6/2016, which documented he received Metoclopramide (a drug used to treat gastroesophageal reflux disease) 5 milliliters before meals and at bedtime. The 2017 Nursing Drug Handbook documented Metoclopramide had the potential to cause TD (tardive dyskinesia, an abnormal movement disorder). However, his record did not contain an assessment related to TD. When asked during and interview on 7/15/16 from 9:10 - 10:15 a.m., RN A stated Individual #2 did not have a TD assessment as the facility's policy for TD assessments did not include Metoclopramide as a drug that could potentially cause TD. The facility failed to ensure Individual #2 received a TD assessment.	W 331			
W 334	3. Refer to W339 as it relates to the facility's failure to ensure nursing services were provided to address an individual's skin care needs. 483.460(c)(3)(i) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination. This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 334			

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W 334	Continued From page 18 was determined the facility failed to ensure quarterly health status reviews were conducted by direct physical examination for 1 of 4 individuals (Individual #2) whose records were reviewed. This resulted in the potential for changes in health status to remain undetected and untreated. The findings include: 1. Individual #2's IPP, dated 10/23/15, documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility. A 4/19/16 physician order stated, "SN [Skilled nursing] to evaluate skin integrity and pressure decubitus on r [right] side of coxxyx [sic]." However, no documentation related to Individual #2's pressure ulcer could be found. Individual #2's 6/1/16 Quarterly Nursing Assessment stated "Skin looks good. [No] reports of breakdown right now," and was signed by RN B. However, a 6/1/16 home health document titled, Nursing Intervention documented a stage 1 pressure ulcer on right hip. During an interview on 7/13/16 at 11:08 a.m., RN B, stated she had not physically examined Individual #2's coccyx area. The facility failed to ensure quarterly exams were completed by direct physical examination for Individual #2.	W 334			
W 339	483.460(c)(4) NURSING SERVICES	W 339			

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W 339	<p>Continued From page 19</p> <p>Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure nursing services were provided to address the identified nursing needs for 1 of 1 individual (Individual #2) who experienced skin breakdown. This resulted in an individual experiencing on-going pressure wounds without appropriate nursing interventions. The findings include:</p> <p>1. Individual #2's IPP, dated 10/23/15, documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility.</p> <p>Individual #2's medical record documented a stage I pressure ulcer on the right side of his coccyx that developed during a 10-day hospital stay in April 2016. However, his record did not include documentation the facility was monitoring and implementing needed pressure relief interventions, as follows:</p> <p>a. A 4/19/16 document titled, New Prescription Order, stated "Skilled nursing to evaluate skin integrity and pressure decubitus on r [right] side of cooxyx [sic]."</p> <p>However, documentation of an assessment of the wound, ongoing monitoring, or instructions for wound care could not be found in the facility's records.</p>	W 339			

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W 339	<p>Continued From page 20</p> <p>During an interview, on 7/13/16 at 11:08 a.m., Registered Nurse B confirmed there was no wound assessment, wound care instructions or related interventions for the pressure ulcer in the facility's records. Registered Nurse B stated a home health agency was being utilized, so the facility was relying on the home health agency to treat and assess the wound.</p> <p>RN A joined the interview on 7/13/16 shortly after 11:08 a.m., by phone. When asked if position change schedules were being implemented, RN A stated that Individual #2 had an air-mattress, therefore, it was her understanding that position rotation schedules were not necessary. In addition, RN A stated Individual #2 was no longer receiving wound care, Individual #2's physician had "signed off," on his wound and Individual #2's wound was healed and no longer needed treatment. When asked when the last time either RN had seen or assessed the wound, they both stated they could not recall the date at that time.</p> <p>The home health agency provided the following documents that were requested by the survey team on 7/13/16:</p> <p>A 4/21/16 document titled, Start or Resumption of Care, stated Individual #2 was admitted to home health services in order to assist with increasing mobility, alleviate pressure to bony prominences, and treatment of the decubitus ulcer including application of Calmoseptine cream (an analgesic and protectant) and dressing changes.</p> <p>A 6/15/16 document titled, Recertification or Other Follow-Up, stated the following: "SN [Skilled Nursing] will also continue to encourage</p>	W 339		

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W 339	<p>Continued From page 21</p> <p>patient and staff to change body positions and keep pressure off of r [right] buttocks and hip to facilitate healing. Due to patients lack of mobility + cerebral palsy the patient has a difficult time keeping pressure off of ulcers."</p> <p>During a follow-up interview, on 7/13/16 at 2:10 p.m., RN A stated she had learned there were some miscommunications with the home health agency and a lack of monitoring and safeguards on the facility's part. Registered Nurse A stated she had learned that Individual #2 still had a pressure ulcer and was still receiving wound care from the home health agency every other day. In addition, after reviewing documentation from the home health agency, she learned pressure relief and rotation schedules were recommended in addition to the air-mattress.</p> <p>Nursing staff did not maintain ongoing communication with the home health agency providing care to Individual #2, and had not implemented position changes for pressure alleviation for treatment of the pressure ulcer.</p> <p>Additionally, due to the lack of monitoring by the facility, the physician was not notified of a potential worsening condition of Individual #2's skin condition in a timely manner as follows:</p> <p>On the 4/21/16 Start or Resumption of Care document, provided by the home health agency, there was 1 documented pressure ulcer, located on his right hip.</p> <p>On the 6/15/16 Recertification or Other Follow-Up document, provided by the home health agency, there were 2 documented pressure ulcers, 1 on the right hip and 1 on the right buttocks.</p>	W 339			

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

PRINTED: 07/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/15/2016
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W 339	Continued From page 22 On 7/13/16 from 2:30 - 2:40 p.m., the surveyor, the Program Supervisor, and RN A observed the Individual #2's skin. Individual #2 had a red area on the right hip that had a skin ointment and a moisture barrier dressing covering the red area, skin intact. There was a second area on his buttocks that was red in color without a dressing. Both red sites were touched by RN A and appeared non-blanching (a lack of color change upon pressure indicating tissue damage). During a follow-up interview, on 7/14/16 at 10:15 a.m., RN A stated she had not been aware of a second pressure ulcer site and the doctor should have been notified of a second pressure ulcer site, but was not. Registered Nurse A stated she had requested Individual #2 to be seen by his physician to correct this issue. The facility failed to ensure nursing interventions were implemented and the physician was promptly notified of Individual #2's potentially worsening skin condition.	W 339			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to	W 436			

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W 436	<p>Continued From page 23</p> <p>ensure individuals were provided with appropriate adaptive equipment for 1 of 3 individuals (Individual #2) who required the use of adaptive equipment. This resulted in Individual #2's wheelchair being in ill-repair and had the potential to cause skin breakdown. The findings include:</p> <p>1. Individual #2's 10/23/15 IPP documented a 74 year old male whose diagnoses included profound mental retardation and cerebral palsy. He was non-ambulatory and utilized a wheelchair for mobility.</p> <p>Individual #2's medical record documented a stage I pressure ulcer on the right side of his coccyx that developed during a 10-day hospital stay in April 2016. However, supportive equipment for wound healing had not been provided before or after development of the pressure ulcer, as follows:</p> <p>During an observation conducted on 7/13/16 from 8:45 - 9:15 a.m., Individual #2 was noted in his wheelchair and was transferred into a reclining chair in the living room. It was noted at this time that his wheelchair did not have a right footrest.</p> <p>Individual #2's 10/23/15 IPP included an OT section that stated, "From Report dated 11/13/14... Pt [Patient] requires new w/c [wheelchair] for appropriate position."</p> <p>Individual #2's 10/23/15 IPP also listed a "positioning wedge," under the Adaptive Equipment section, that specified, "Used to support hips when sleeping at night. Clean when needed."</p> <p>Individual #2's record was reviewed and</p>	W 436		

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W 436	<p>Continued From page 24</p> <p>contained the following supportive equipment orders and recommendations:</p> <ul style="list-style-type: none"> - A 4/19/16 physician's order stated "OT to evaluate options/wheelchair/etc to manage skin integrity [and] prevent/decrease breakdown." - A 4/18/16 physician's order stated "ROHO or comparable cushion." - A 5/2/16 OT noted stated "Wheelchair recommendations: Pt [Patient] would benefit from a r [right] foot rest to provide pressure relief to RLE [right lower extremity] and buttock to protect skin integrity. Angled foot rest/wedge needed as r [right] ankle is limited in dorsi [sic] flexion. Pressure relieving cushion needed to promote healing of current decub [sic] and prevent further risk to skin integrity. A waterproof cover would promote good hygiene and again promote skin integrity. Abductor wedge cushion needed to protect knees from creating skin damage d/t [due to] contractures. Pt [Patient] should utilize abductor wedge cushion at all times unless performing hygiene, grooming, or toileting tasks." <p>During an interview on 7/15/16 from 9:10 - 10:15 a.m., RN A stated the facility had been attempting to get a new wheelchair for Individual #2 for over a year, but have not yet been able to obtain one, despite frequent phone calls and emails to suppliers. Registered Nurse A also confirmed the new ROHO cushion for Individual #2's wheelchair had not been obtained. Registered Nurse A stated the wedge pillow had been previously used, but had "broke down," and they had not been able to obtain a replacement. During the interview, RN A was not able to recall how long</p>	W 436		
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W 436	Continued From page 25 the wedge pillow had been missing. During an interview with Individual #2's physician, on 7/15/16 at 10:56 a.m., the physician stated Individual #2 has a persistence in his positioning that they have not been able to correct, making wound healing challenging. He also stated he was frustrated that the ROHO cushion had not yet been provided as ordered. The facility failed to ensure Individual #2's wheelchair and supportive cushions were maintained and replaced necessary to meet his needs.	W 436		
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 interview, the facility failed to ensure 4 of 4 Ninja food processors were maintained under sanitary conditions for food preparation. This affected 3 of 3 individuals (Individuals #1 - #3) who required food textures to be mechanically altered according to their needs. This placed the individuals at risk for food borne illnesses. The findings include: 1. An observation was conducted at the facility on 7/12/16 from 3:55 - 5:50 p.m. During that time, 4 Ninja food processors had an accumulation of dried and wet multi-colored food particles on the inside of the top of the processor. This area was located in the cavity, above the food, where the plastic frame of the blade connected to the gear box.	W 454		

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W 454	Continued From page 26 The Program Supervisor and Lead Worker, who were present during the observation on 7/12/16, were asked about the condition of the food processors. They both agreed the food processors were not cleaned to an acceptable condition, and they should have been cleaned after each use. The Program Supervisor immediately cleaned all 4 food processors at that time. The facility failed to ensure food processing equipment was maintained in a sanitary manner.	W 454			



444 Hospital Way Suite 701 Pocatello, Idaho 83201 | Office – 208-238-5950 | Fax 208-238-5860

August 10, 2016

Jim Troutfetter
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

Dear Mr. Troutfetter

I would like to thank you for your recent visit to Crestview Care Center (Provider #13G050). Although this visit was not under the best of circumstances, we always invite others to share their perspective of our program, so we can continue to grow and provide the best quality of care for the people we serve.

Abbreviations used in this document:

RN – Registered Nurse
DSP – Direct Support Professional
IPP – Individual Program Plan
CFA – Comprehensive Functional Assessment
ATS – Active Treatment Schedule
QIDP – Qualified Intellectual Disability Professional
OT – Occupational Therapy/Therapist

Please see the following corrections for areas found to be in deficiency.

W104

Please refer to W120 and W159

W120

1. Records regarding outside services were received and included into individual's file 7/15/16. Communication between outside services and Aspire Human Services has been increased with the use of a communication binder. Outside services will leave copies of their notes in the communication binder. Nursing notes were updated to reflect changes and to ensure implementation of outside service recommendations and primary care provider orders.
2. Notes from outside services will be reviewed by Aspire Human Service nursing team prior to weekly Aging Concern meetings. Outside services will notify nursing team on the nursing call phone immediately if any change or concern with resident arises.
3. Aspire Human Services will use the communication binder to coordinate the care with outside services.
4. Team meetings have been scheduled for 2016/2017 and will incorporate the topic of outside services.
5. Person Responsible: Program Supervisor, Registered Nurse (RN) , Program Manager
6. 8/21/2016

W159

1. Individual #2's Individual Program Plan (IPP), Comprehensive Functional Assessment (CFA) and Active Treatment Schedule (ATS) have been updated to reflect current needs, programs and schedules as of 8/1/2016.
2. Individual charts will be reviewed to reflect current function level, needs and programming are accurately shown in each assessment.
3. Aspire Human Services has chart reviews for all the homes. One part of the chart review will be to ensure that current needs and programming are being addressed.
4. Aspire Human Services will follow the schedule to review charts. After charts are reviewed the Clinical Director will coordinate the correction of any identified errors.
5. Person responsible: Qualified Intellectual Disability Professional (QIDP), Clinical Director, Program Manager
6. Completion Date 8/21/2016

W234

1. Shower programming and protocol was developed, written and implemented for Individual #1 by 8/8/2016.
2. Programming will be revised to instruct Direct Support Professional (DSP) of what to do in the event of a refusal.
3. Aspire Human Services has recently implemented chart reviews for all the homes. One part of the chart reviews included what should be done in the case of a refusal.
4. Aspire Human Services in Pocatello is creating a schedule for the completion of the chart reviews. After chart reviews are completed the Clinical Administrator will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion Date: 8/21/16

W250

1. Individual #2's ATS was updated to reflect re-positioning schedule.
2. ATSs will be reviewed for all individuals at the minimum of once per year or when there is a change in need and/or schedule.
3. Aspire Human Services will complete chart reviews for all the individuals in the home. One part of the chart reviews will be to ensure the ATS is up to date and reflects the current need and schedule.
4. Aspire Human Services in Pocatello has created a schedule for the completion of the chart reviews. After chart reviews are completed the Clinical Administrator will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion Date: 8/21/2016

W259

1. Individual #2 CFA was updated to reflect current level of function for catheter use, repositioning needs and dietary needs.
2. CFAs will be reviewed annually, at minimum, or when there is a change in functioning level or need.
3. Aspire Human Services will complete chart reviews for all the individuals in the home. One part of the chart reviews will be to ensure the CFA is up to date and reflects the current level of function and need.
4. Aspire Human Services in Pocatello has created a schedule for the completion of the chart reviews. After chart reviews are completed the Clinical Administrator will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Administrator, Program Manager
6. Completion Date: 8/21/2016

W260

1. Individual #2's IPP has been updated to reflect skin health, positioning requirements and condom catheter use. Programs have also been updated with an objective goal.
2. IPPs will be reviewed annually, at minimum or when there is a change in functioning level or need.
3. Aspire Human Services has recently implemented chart reviews for all the individuals in the home. One part of the chart reviews will be to ensure the IPP reflects current needs with both formal and informal programming.
4. Aspire Human Services of Pocatello has created a schedule for the completion of the chart reviews. After chart reviews are completed the Clinical Administrator will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion date: 8/21/2016

W318

Please refer to W331, W334 and W339

W331

1. Clarified standing orders with primary care provider and defined non-complicated wound care. Tardive Dyskinesia policy revised to include Metoclopramide.
2. Reviewed all individuals' standing orders after receiving clarification and defined non-complicated wound care. Reviewed all resident orders to determine others taking Metoclopramide.
3. Recaps and standing orders were revised to reflect clarifications. Education and training on recaps and standing orders will be reviewed for all direct care staff.
4. Standing orders and recaps will be reviewed quarterly by physician and pharmacist. Medication are reviewed at least quarterly by RN with assessment and Tardive Dyskinesia evaluations will be completed if indicated.
5. Person Responsible: RN, Nursing Assistant, Program Supervisor, Program Manager.
6. Completion date: 8/21/2016

W334

1. Individual #2 has been reassessed to reflect current status. Implemented procedure for assessment to include Braden Scale on admission and quarterly if score on admission is less than 14. Braden score will also be re-assessed if there is a significant change in health status.
2. Braden Scale will be done on all individuals residing at Crestview Care Center. Assessment will be reviewed and amended to reflect Braden score and need for additional monitoring based on that score.
3. Braden scores to assess risk for skin breakdown will be done on all clients on admission and then quarterly if that score was less than 14.
4. Quarterly assessments and Braden Scales will be monitored by chart review at least quarterly.
5. Person Responsible: RN, Nursing Assistant
6. Completion date: 8/21/2016

W339

1. Home health recommendations for position change program for Individual #2 were immediately implemented. Communication between home health and Aspire Human Services was increased by the use of a communication binder. Weekly meetings addressing Aging Concerns are being held to increase communication between clinical team and the Program Supervisor/ DSP.
2. Team meeting was held to review and discuss if any other individuals were currently receiving outside services. Continued review of all clients with clinical team in Nursing Concern meetings will occur at least quarterly.
3. Home health recommendations were implemented. Position program was initiated for Individual #2. Training for all direct care staff will be done to ensure understanding of importance and consistency of program. Communication binder will be reviewed at least weekly to update nursing staff on current recommendations from outside services, such as home health.

4. Data collection from program will be reviewed monthly to ensure health services based on recommendations are being completed. Programs and recommendations will also be reviewed at least quarterly in Nursing Concern meetings.
5. Person Responsible: QIDP, RN, Program Supervisor, Program Manager
6. Completion Date: 8/21/2016

W436

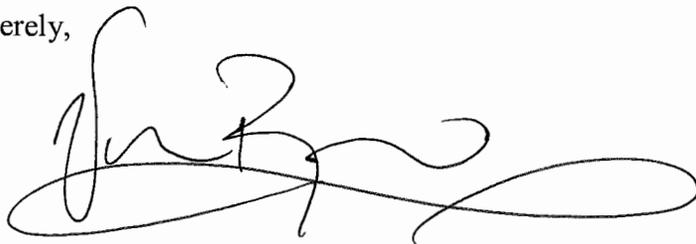
1. Occupational Therapist (OT) recommended equipment is being purchased for individual #2:
 - Right foot rest
 - Angled foot wedge
 - ROHO, pressure relieving cushion, with waterproof cover for wheelchair
 - Abductor wedge
2. New OT evaluations were ordered for other residents who are in a wheelchair at Crestview. Recommendations will be implemented.
3. All residents will have their adaptive equipment reviewed. Any concerns with equipment will be brought to Aging Concerns meeting and addressed in a timely manner.
4. Quarterly nursing assessment will be revised to include review of adaptive equipment availability and functionality.
5. Person Responsible: RN, Nursing Assistant, Program Manager
6. Completion Date: 8/21/2016

W454

1. The food processors at the facility were replaced by 8/8/2016. The new model allowed for complete disassembly and submersion of moving part and the motor is encased in a way that is easily sanitized.
2. Food processors will be purchased with cleaning ability and ease of use in mind for the individuals who use the food processors as part of programming.
3. Kitchen inspection form will be revised to ensure dietary equipment is in good, sanitary working order.
4. Kitchen inspection form will be completed by the dietary team on a monthly basis. Any concerns with equipment will be reported to the Program Supervisor and correction of the concerns will be coordinated by the Dietary team.
5. Person responsible: Dietary Manager, Dietician, Program Supervisor, Program Manager
6. Completion date: 8/21/2016

Please contact me if you have any further questions regarding this Plan of Correction.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valentina Reudter', with a large, sweeping flourish at the end.

Valentina Reudter
Program Manager | Aspire Human Services
444 Hospital Way Suite 701 Pocatello, Idaho 83201
O - 208-238-5950 ext-106 | C - 208-223-5863

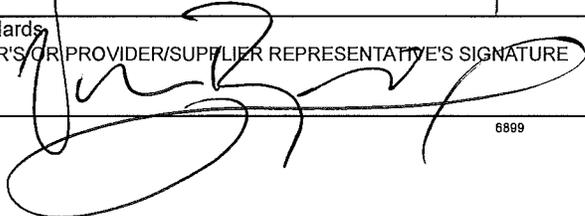
Bureau of Facility Standards

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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the complaint survey conducted from 7/12/16 to 7/15/16.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD Autumn Bernal, RN, BSN</p>	M 000	<p>Please see attached POC for corrections.</p>	
MM080	<p>16.03.11100 Governing Body and Management</p> <p>The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W104 and W120.</p>	MM080	<p style="text-align: center;">RECEIVED AUG 15 2016 FACILITY STANDARDS</p>	
MM155	<p>16.03.11300 Facility Staffing</p> <p>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</p> <p>This Rule is not met as evidenced by: Refer to W159.</p>	MM155		

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



TITLE
Program Manager
(X6) DATE
8/10/16

Bureau of Facility Standards

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MM159	Continued From page 1	MM159		
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 W234, W250, W259 and W260.	MM159		
MM166	16.03.11600 Health Care Services 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. This Rule is not met as evidenced by: Refer to W318, W331, W334, and W339.	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."	MM169		

Bureau of Facility Standards

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MM169	Continued From page 2 This Rule is not met as evidenced by: Refer to W436 and W454.	MM169		



444 Hospital Way Suite 701 Pocatello, Idaho 83201 | Office – 208-238-5950 | Fax 208-238-5860

August 10, 2016

Jim Troutfetter | Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009

Dear Mr. Troutfetter,

Please see the following corrections for areas found to be in deficiency.

MM080

Please see response to W104 and W120

MM155

Please see response to W159

MM159

Please see response to W234, W250, W259 and W260

MM166

Please see response to W318, W331, W334 and W339

MM169

Please see response to W436 and W454

Please contact me if you have any further questions regarding this Plan of Correction.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valentina Reudter', with a large, sweeping flourish at the end.

Valentina Reudter

Program Manager | Aspire Human Services

444 Hospital Way Suite 701 Pocatello, Idaho 83201

O - 208-238-5950 ext-106 | C - 208-223-5863



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
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July 28, 2016

Valentina Reudter, Administrator
Belmont Care Center Crestview
Aspire Human Services
444 Hospital Way Suite 701
Pocatello, ID 83201-2744

Provider #13G050

Dear Ms. Reudter:

An unannounced on-site complaint investigation was conducted from July 12, 2016 to July 15, 2016 at Belmont Care Center Crestview. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007324

Allegation #1: Individuals are not bathed regularly.

Findings #1: During the investigation, records were reviewed and staff were interviewed, with the following results:

Four individuals' Shower Logs were reviewed. One individual's Shower Log documented he had not received a shower for four consecutive days from 6/1/16 - 6/4/16 and for seven consecutive days from 6/12/16 - 6/18/16.

Additionally, his May 2016 Shower Log documented he had not received a shower for six consecutive days from 5/1/16 - 5/6/16.

His record also contained a Showering Social Story program, dated 2/2016, that did not include instructions for staff on what to do if he refused showering for an extensive period of time.

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During an interview on 7/13/16 at 11:50 a.m., the Qualified Intellectual Disabilities Professional (QIDP) stated she did not think there was a protocol that provided directions to staff on what to do if an individual refused a shower for extended periods of time and that the individual's showering program did not contain information related to shower refusals.

It was determined an individual did not receive a shower for an extended period of time, and his programming was insufficient to address his showering needs.

Therefore, the allegation was substantiated and deficient practice was cited at W234.

Conclusion #1: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: Food preparation equipment was not properly cleaned and was used under unsanitary conditions.

Findings #2: During the investigation, an observation of the facility's food processing equipment and staff interviews were conducted with, the following results:

An observation was conducted at the facility on 7/12/16 from 3:55 - 5:50 p.m. During that time, four Ninja food processors had an accumulation of dried and wet multi-colored food particles on the inside of the top of the processor. This area was located in the cavity, above the food, where the plastic frame of the blade connected to the gear box.

The Program Supervisor and Lead Worker, who were present during the observation on 7/12/16, were asked about the condition of the food processors. They both stated the food processors were not cleaned to an acceptable condition, and they should have been cleaned after each use. The Program Supervisor immediately cleaned all four food processors at that time.

It was determined that the food processors were not properly cleaned.

Therefore, the allegation was substantiated and deficient practice was cited at W454.

Conclusion #2: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: Staff do not provide personal care for incontinent individuals in a timely manner.

Findings #3: During the investigation, observations were conducted, records were reviewed and staff were interviewed, with the following results:

The facility's Incident and Accident logs from 4/1/16 - 6/30/16 were reviewed. There were no relevant patterns or incidents related to individuals not receiving incontinence care.

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Observations were conducted in the facility on 7/12/16 from 3:55 - 5:50 p.m., on 7/13/16 from 6:00 - 7:30 a.m. and from 1:50 - 3:10 p.m. Individuals were observed being assisted to the bathroom and their toileting needs were addressed.

Nine direct care staff were interviewed across shifts on 7/13/16 and were asked if incontinence care was done regularly and in a timely manner. All nine direct care staff stated incontinence care was always done in a timely manner. One direct care staff stated he heard a rumor that a former employee did not always provide incontinence care, however, he never witnessed anything directly.

It could not be determined staff did not provide personal care for incontinent individuals in a timely manner.

Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Individuals do not receive an appropriate diet to meet their needs.

Findings #4: During the investigation, observations were conducted, records were reviewed and staff were interviewed with the following results:

Dietary requirements for eight individuals were reviewed. The documentation showed three individuals received a pureed diet, two individuals received a calorie count diet, one individual received a modified calorie count diet, one individual received a lactose calorie count diet, and one received a regular diet.

During an observation of a meal on 7/12/16 from 3:55 - 5:50 p.m., all individuals were noted to receive their meals as prescribed.

Additionally, nine staff were interviewed on 7/13/16 regarding individuals' diets. Eight staff were able to state the dietary requirements for all individuals and one staff stated she could find the individuals' dietary requirements in their floor books.

It could not be determined Individuals did not receive an appropriate diet to meet their needs.

Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Individuals are not receiving appropriate skin care.

Findings #5: During the investigation, observations were conducted, records were reviewed and staff were interviewed, with the following results:

The facility's Incident and Accident logs from 4/1/16 to 6/30/16 were reviewed. Minor skin issues were noted on the Incident and Accident reports, none of which were found to have worsened.

Five of nine direct care staff, who were interviewed across all shifts, stated there was one individual with a sore on his bottom that was being treated by nursing.

The records of four individuals were reviewed. One of the four individuals had an on-going pressure ulcer. The individual's record included a 4/18/16 physician note that documented a stage I pressure ulcer to the right side of his coccyx that had developed during a 10-day hospital stay in April 2016. However, the record did not include documentation of a wound assessment, instructions for wound care, or related interventions to treat the wound.

During an interview, on 7/13/16 at 11:08 a.m., one of the facility's Registered Nurses (RNs) stated when the individual was discharged from the hospital in April 2016 and his physician ordered home health services. A home health agency was being utilized, and the facility was relying on the agency to treat and assess the wound. The RN also confirmed there was no wound assessment, wound care instructions or related interventions for the individual's pressure ulcer in the facility's records.

The individual's records did not include the home health agency's plan of treatment or nurse's progress notes and assessments of the individual's wound.

On 7/13/16, the surveyors requested documents from the home health agency. Review of the home health agency's documents demonstrated inconsistencies related to the wound. The following concerns were noted after review of the facility's and the home health agency's records:

- Pressure relief interventions were recommended by the home health agency and physician. However, there was no documentation in the facility's records indicating pressure relief interventions were being implemented as ordered. During the interview with one of the facility's RNs, on 7/13/16 at 11:08 a.m., the facility's other RN joined the conversation, by phone. When asked if position change schedules were being implemented for the individual with the pressure ulcer, the RN stated the individual had an air-mattress and it was her understanding that position rotation schedules were not necessary.

- The individual's physician had recommended a new wheelchair, and new cushions to assist in healing of the pressure ulcer, however, these had not been obtained. During an interview on 7/15/16 from 9:10 - 10:15 a.m., the facility's other RN stated the facility had been attempting to get a new wheelchair for the individual for over a year, but have not yet been able to obtain one, despite frequent phone calls and emails to suppliers.

- A 6/1/16 home health document stated the individual had a stage 1 pressure ulcer on right hip. However, the 6/1/16 Quarterly Nursing Assessment, completed by the facility RN stated "Skin looks good. No reports of breakdown right now." During an interview, on 7/13/16 at 11:08 a.m., the RN stated, when she completed the 6/1/16 quarterly physical assessment of the individual's skin, she had not physically examined the individual's coccyx area.

- Documentation of the individual's pressure ulcer indicated one site in April 2016 and two sites on a follow-up assessment in June 2016. However, there was no documentation in the facility's records which addressed the individual's potentially worsening skin condition. During an interview, on 7/14/16 at 10:15 a.m., the RN stated she was not aware of a second pressure ulcer site on his buttocks, and did not think the physician had been notified.

Additionally, the individual's comprehensive functional assessment, program plans, and active treatment schedule were not updated related to his current skin condition and the facility had noted the individual had a 5.95% weight loss. No additional assessment was documented regarding the weight loss or how the loss may impact his wounds and/or intervention strategies.

During a follow-up interview on 7/15/16 from 09:10 -10:15 a.m., the QIDP stated no updates had been made to the individual's comprehensive functional assessment, his individual program plan, or his active treatment schedule.

On 7/13/16 from 2:30 - 2:40 p.m., the surveyor, the Program Supervisor, and one of the facility's RNs observed the individual's skin. The individual had a red area on the right hip that had a skin ointment and a moisture barrier dressing covering the red area. The skin was intact. There was also a second area on his buttocks that was red in color without a dressing.

During an interview, on 7/15/16 at 10:56 a.m., the individual's physician stated the individual did have two pressure ulcers. But in his opinion, the pressure ulcers had not gotten worse since the 10-day hospital stay in April 2016.

It was determined that an individual did not receive appropriate services and interventions for his on-going skin condition. Therefore the allegation was substantiated and deficient practice was identified at W104, W120, W159, W250, W259, W260, W318, W331, W334, W339, and W436.

Conclusion #5: Substantiated. Federal and State deficiencies related to the allegation are cited.

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Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care 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