



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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July 29, 2016

Steve Young, Administrator
Yellowstone Group Home #4 Fox Hollow
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #4 Fox Hollow, Provider #13G066

Dear Mr. Young:

This is to advise you of the findings of the complaint survey of Yellowstone Group Home #4 Fox Hollow, which was conducted on July 21, 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 **August 11, 2016**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by August 11, 2016. If a request for informal dispute resolution is received after August 11, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during 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

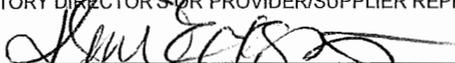
PRINTED: 07/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2016
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint survey conducted from 7/18/16 - 7/21/16.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>ABC - Antecedent Behavior Consequence ADHD - Attention Deficit Hyperactivity Disorder AOD - Administrator on Duty CFA - Comprehensive Functional Assessment IED - Intermittent Explosive Disorder IPP - Individual Program Plan OT - Occupational Therapist/Therapy QIDP - Qualified Intellectual Disabilities Professional SIB - Self-Injurious Behavior</p>	W 000		
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility's policies, review of Abuse Investigations, Incident/Accident reports, ABC Logs, and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently developed and updated. This failure had the potential to impact 5 of 5 individuals</p>	W 149	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG -9 2016</p> <p style="text-align: center;">FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE QIDP	(X6) DATE 8/8/16
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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 149	<p>Continued From page 1</p> <p>(Individuals #1 - #5) residing in the facility. This resulted in the potential for individual to individual altercations to continue without appropriate intervention. The findings include:</p> <p>1. The facility's investigations, Incident/Accident Reports, and ABC Logs from 4/18/16 - 7/20/16 were reviewed and included, but were not limited to, the following individual to individual physical altercations:</p> <ul style="list-style-type: none"> - 6/7/16: Individual #4 grabbed Individual #2 twisted his arm and pushed him against a wall. - 6/22/16: Individual #5 pinched Individual #1 and kicked his shins. - 6/22/16: Individual #1 pushed Individual #2. - 7/19/16: Individual #5 grabbed Individual #2's arm six times and tried to kick him. - 7/19/16: Individual #5 grabbed Individual #1's wrist and Individual #1 slapped Individual #5's hand. - 7/19/16: Individual #5 grabbed Individual #1's arm twice. - 7/20/16: "[Individual #4] another resident [Individual #2] were horseplaying and became aggressive..." <p>However, no trending or tracking data related repeated individual to individual physical altercations (i.e. which individual(s) might consistently be victims or perpetrators) be could found.</p>	W 149		

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W 149	<p>Continued From page 2</p> <p>The facility's Qualified Intellectual Disabilities Professional (QIDP) Field Manual, undated, did not include information related to trending and tracking individual to individual altercations.</p> <p>The facility's policy titled Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source, revised 10/12/15, documented the following:</p> <p>The Child Protection section stated:</p> <p>"For Individuals under the age of 18 the Administrator, Administrator Designee or A.O.D. will notify the Care Intake Unit [phone number] within 24 hours under the following circumstances... (4) Repeated individual to individual physical or verbal altercations, not resulting in observable physical or mental injury, but constituting an ongoing pattern of individual behavior that the facility's staff are unable to remedy through reasonable efforts."</p> <p>The Adult Protection section stated:</p> <p>"The Administrator, AOD, or State Operations Manager will notify Adult protection immediately under the following circumstances... (4) Repeated individual to individual physical or verbal altercations, not resulting in observable physical or mental injury, but constituting an ongoing pattern of individual behavior that the facility's staff are unable to remedy through reasonable efforts."</p> <p>During a follow up interview on 7/27/16 at 3:00 p.m., the Program Manager stated Individuals #1, #2, and #4 were under the age of 18 and Individuals #3 and #5 were adults.</p>	W 149		

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W 149	Continued From page 3 During an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated they were not trending or tracking individual to individual altercations and that they would have to go through previous incident/accident forms and ABC forms to identify individual to individual altercation trends. The facility failed to ensure patterns of individual to individual altercations were tracked.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of the facility's policies, review of Abuse Investigations and Incident/Accident reports, ABC Logs, and staff interview, it was determined the facility failed to ensure thorough investigations were conducted for all allegations of abuse, neglect and mistreatment. This failure directly impacted 1 of 1 individual (Individual #2) for whom an investigation was conducted and had the potential to impact 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in a lack of sufficient information being collected to determine patterns of individual to individual altercations. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 10/12/15, stated the Company and/or	W 154		

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W 154	<p>Continued From page 4</p> <p>Administrator "will ensure that all allegations of Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source are thoroughly investigated."</p> <p>The definitions section of the policy stated "Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The policy stated "The Administrator, Administrator Designee, A.O.D. or State Operations Manager will establish evidence and documentation that all allegations have been thoroughly investigated."</p> <p>The facility's investigations, Incident/Accident Reports, and ABC Logs from 4/18/16 - 7/20/16 were reviewed.</p> <p>A 6/7/16 report documented Individual #1 grabbed Individual #2 by the wrist and pushed him against a wall causing scratches and red marks to Individual #2's skin.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) completed an investigation of the 6/7/16 incident. During the QIDP's investigation process, Individual #2 provided the QIDP with a handwritten statement, dated 6/12/16, that documented Individual #1 had:</p> <ul style="list-style-type: none"> - slammed him against a fence and cut his arm, - gave him a bloody jaw and nearly broke his wrist, - stuck his hand down his backside while outside playing, - choked him 12 times using a choke hold on his neck, - slapped his butt and front side, - purposely caused him to wreck his bike, and 	W 154		

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W 154	<p>Continued From page 5</p> <p>- tied a blanket around his head and neck.</p> <p>In addition, Individual #2's statement documented he was afraid of being Individual #1's roommate because he did not know what Individual #1 would do to him.</p> <p>The QIDP's 6/13/16 investigation into the 6/7/16 incident documented the QIDP interviewed both individuals. Individual #1 told the QIDP that he did do all of the things as written in Individual #2's statement. Individual #1 said he put his hand in the back of Individual #2's pants like he was going to grab his underwear and give him a snuggie (wedgie). The QIDP documented she did not feel a room change would be necessary and the facility would work on more appropriate interactions between Individual #1 and Individual #2 and teach them how to play appropriately.</p> <p>However, the investigation did not include documentation that the QIDP had interviewed or obtained written statements from staff or other individuals regarding the alleged incidents.</p> <p>During an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated she had investigated all of the allegations and had interviewed staff and individuals, but had not taken written statements or documented the results of the investigation.</p> <p>The Program Manager, who was also present during the interview, stated the allegations were investigated by the QIDP. However, the results of the investigation should have included when the interviews were conducted, and who was interviewed and their statements to rule out the allegations in the victim's statement.</p>	W 154		

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W 154	Continued From page 6 The facility failed to ensure all allegations of potential abuse, neglect and mistreatment were thoroughly investigated.	W 154			
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 record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight for 1 of 3 individuals (Individual #2) whose records were reviewed. This failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include: 1. Individual #2's 7/1/16 IPP documented he was a 15 year old male whose diagnoses included mild intellectual disability, autism, ADHD, and IED. The QIDP failed to provide sufficient monitoring and oversight of Individual #2's active treatment services, as follows: a. Individual #2's record was reviewed. Individual #2's IPP meeting was held at the facility on 6/16/16. However, the following assessments were completed after Individual #2's 6/16/16 IPP meeting: - Individual #2's social history was dated 7/1/16 and documented the date of the assessment was 6/21/16. - Individual #2's OT evaluation was dated 6/21/16.	W 159			

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W 159	<p>Continued From page 7</p> <p>- Individual #2's speech and language development assessment had not been completed.</p> <p>When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated Individual #2's social history and OT evaluations were not completed until after his IPP meeting and his speech and language assessment was still pending.</p> <p>The QIDP failed to ensure comprehensive assessment information was garnered prior to the development of Individual #2's IPP.</p> <p>b. Individual #2's Functional Behavioral Assessment was dated 7/10/16.</p> <p>However, Individual #2's behavior intervention plans for elopement, physical aggression, SIB, socially inappropriate/disruptive behavior, and property destruction were all dated 7/1/16.</p> <p>When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated Individual #2's Functional Behavior Assessment was completed on 7/10/16 and his behavior intervention plans were developed on 7/1/16.</p> <p>The QIDP failed to ensure comprehensive assessment information was garnered prior to the development of Individual #2's behavior intervention plans.</p> <p>c. Individual #2's 6/21/16 OT evaluation included a recommendation to evaluate him for an electronic device, such as a tablet or an I-Pad. The recommendation stated keyboarding would</p>	W 159		

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W 159	Continued From page 8 be excellent for him, especially since he was not in school this summer. When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP also stated the OT's goal to evaluate him for an electronic device had not been addressed or completed. The QIDP failed to provide sufficient monitoring and oversight of Individual #2's active treatment services.	W 159			
W 210	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 record review and staff interview, it was determined the facility failed to ensure appropriate assessments were conducted within 30 days for 1 of 1 individual (Individual #2) 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. Individual #2's 7/1/16 IPP documented he was a 15 year old male whose diagnoses included mild intellectual disability, autism, ADHD, and IED. He was admitted to the facility on 6/1/16 from his home. Individual #2's record was reviewed with the	W 210			

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W 210	Continued From page 9 following results: a. His Functional Behavioral Assessment was dated 7/10/16. When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated she had not completed Individual #2's Functional Behavioral Assessment until 7/10/16. b. Individual #2's speech and language development assessment had not been completed. When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated the speech and language assessment was still pending. The facility failed to ensure comprehensive assessments were conducted within 30 days of Individual #2's admission.	W 210			
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's CFA included a speech and language assessment for 1 of 1 individual (Individual #2) who was recently admitted to the facility. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's 7/1/16 IPP documented he was	W 220			

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W 220	Continued From page 10 a 15 year old male whose diagnoses included mild intellectual disability, autism, ADHD, and IED. Individual #2's record was reviewed. He was admitted to the facility on 6/1/16 from his home. However, a speech and language development assessment had not been completed. When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated the speech and language assessment was still pending.	W 220			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure an individual received training and services consistent with his program plans for 1 of 3 individuals (Individuals #2) whose behavior programs were reviewed. This resulted in Individual #2 not receiving training in accordance with his identified needs. The findings include:	W 249			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/21/2016
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	<p>Continued From page 11</p> <p>1. Individual #2's 7/1/16 IPP documented he was a 15 year old male whose diagnoses included mild intellectual disability, autism, ADHD, and IED. He was admitted to the facility on 6/1/16 from his home.</p> <p>Individual #2's record was reviewed. Individual #2's IPP meeting was held at the facility on 6/16/16 with an IPP implementation date of 7/1/16.</p> <p>Individual #2's behavior intervention plans for elopement, physical aggression, SIB, socially inappropriate/disruptive behavior, and property destruction were all dated 7/1/16.</p> <p>Observations were conducted at the facility on 7/18/16 from 4:15 - 5:00 p.m., on 7/19/16 from 7:50 - 8:52 a.m., and on 7/20/16 from 11:40 - 11:50 a.m.</p> <p>However, during these timeframes, Individual #2's floor book was reviewed and did not include his behavior intervention plans.</p> <p>Interviews were conducted with facility staff on 7/20/16 from 11:40 - 11:50 a.m.</p> <p>- At 11:40 a.m., the Lead Worker stated there were no behavior intervention plans at the facility for Individual #2.</p> <p>- At 11:45 a.m., a direct care staff stated there were no behavior intervention plans at the facility for Individual #2.</p> <p>When asked during an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated earlier that</p>	W 249		

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

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W 249	Continued From page 12 same day, she took Individual #2's 7/1/16 behavior intervention plans to the facility. The facility failed to ensure Individual #2's behavior intervention plans were implemented as soon as possible after the planning meetings.	W 249		
W 270	483.450(a)(1)(iii) CONDUCT TOWARD CLIENT These policies and procedures must specify client conduct to be allowed or not allowed. This STANDARD is not met as evidenced by: Based on review of the facility's facility's policies, review of Abuse Investigations and Incident/Accident reports, ABC Logs, record review, and staff interview, it was determined the facility failed to ensure facility policies specified conduct that was allowed or not allowed between individuals for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This failure resulted in insufficient direction for staff to prevent inappropriate interactions between individuals. The findings include: The facility's investigations, Incident/Accident Reports and ABC Logs, from 4/18/16 - 7/20/16, were reviewed and included, but were not limited to, the following individual to individual physical altercations: - 6/7/16: Individual #4 grabbed Individual #2 twisted his arm and pushed him against a wall. - 6/22/16: Individual #5 pinched Individual #1 and kicked his shins. - 6/22/16: Individual #1 pushed Individual #2.	W 270		

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W 270	<p>Continued From page 13</p> <p>- 7/19/16: Individual #5 grabbed Individual #2's arm six times and tried to kick him.</p> <p>- 7/19/16: Individual #5 grabbed Individual #1's wrist and Individual #1 slapped Individual #5's hand.</p> <p>- 7/19/16: Individual #5 grabbed Individual #1's arm twice.</p> <p>- 7/20/16: "[Individual #4] and another resident [Individual #2] were horseplaying and became aggressive..."</p> <p>However, the facility did not have a policy which addressed conduct to be allowed or not allowed between individuals. Information related to when and how staff were to intervene when individuals engaged in "horseplay" was not present in the facility's policies.</p> <p>During an interview on 7/19/16 from 2:50 - 2:54 p.m., the Lead Worker stated there were incidents where individuals get rowdy, but staff intervene in horseplay and "nip it in the bud."</p> <p>During an interview on 7/20/16 at 11:23 a.m., the QIDP stated the facility did not have house rules to provide direction to staff related to horseplay.</p> <p>During a follow up interview on 7/27/16 at 3:00 p.m., the Program Manager confirmed the facility's policies did not include conduct that was allowed or not allowed between individuals.</p> <p>The facility failed to ensure clear direction was provided to staff regarding what conduct that was allowed or not allowed between individuals.</p>	W 270		

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W 290	<p>483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Standing or as needed programs to control inappropriate behavior are not permitted.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure standing programs to control inappropriate behavior were not in place for 1 of 3 individuals (Individual #3) whose behavioral interventions were reviewed. This resulted in a replacement behavior for Individual #3 being incorporated into his behavior plan without justification for the use. The findings include:</p> <p>1. Individual #3's 12/28/15 IPP documented he was a 37 year old male whose diagnoses included mild intellectual disability and autism.</p> <p>Individual #3's 12/18/15 Behavioral Assessment documented socially offensive maladaptive behavior. The behavior definition included standing in close proximity of females and having a persistent gaze at their breasts and/or buttocks. The replacement behavior included maintaining a distance of three feet or more from others.</p> <p>During an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP was asked how maintaining a distance of three feet or more from others would prevent a persistent gaze. The QIDP stated Individual #3's behavior program was "as needed." The QIDP stated Individual #3 had not displayed any socially offensive maladaptive behaviors and his program needed to be updated.</p>	W 290		

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W 290	Continued From page 15 The facility failed to ensure standing programs were not implemented.	W 290		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2016
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 FOX HOLL	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint survey conducted from 7/18/16 - 7/21/16. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000		
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W149 and W154.	MM134		
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	MM159		

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AUG - 9 2016
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE QIDP	(X6) DATE 8/8/16
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2016
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MM159	Continued From page 1 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 W210, W220, and W249.	MM159		
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W270 and W290.	MM162		



8/8/2016

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

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AUG -9 2016

FACILITY STANDARDS

RE: Foxhollow, Provider #13G066

Dear Jim Troutfetter:

Thank you for your considerateness during the recent annual recertification survey at the Foxhollow home. Please see our responses below for each citation and give us a call if you have any questions or concerns.

W149

1. Individuals #1-#5, the trending or tracking data related to repeated individual physical altercations is current and updated as each incident occurs and reviewed by the IDT.
2. All individual files are being reviewed to verify that all mental health needs are being addressed and comprehensive interventions are implemented to avoid further physical altercations.
3. A training is scheduled for the Foxhollow IDT. The training will focus on the team approach to tracking and trending of physical altercations and implementing strategies for interventions.
4. Currently Aspire Human Services meets weekly to review Accident and Incident reports to ensure the health and safety needs of the individuals served.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 9/30/16

Please refer to the responses given under W154.

W154

1. For individual's #1-#5, a training has been scheduled for the Program Supervisors, QIDP's and Program Manager at Aspire Human Services. The training will focus on the completion of thorough investigations. Specifically, interviewing the individuals and DSP's involved in all investigations and a thorough record review.
2. After the training has occurred for the Program Supervisors, QIDP's and Program Manager, will review all individuals that will be affected as each incident will be thoroughly investigated with a record review.
3. IDT currently meets at least weekly to review each incident report and verify that a thorough investigation has occurred including interview of individuals and DSP's involved and a thorough record review.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served.

5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 9/30/16

W159

1. For Individual #2, a training has been scheduled for the QIDP, on policy and procedure of the development and implementation of an Individual Person Plan and proper oversight and monitoring to promote an integrated and coordinated active treatment program for new admissions.
2. After the training has occurred for the QIDP, the QIDP will review current individual records and assessments in order to make necessary changes as needed.
3. IDT will develop a checklist for all necessary assessments, guidelines and timelines, based on policy to promote an integrated and coordinated active treatment program for new admissions.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review of all new admissions and coordinated services.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 9/30/16

W210

Please refer to the responses given under W159.

W220

Please refer to the response given under W159.

W249

1. For individual #2 behavioral intervention plans are implemented in accordance with his identified needs.
2. The QIDP and Program Supervisor are currently scheduled to complete at least weekly observations in the home to verify the staff understand all supervision guidelines.
3. A training has been scheduled with the QIDP's and Program Supervisors with Aspire Human Services. The training will focus on the expectation that weekly observations are to occur to verify IPP's are appropriately being implemented.
4. Currently Aspire Human Services has scheduled observations to be completed at least one time weekly by the QIDP and Program Supervisor to verify that IPP's are being implemented as written.
5. Person Responsible: Program Manager, QIDP, and Program Supervisor
6. Completion Date: 9/30/16

W270

1. For individual's #1-#5, the facility has implemented house rules that are allowed or not allowed between individuals.
2. The facility will implement house rules that are allowed or not allowed between individuals based on the needs of the individuals in each facility.
3. A training is scheduled for the DSP's in each identified facility on the guidelines set forth to ensure the safety of the individuals in each identified facility.
4. Each facility will review the rules monthly with individuals during their resident rights training.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 9/30/16

W290

1. Individual #3's functional behavioral assessment and behavior management plan is updated.
2. All files are being reviewed to verify that the functional behavioral assessment and behavior management plans correspond with the individuals current behavioral supports.
3. A training is scheduled for the QIDP's at Aspire Human Services to focus on the importance of adequate assessments and updating changes in behavioral supports.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual record.
5. Person Responsible: Program Manager, QIDP, Program Supervisor
6. Completion Date: 9/30/16

MM134

Please see the responses given under W149 and W154

MM155

Please see the responses given under W159

MM159

Please see the responses given under W210, W220, and W249.

MM162

Please see the responses given under W270 and W290.



Kim Eckstein
QIDP



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 29, 2016

Steve Young, Administrator
Yellowstone Group Home #4 Fox Hollow
560 West Sunnyside
Idaho Falls, ID 83402

Provider #13G066

Dear Mr. Young:

An unannounced on-site complaint investigation was conducted from July 18, 2016 to July 21, 2016 at Yellowstone Group Home #4 Fox Hollow. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007336

Allegation: There were multiple incidents of inappropriate sexual contact between individuals residing at the facility and staff were not intervening appropriately.

Findings: During the investigation, interviews were conducted, observations were conducted at the facility, and records were reviewed with the following results:

An individual who resided at the facility was interviewed. When asked if there were individuals inappropriately touching other individuals, the individual stated he had not observed or heard of individuals inappropriately touching other individuals.

A total of seven direct care staff (DCS) across shifts were interviewed on 7/18/16 and 7/19/16. When asked if there were individuals inappropriately touching other individuals, all the staff stated they had not observed individuals inappropriately touching other individuals. The staff all stated there were two individuals who could become physically aggressive when pushing each other around and their horseplay sometimes got out of hand.

Steve Young, Administrator
July 29, 2016
Page 2 of 3

The seven DCS were asked what they would do when they observe an individual inappropriately touching another individual. All the staff stated that they would separate the individuals, ensure the safety of the individual who was the victim, maintain visual contact with the individuals, notify their supervisor and facility administrator, and position themselves between the aggressor and the victim, if and when necessary.

Observations were conducted at the facility on 7/18/16 from 4:15 - 5:00 p.m., on 7/19/16 from 7:50 - 8:52 a.m., and on 7/20/16 from 11:40 - 11:50 a.m. During these timeframe's, there were no incidents of inappropriate sexual contact observed between the individuals who resided at the facility.

The records of three individuals were reviewed. The records did not contain any documentation of inappropriate sexual contact between individuals residing at the facility.

The facility's Abuse, Neglect, Mistreatment, and Injuries of an Unknown Source policy, revised 10/12/15 and Incident and Accident reports and Antecedent Behavior Consequence logs from 4/18/16 to 7/20/16 were reviewed.

A 6/7/16 report documented one individual (the aggressor) grabbed another individual (the victim) by the wrist and pushed the victim against a wall causing scratches and red marks to the victim's skin.

The Qualified Intellectual Disabilities Professional (QIDP) completed an investigation of the 6/7/16 incident. During the QIDP's investigation process, the victim provided the QIDP with a 6/12/16 handwritten statement that documented the aggressor had:

- slammed him against a fence and cut his arm,
- gave him a bloody jaw and nearly broke his wrist,
- stuck his hand down his backside while outside playing,
- choked him 12 times using a choke hold on his neck,
- slapped his butt and front side,
- purposely caused him to wreck his bike, and
- tied a blanket around his head and neck.

In addition, the victim's statement documented he was afraid of being the aggressor's roommate because he did not know what the aggressor would do to him.

The QIDP's 6/13/16 investigation into the 6/7/16 incident documented the QIDP interviewed both individuals. The aggressor told the QIDP that he did do all of the allegations as written in the victim's statement. The aggressor said he put his hand in the back of the victim's pants like he was going to grab his underwear and give him a snuggie (wedgie).

Steve Young, Administrator
July 29, 2016
Page 3 of 3

The QIDP documented she did not feel a room change would be necessary and the facility would work on more appropriate interactions between the aggressor and the victim and teach them how to play appropriately.

However, the investigation did not include documentation that the QIDP had interviewed or obtained written statements from staff or other individuals regarding the alleged incidents.

During an interview on 7/20/16 from 2:25 - 3:45 p.m., the QIDP stated she interviewed the aggressor, the victim, and the DCS related to the allegations in the victim's statement. The QIDP also stated the two individuals both said they did not want to change rooms, the staff said they checked the victim's mouth when he stated the aggressor hit him and his mouth was not bleeding, none of the staff witnessed the physical assaults as described in the victim's statement. The Program Manager, who was also present during the interview, stated the allegations were investigated by the QIDP, however the results of the investigation should have included when the interviews were conducted, and who was interviewed and their statements to rule out the allegations in the victim's statement.

It could not be determined there was inappropriate sexual contact between individuals. Therefore, due to lack of sufficient evidence, the allegation was unsubstantiated. However, a related deficiency was cited at W154 for the lack of a thorough investigation being conducted.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt