



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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September 12, 2016

Valentina Reudter, Administrator  
Belmont Care Center  
444 Hospital Way Ste 701  
Pocatello, ID 83201-2744

RE: Belmont Care Center, Provider #13G046

Dear Ms. Reudter:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center, which was conducted on August 26, 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

Valentina Reudter, Administrator

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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 **September 26, 2016**, and keep a copy for your records.

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

[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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

This request must be received by September 26, 2016. If a request for informal dispute resolution is received after September 26, 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,



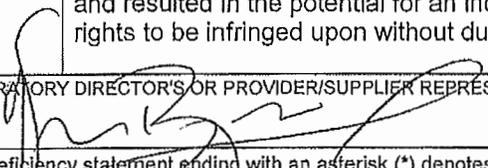
NICOLE WISENOR, Supervisor  
Non-Long Term Care

NW/pmt  
Enclosures

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

PRINTED: 09/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2016
NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint and recertification survey conducted from 8/23/16 - 8/26/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD, Team Lead Jim Troutfetter, QIDP  Common abbreviations used in this report are:  CPAP - Continuous Positive Airway Pressure DCS - Direct Care Staff DM - Dietary Manager HRC - Human Rights Committee IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian	W 000	<p>Please see attached Plan of Correction.</p>  <p>RECEIVED SEP 26 2016 FACILITY STANDARDS</p>	
W 123	483.420(a)(1) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility.  This STANDARD is not met as evidenced by: Based on record review, and staff interview, it was determined the facility failed to ensure that prior to an individual's admission, the legal guardian was informed of the rules of the facility. This failure impacted 1 of 1 individual (Individual #1) admitted to the facility within the past year and resulted in the potential for an individual's rights to be infringed upon without due process.	W 123		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Program Manager (X6) DATE 9/26/2016

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 123	Continued From page 1 The findings include:  1. Individual #1's 4/26/16 IPP documented he was a 32 year old male whose diagnoses included mild intellectual disability and schizophrenia. He was admitted to the facility on 4/7/16.  Individual #1's record was reviewed. His Admissions Agreement was dated 4/11/16 and documented the QIDP had contacted the guardian by phone regarding the rules of the facility.  When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the QIDP said Individual #1's guardian was contacted by telephone on 4/11/16 regarding the Admissions Agreement. The QIDP also stated she did not follow up to obtain the guardian's signature.  The facility failed to ensure Individual #1's guardian was informed of the rules of the facility prior to Individual #1's admission.	W 123			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 124			

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W 124	<p>Continued From page 2</p> <p>was determined the facility failed to ensure a guardian was provided with comprehensive information necessary to make informed decisions for 2 of 4 individuals (Individuals #1 and #4) whose consents were reviewed. This resulted in insufficient information being provided to guardians on which to base consent decisions. The findings include:</p> <p>1. Individual #4's IPP, dated 12/14/15, documented a 26 year old male whose diagnoses included mild intellectual disability.</p> <p>His record contained a Physician's Order, dated 6/2016, that documented Individual #4 received Wellbutrin (an antidepressant drug) 200 mg each morning.</p> <p>However, his record did not contain documentation of guardian consent related to the use of Wellbutrin.</p> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the Program Coordinator stated the missing consent for Wellbutrin was an oversight.</p> <p>The facility failed to ensure Individual #4 had guardian consent prior to the use of Wellbutrin.</p> <p>2. Individual #1's 4/26/16 IPP documented he was a 32 year old male whose diagnoses included mild intellectual disability and schizophrenia. He was admitted to the facility on 4/7/16.</p> <p>The QIDP documented Individual #1's guardian verbally consented to the following:</p>	W 124			

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W 124	<p>Continued From page 3</p> <p>- On 4/18/16 verbal consent was garnered for the use of the psychotropic medication Celexa (an antidepressant drug), for restricting access to chemicals and knives, for restricting privacy through increased supervision and monitoring phone calls, and for the use of video and audio recordings and photographs to be taken and used by the facility.</p> <p>- On 4/20/16 verbal consent was garnered for the use of the psychotropic medication Geodon (an antipsychotic drug) and a Suicide Intervention Plan with restrictive interventions of increased supervision and the removal of any potentially dangerous items from his environment.</p> <p>However, Written Informed Consents for the restrictive interventions had not been signed by the guardian.</p> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the QIDP said she did not follow up to obtain the guardian's signature.</p> <p>The facility failed to to ensure written guardian consent for Individual #1's restrictive interventions was obtained.</p>	W 124		
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health 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 staff were able to demonstrate</p>	W 192		

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W 192	<p>Continued From page 4</p> <p>competencies related to individuals' health needs for 2 of 3 individuals (Individuals #1 and #5) reviewed, who used a CPAP. This resulted in a lack of appropriate intervention and monitoring of individuals' health needs. The findings include:</p> <p>1. Individual #1's 4/26/16 IPP documented he was a 32 year old male whose diagnoses included mild intellectual disability and severe sleep apnea (sleep apnea occurs when a person regularly stops breathing for 10 seconds or longer during sleep. Severe occurs when there are 30 or more episodes of reduced airflow to the lungs every hour).</p> <p>Individual #1's record included the following:</p> <ul style="list-style-type: none"> <li>- Individual #1 participated in a Polysomnogram (a test used to diagnose sleep disorders) on 6/21/16.</li> <li>- The plan and treatment recommendations were for 12 centimeters of water and stated if Individual #1 remained symptomatic on the CPAP then BIPAP (bilevel positive airway pressure) support with a back-up rate was recommended.</li> <li>- Individual #1's Medical Appointment Form documented that on 8/3/16 the van driver escorted Individual #1 to obtain his CPAP.</li> <li>- His IPP included a Service Objective, dated 8/2016, titled Daily C-PAP Routine.</li> </ul> <p>During an observation at the facility on 8/25/16 from 8:05 - 8:40 a.m., Individual #1's CPAP was laying on the floor beside his bed. His floor book contained a "C-PAP Routine" Service Objective Record, dated 8/2016. The Service Objective</p>	W 192			

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W 192	<p>Continued From page 5</p> <p>Record sheet contained incomplete staff information related to Individual #1's use of the CPAP.</p> <p>When asked during an interview on 8/25/16 at 8:05 a.m., DCS A stated she had not received any training related to Individual #1's CPAP or for monitoring the use of the CPAP.</p> <p>When asked during an interview on 8/25/16 at 8:10 a.m., DCS B stated the staff had not received training related to the use of Individual #1's CPAP and he did not know how to fill the CPAP with water. DCS B also stated Individual #1 refused to use the CPAP.</p> <p>When asked during an interview on 8/24/16 at 9:20 a.m., the Home Manager stated the staff had not received training related to Individual #1's CPAP.</p> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the facility's RN and the facility's Nurse Aide both said staff had not been trained on the proper use of the CPAP for Individual #1. The QIDP, who was present during the interview, stated the Service Objective information had not been and should have been monitored for Individual #1.</p> <p>2. Individual #5's 12/1/15 IPP documented he was a 39 year old male whose diagnoses included mild intellectual disability and moderate sleep apnea.</p> <p>Individual #5's record included the following:</p> <p>- Individual #5 participated in a Polysomnogram on 7/5/16.</p>	W 192			

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W 192	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>- The plan and treatment recommendations included, but were not limited to, if the CPAP was not tolerated, then supplemental oxygen during sleep was recommended.</li> <li>- Individual #5's Medical Appointment Form documented that on 8/1/16 the van driver escorted Individual #5 to obtain his CPAP.</li> <li>- His IPP included a Service Program, dated 8/2016, titled CPAP Maintenance.</li> <li>- The Service Program sheet contained incomplete staff information related to Individual #5's CPAP.</li> </ul> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the facility's RN and the facility's Nurse Aide both said staff had not been trained on the proper use of the CPAP for Individual #5. The QIDP, who was present during the interview, stated the Service Program information had not been and should have been monitored for Individual #5.</p>	W 192		
W 227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p>	W 227		

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W 227	<p>Continued From page 7</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 an individual's IPP included an objective to meet an identified need for 1 of 4 individuals (Individual #3) whose IPPs were reviewed. This resulted in a lack of program plans designed to address an individual's uncooperative behavior. The findings include:</p> <p>Individual #3's IPP, dated 5/18/16, documented a 22 year old male whose diagnoses included mild intellectual disability.</p> <p>His Behavior Assessment, dated 5/31/16, documented Individual #3 was a new admit and did not know his treatment or probation stipulations and this was related to his uncooperative behavior.</p> <p>The Service Objective section of his Functional Behavior Assessment, stated "Tracking of uncooperative behavior will be done through informal programming."</p> <p>Individual #3's QIDP summaries for May 2016 documented he had engaged in uncooperative behavior two times and had seven incidents of uncooperative behavior in June 2016.</p> <p>However, his record did not contain a training objective or plan that directed staff on how to intervene when he engaged in uncooperative behavior.</p> <p>When asked on 8/25/16 from 2:48 - 3:40 p.m., the Program Coordinator stated Individual #3 did not have a training objective or plan that instructed staff on how to intervene when</p>	W 227			

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W 227	Continued From page 8 Individual #3 engaged in uncooperative behavior.	W 227			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 1 of 4 individuals (Individual #4) whose data was reviewed. That failure had the potential to impede the ability of the treatment team in evaluating the effectiveness of programmatic techniques. The findings include:  1. Individual #4's IPP, dated 5/8/16, documented a 26 year old male whose diagnoses included mild intellectual disability.  Individual #4's QIDP data tracking forms were reviewed from 11/2015 - 6/2016. The QIDP notes documented insufficient data collection. Examples included, but were not limited to, the following:  a. Money Management: QIDP entries for November 2015 - March 2016, and June 2016 all stated "Since staff seemed to struggle with data	W 252			

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W 252	Continued From page 9 collection [sic] this month's data will not count toward or against the consecutive total."  b. Treatment/Risky: QIDP entries for November 2015, and March 2016 - May 2016 all stated "Since staff seemed to struggle with data collection [sic] this month's data will not count toward or against the consecutive total."  c. Self-Feeding: QIDP entries for December 2015 stated "Since staff seemed to struggle with data collection [sic] this month's data will not count toward or against the consecutive total."  d. Coping Skills: QIDP entries for December 2015, April 2016, and June 2016 all stated "Since staff seemed to struggle with data collection [sic] this month's data will not count toward or against the consecutive total."  e. Treatment/Manipulation: QIDP entries for March 2016 - May 2016 all stated "Since staff seemed to struggle with data collection [sic] this month's data will not count toward or against the consecutive total."  When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the Program Coordinator stated he had done training with the staff on data collection, but it did not seem to work.  The facility failed to ensure sufficient data was collected to evaluate progress toward objectives.	W 252			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE  The committee should review, approve, and monitor individual programs designed to manage	W 262			

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W 262	Continued From page 10 inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 1 of 4 individuals (Individual #4) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include:  1. Individual #4's IPP, dated 12/14/15, documented a 26 year old male whose diagnoses included mild mental retardation.  His record contained a Physician's Order, dated 6/2016, which documented Individual #4 received Wellbutrin (an antidepressant drug) 200 mg each morning.  However, his record did not contain documentation of HRC consent related to the use of Wellbutrin.  When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the Program Coordinator stated the missing HRC approval for the Wellbutrin was an oversight.  The facility failed to ensure Individual #4 had HRC approval prior to the use of Wellbutrin.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	W 263		

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

PRINTED: 09/12/2016  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2016
NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204	
(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 263	Continued From page 11  The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the HRC ensured restrictive interventions were implemented only with the written informed consent of the guardian for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in the potential for an individual's rights to be restricted without due process. The findings include:  Individual #1's 4/26/16 IPP documented he was a 32 year old male whose diagnoses included mild intellectual disability and schizophrenia. He was admitted to the facility on 4/7/16.  The QIDP documented Individual #1's guardian verbally consented to the following:  - On 4/18/16 verbal consent was garnered for the use of the psychotropic medication Celexa (an antidepressant drug), for restricting access to chemicals and knives, for restricting privacy through increased supervision and monitoring phone calls, and for the use of video and audio recordings and photographs to be taken and used by the facility.  - On 4/20/16 verbal consent was garnered for the use of the psychotropic medication Geodon (an antipsychotic drug) and a Suicide Intervention Plan with restrictive interventions of increased	W 263		

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W 263	<p>Continued From page 12</p> <p>supervision and the removal of any potentially dangerous items from his environment.</p> <p>However, Written Informed Consents for the restrictive interventions had not been signed by the guardian. Further, the QIDP documented verbal approval for the individualized Suicide Intervention plan was garnered from an HRC member on 4/22/16 and the HRC had given approval for the other restrictive interventions listed above on 4/18/16.</p> <p>Individual #1's record did not include documentation that the HRC had ensured Individual #1's guardian's written consent had been obtained prior to the implementation of the restrictive interventions.</p> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the QIDP said she did not follow up to obtain the guardian's signature or obtain written approval from the HRC.</p> <p>The facility failed to ensure the HRC ensured that Individual #1's restrictive interventions were implemented only after written informed consent was obtained from Individual #1's guardian.</p>	W 263		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their 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 adequate nursing services were provided for 2 of 3 individuals (Individuals #1 and #5)</p>	W 331		

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W 331	<p>Continued From page 13</p> <p>reviewed, who used a CPAP. This resulted in a lack of clear direction related to interventions and a lack of monitoring necessary to meet the individuals' health needs. The findings include:</p> <p>1. Individual #1's 4/26/16 IPP documented he was a 32 year old male whose diagnoses included mild intellectual disability and severe sleep apnea (sleep apnea occurs when a person regularly stops breathing for 10 seconds or longer during sleep. Severe occurs when there are 30 or more episodes of reduced airflow to the lungs every hour).</p> <p>Individual #1's record included the following:</p> <ul style="list-style-type: none"> <li>- Individual #1 participated in a Polysomnogram (a test used to diagnose sleep disorders) on 6/21/16.</li> <li>- The plan and treatment recommendations were for 12 centimeters of water and stated if Individual #1 remained symptomatic on the CPAP then BiPAP (bilevel positive airway pressure) support with a back-up rate was recommended.</li> <li>- Individual #1's Medical Appointment Form documented that on 8/3/16 the van driver escorted Individual #1 to obtain his CPAP.</li> <li>- His IPP included a Service Objective, dated 8/2016, titled Daily C-PAP Routine.</li> </ul> <p>During an observation at the facility on 8/25/16 from 8:05 - 8:40 a.m., Individual #1's CPAP was laying on the floor beside his bed. His floor book contained a "C-PAP Routine" Service Objective Record, dated 8/2016. The Service Objective Record sheet contained incomplete staff</p>	W 331		

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W 331	<p>Continued From page 14 information related to Individual #1's use of the CPAP.</p> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the facility's RN and the Nurse Aide both said Individual #1's CPAP was not monitored by nursing.</p> <p>2. Individual #5's 12/1/15 IPP documented he was a 39 year old male whose diagnoses included mild intellectual disability and moderate sleep apnea.</p> <p>Individual #5's record included the following:</p> <ul style="list-style-type: none"> <li>- Individual #5 participated in a Polysomnogram on 7/5/16.</li> <li>- The plan and treatment recommendations included, but were not limited to, if the CPAP was not tolerated, then supplemental oxygen during sleep was recommended.</li> <li>- Individual #5's Medical Appointment Form documented that on 8/1/16 the van driver escorted Individual #5 to obtain his CPAP.</li> <li>- His IPP included a Service Program, dated 8/2016, titled CPAP Maintenance.</li> <li>- The Service Program sheet contained incomplete staff information related to Individual #5's CPAP.</li> </ul> <p>When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the facility's RN and the Nurse Aide both said Individual #5's CPAP was not monitored by nursing.</p>	W 331		

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W 331	Continued From page 15 The facility failed to ensure Individuals #1 and #5 received nursing services according to their needs.	W 331		
W 481	483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, review of menus and interview, it was determined the facility failed to ensure a record of food served was kept for 30 days. This failure directly impacted 14 of 14 individuals (Individuals #1 - #14) observed. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:  1. The facility's dinner menu on 8/23/16 was to consist of the following:  - Chicken Patties - Hamburger Bun - Pineapple Tidbits - Cucumber Salad  a. An observation was conducted at the facility on 8/23/16 from 3:30 - 5:25 p.m. During that time, the dinner meal was served. However, Pineapple Tidbits were not served.  The facility's 8/23/16 Dinner Preparation Production Sheet was reviewed. However, the Production Sheet documented that Pineapple Tidbits were served.  When asked during an interview on 8/25/16 from 2:48 - 3:45 p.m., the RD and the DM both stated the individuals who prepared the meal must have	W 481		

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

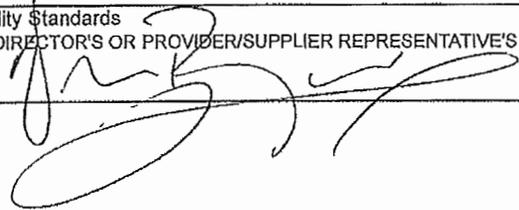
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W 481	Continued From page 16 forgotten to serve the Pineapple Tidbits.  The facility failed to ensure accurate documentation of food actually served was kept.	W 481		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2016
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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the complaint and state licensure survey conducted from 8/23/16 - 8/26/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD Team Lead Jim Troutfetter, QIDP	M 000	<p>Please see attached Plan of correction</p>  <p>RECEIVED SEP 26 2016 FACILITY STANDARDS</p>	
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 W123 and W124.	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 W192.	MM155		
MM159	16.03.11400 Active Treatment Services  The requirements of Sections 400 through 499 of	MM159		

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



TITLE

Program Manager

(X8) DATE

9/26/2016

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2016
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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 W227,W252, W262 and W263.	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 W331.	MM166		
MM215	16.03.11711.01 Good Repair  Each building used by the ICF/ID and its equipment must be in good repair.  This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 14 of 14 individuals (Individuals #1 - #14) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An environmental review was conducted at the facility on 8/24/16 from 3:10 - 3:40 p.m. During	MM215		

Bureau of Facility Standards

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MM215	Continued From page 2 that time, the following was noted:  - There was food splatter on the interior of the microwave in the dining area.  - There was an unidentified sticky substance on the interior of the dining room freezer with paper stuck to it.  - The electrical outlet covers were missing under the table where the toaster was located in the dining room.  - There was a hole approximately 1 inch by one and one-half inches in the dining room wall to the left of the dining room door.  - The cover on the light switch in the day room was not secure.  - The first and fourth drawers of the four-drawer unit to the left of the toaster in the dining room were broken.  - There was assorted trash on Individual #4's bedroom floor.  - The dresser in Individual #10's room was missing all the drawers.  - The bottom drawer of the first dresser on the right in Individual #12's bedroom was broken.  The facility failed to ensure environmental repairs were completed and maintained.	MM215			
MM366	16.03.11800 Dietetic Services  The requirements of Sections 800 through 899 of	MM366			

Bureau of Facility Standards

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MM366	<p>Continued From page 3</p> <p>these rules are modifications and additions to the requirements of 42 CFR 483.480 - 483.480(d)(5), Condition of Participation: Dietetic Services incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W481.</p>	MM366		
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444 Hospital Way Suite 701 Pocatello, Idaho 83201 | Office – 208-238-5950 | Fax 208-238-5860

9/23/2016

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

Dear Ms. Wisenor, Mr. Troutfetter and Ms. Marshall –

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

MM134

Please see response to W123 and W124

MM155

Please see response to W192

MM159

Please see response to W227, W252, W262 and W263

MM166

Please see response to W331

M366

PLEASE SEE RESPONSE TO W481 - By Jim King for PER PROGRAM  
MANAGER 9-30-16 12:15 PM

-Continue on following page-

MM215

1. The food splatter on the interior of the microwave was cleaned, sticky substance on the interior of freezer in dining room was cleaned, missing electrical covers were replaced, 1 inch hole in the dining room drywall was repaired, light switch cover was replaced, cabinet in the dining room was replaced, trash on individuals #4's room was cleaned up, Individual #10's dresser was replaced and Individual #12's dresser drawer was repaired by 9/9/2016.
2. Aspire Human Services will ensure environmental repairs are completed and the facility will be kept in good repair.
3. Aspire Human Services in Pocatello currently has a monthly checklist which is completed by the home supervisor or lead worker. The checklist will include general cleanliness of the facility and ensure furniture in each individual's room be in good repair, including dressers and dresser drawers.
4. Each month the after the Program Supervisor or lead worker has completed their monthly checklist, the documentation will be turned into the Program Manager for verification that the inspection has occurred. Program Manager will coordinate the correction of deficiencies found.
5. Person Responsible: Program Supervisor, Program Manager
6. Completion Date: 10/15/2016

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 long, sweeping horizontal flourish extending to the right.

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



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

9/23/2016

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

RECEIVED  
OCT - 5 2016  
FACILITY STANDARDS

Dear Ms. Wisenor, Mr. Troutfetter and Ms. Marshall -

I would like to thank you for your recent visit to Belmont Care Center (Provider #13G046). Although an annual recertification survey is always stressful, especially with an accompanying complaint survey, your team approached this survey teaching opportunity and not as an opportunity to be belittling and punitive. That approach helps us grow as a team and a company to better serve the individuals in our care. The way the survey is conducted is greatly appreciated.

Abbreviations used in this document:

RN – Registered Nurse  
DSP – Direct Support Professional  
CPAP – Continuous Positive Airway Pressure  
QIDP – Qualified Intellectual Disabilities Professional  
HRC – Human Rights Committee

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

W123

1. Written guardian consent for the admissions agreement have been gained for individual #1.
2. Aspire Human Services will review all admission agreements for all individuals in the home to ensure that written consent has been gained.
3. Aspire Human Services will have an admission packet sent to guardians before admission into the program.
4. Pre-Admission team meetings will be held prior to admission dates. At that time, the admission agreements will be discussed and sent to guardians (if the individual has a guardian).
5. Person Responsible: Qualified Intellectual Disabilities Professional (QIDP), Clinical Director, Program Manager
6. Completion Date: 10/10/2016

W124

1. Written guardian consent for medication and restrictive interventions were gained for Individuals #1 and #4.
2. Aspire Human Services will review all restrictive components of treatment for all individuals in the home to ensure informed consent is provided to the guardian about the restrictive components.
3. Aspire Human Services has record reviews for all the homes. One part of the record review will be to ensure written consent is gained for all restrictive components of treatment.
4. Aspire Human Services will follow a schedule to review all records. After records are reviewed the Clinical Director will coordinate the correction of any identified errors.
5. Person responsible: QIDP, Clinical Director, Program Manager
6. Completion Date 10/1/2016

W192

1. Trainings for Direct Support Professionals (DSPs) has been completed for individuals #1 and #5 regarding individual's current health status and Continuous Positive Airway Pressure (CPAP) machine use.
2. Training for all individuals in the home with health status concerns will be completed as the concerns arise to ensure safety.
3. DSPs will receive training on new programming before the program is implemented to ensure knowledge of individuals' health needs.
4. Trainings will occur at minimum monthly during scheduled staff meetings or as needed prior to program implementation.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion Date: 10/15/2016

W227

1. A formal training objective has been implemented for individual #3 to address uncooperative behavior.
2. Programming will be reviewed and revised as needed for all individuals in the home to ensure specific identified needs are being addressed objectively.
3. Aspire Human Services will complete record reviews for all the individuals in the home. One part of the record reviews will be to ensure objective training is provided when a need is assessed.
4. Aspire Human Services will follow a schedule to review all records. After records are reviewed the Clinical Director will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion Date: 10/10/2016

W252

1. Objective programming for Individual #4 has been reviewed and revised to improve data collection.
2. Objective programs will be reviewed and revised for programming that has inconsistent data collection to be able to evaluate progression or regression of functioning level. Program Supervisor will ensure programming documentation is completed for formal programming as recommended for each program daily.
3. Aspire Human Services will complete chart reviews for all the individuals in the home. One part of the chart reviews will be to review data collection for objective programming. Programs with inconsistent data collection will be reviewed and revised as needed.
4. Aspire Human Services will follow a schedule to review all records. After records are reviewed the Clinical Director will coordinate the correction of any identified errors.
5. Person Responsible: Program Supervisor, QIDP, Clinical Director, Program Manager
6. Completion Date: 10/10/2016

W262

1. Written Human Rights Committee (HRC) consent has been gained for the use of medication for Individual #4.
2. Records for all individuals in the home will be reviewed to ensure written HRC consent has been gained for restrictive components of treatment including medications requiring approval.
3. Aspire Human Services preforms record reviews for all the individuals in the home. One part of the record reviews will be to ensure HRC has given written consent for restrictive components of treatment, including medications requiring approval.
4. Aspire Human Services will follow a schedule to review all records. After record reviews are complete the Clinical Director will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion date: 10/1/2016

W263

1. Written guardian consent was gained for restrictive components of programming for Individual #1.
2. Records all will be reviewed to ensure written guardian consent has been gained for all individuals in the home.
3. Aspire Human Services preforms record reviews for all the individuals in the home. One part of the record reviews will be to ensure guardian consent has been gained for all restrictive components of treatment.
4. Aspire Human Services will follow a schedule to review all records. After record reviews are complete the Clinical Director will coordinate the correction of any identified errors.
5. Person Responsible: QIDP, Clinical Director, Program Manager
6. Completion date: 10/15/2016

W331

1. Facility nurse (RN oversight) is monitoring CPAP machine use for Individuals #1 and #5.
2. Nursing needs for all individuals in the home will be reviewed and nursing services will be provided as recommended.
3. Aspire Human Services preforms record reviews for all the individuals in the home. One part of the record reviews will be to ensure medical equipment is being monitored by facility nurse and nursing services are being provided as recommended.
4. Aspire Human Services will follow a schedule to review all records. After record reviews are complete the Clinical Director will coordinate the correction of any identified errors.
5. Person Responsible: Facility Nurse (RN oversight), Clinical Director, Program Manager.
6. Completion date: 10/25/2016

W481

1. DSPs and individuals living in the home have been trained how to complete the production sheet by the Dietary Manager.
2. Dietary manager will train all individuals who live and work in the home how to complete the production sheet to ensure menu items are served. Also will train how to document any substituted menu items or items not served.
3. Production sheet training will be covered in new hire orientation to ensure all oncoming staff have been trained how to complete the production sheets.
4. Production sheet training will be completed at least annually with individuals who work and live in the home to ensure correct completion.
5. Person Responsible: Dietary Manager, Program Supervisor, Program Manager
6. Completion date: 10/15/2016

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 long horizontal flourish extending to the right.

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**

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
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September 13, 2016

Valentina Reudter, Administrator  
Belmont Care Center  
444 Hospital Way Ste 701  
Pocatello, ID 83201-2744

Provider #13G046

Dear Ms. Reudter:

An unannounced on-site complaint investigation was conducted from August 23, 2016 to August 26, 2016 at Belmont Care Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007351**

**Allegation #1:** Staff do not provide appropriate supervision and active treatment services to individuals and appropriate reporting of abuse and neglect is not done.

**Findings #1:** During the investigation, observations were conducted, individual records, incident reports and investigations were reviewed, and staff and individuals were interviewed with the following results:

Morning, day program, afternoon and evening observations were conducted on 8/23/16 and 8/24/16 for a cumulative 4 hours and 5 minutes of observation. During all observations, individuals were noted to be provided with appropriate staff supervision and active treatment services. Staff were not observed to be involved in other activities such as using their cell phones, which precluded them from providing appropriate care and all staff were noted to be respectful to individuals in their interactions.

The Active Treatment Schedules (ATS) for all 14 individuals were reviewed and found to be current. One individual's floor book did not include an ATS. At that time, 2 direct care staff (DCS) were interviewed as to how they would provide that specific individual with active treatment. Both DCS stated the individual's floor book included all the individual's programs. One of the DCS reviewed the floor book and showed the surveyor what the individual's programs were.

The facility's Qualified Intellectual Disabilities Professional (QIDP) was interviewed and asked about the ATS that was not located in the individual's floor book. The QIDP stated the individual's ATS was being reviewed and updated. The individual's updated ATS was reviewed and included what was noted during the observations conducted at the facility.

Four individuals were selected for in-depth review. One of the 4 individual records reviewed included an individualized suicide intervention plan. The plan included the use of increased staff supervision should the individual actively engage in suicidal ideation.

Three individuals were interviewed and asked about staff supervision of individuals on suicide watch. None of the individuals stated they had witnessed staff not properly supervising individuals on suicide watch. When asked about staff interactions, none of the individuals stated staff had been inappropriate or antagonistic towards them or other individuals.

Additionally, 9 DCS were interviewed. All of the staff interviewed stated they had not witnessed or heard of the current staff provoking or antagonizing individuals. When asked, all staff were able to state the requirements for the various levels of suicide watch. None of the staff stated they had witnessed staff not following the protocol for suicide watch.

Further, the facility's Incident and Accident (I&A) reports from 5/23/16 to 8/23/16 were reviewed. None of the reports documented allegations of inappropriate staff behavior (e.g. staff engaging in physical abuse, sexual abuse, and/or verbal or psychological abuse, such as antagonizing individuals) or neglect (e.g. staff not providing appropriate staff supervision).

Seven DCS were interviewed regarding I&A reporting. All staff stated I&A reports had to be completed any time an individual fell, was injured, bumped a part of their body such as their knee, was hurt in any way, or when anything happened that could harm the individual. Two additional staff were interviewed and both stated they had not yet witnessed anything that would require an I&A to be completed but if they had to complete an I&A, they had been trained and would ask senior staff to help them complete the I&A process. Further, the Administrator stated there had not been any potential or substantiated abuse investigations since the facility's last survey on 9/25/15.

It could not be determined that staff did not provide appropriate supervision and active treatment services to individuals. Therefore, due to lack of sufficient evidence, the allegation was

unsubstantiated and no deficient practice was identified.

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

**Allegation #2:** The facility, especially the kitchen, is not clean and food is not served at the appropriate temperatures.

**Findings #2:** During the investigation, observations were conducted, records were reviewed, and staff and individuals were interviewed with the following results:

During observations conducted on 8/23/16 and 8/24/16, the following was noted:

- On 8/23/16 from 11:15 a.m. - 12:10 p.m., the common areas and dining area were noted to be clean and trash had been emptied. One direct care staff (DCS) and 2 individuals were observed in the facility's kitchen preparing the lunch meal. The menu consisted of ham salad pita pocket, coleslaw, oranges and pears. At 11:38 a.m. after the foods had been prepared, covered and labeled, the ham salad and coleslaw were placed into a temperature control device (refrigerator).

After the foods for the meal had been prepared and sent to the dining room, the DCS and the individuals wiped down the counters, the outsides of the microwave and refrigerators, washed dishes, and swept the floor. In addition, the lunch meal production sheet contained an "Every Meal Cleaning List." After the DCS and the individuals were done with kitchen clean-up, all the items on the cleaning list were documented as completed.

At 12:12 p.m., the ham salad and coleslaw were removed from the refrigerator and all foods were taken to the dining room. At 12:20 p.m., the individuals began serving themselves. The foods were served within 15 minutes of being removed from the refrigerator. During that time no individuals or staff had complained about the temperature of the food.

- On 8/23/16 from 4:40 - 4:45 p.m., 1 DCS and 2 individuals were in the facility's kitchen preparing the dinner meal. The menu consisted of chicken patties, hamburger buns, pineapple tidbits, and cucumber salad. The meat was observed in the oven and the oven was set at 185 degrees Fahrenheit. The cucumber salad was observed in the refrigerator. At that time, the 2 individuals were interviewed and stated the chicken patties were ready to be served and were being held in the oven at 185 degrees Fahrenheit. Both individuals also said they would serve pineapple tidbits and cucumber salad with the chicken patties.

Further, the dinner meal preparation production sheet was laying on the counter. After the DCS and the individuals were done cleaning the kitchen, all the items on the cleaning list were

documented as completed.

During the observation the staff and individuals were interviewed about cleaning the kitchen. The DCS and the 2 individuals all stated kitchen clean-up was to be completed after the food was prepared.

A meal observation was conducted on 8/23/16 from 4:55- 5:25 p.m. At 4:55 p.m., the chicken patties and cucumber salad were removed from temperature control and along with the hamburger buns were taken to the dining room. At 5:00 p.m. the individuals began serving themselves. The foods were served within 15 minutes of being removed from the temperature control devices (oven and refrigerator). During that time no individuals or staff had complained about the temperature of the food or were observed to reheat food in the microwave.

On 8/23/16, 3 individuals were interviewed regarding food temperatures. Two stated the hot food was served hot and the cold food was served cold. One individual stated the meat was not always hot, but he would place it in the microwave. Nine staff were interviewed regarding food temperatures. All staff stated hot foods were served hot and cold foods were served cold.

- During an observation on 8/24/16 from 9:25 - 9:45 a.m., 1 individual was noted to sweep and mop the dining room floor. The common areas and dining areas were again noted to clean and free of trash.

However, during an environmental review conducted at the facility on 8/24/16 from 3:10 - 3:40 p.m., the following was noted:

- There was food splatter on the interior of the microwave in the dining area.
- There was an unidentified sticky substance on the interior of the dining room freezer with paper stuck to it.
- There was assorted trash on 1 individual's bedroom floor.

It could not be determined that food was not served at the appropriate temperatures or that the kitchen was not kept in a clean and sanitary manner. However, a lack of general cleaning in the dining area and trash on an individual's floor were observed. Therefore, the allegation was substantiated and the deficient practice was identified at state rule 16.03.11711.01.

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

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

Valentina Reudter, Administrator  
September 13, 2016  
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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,

A handwritten signature in black ink, appearing to read "Nicole Wisenor". The signature is fluid and cursive, with a large initial "N" and "W".

NICOLE WISENOR, Supervisor  
Non-Long Term Care

NW/pmt