



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 16, 2016

Russell McCoy, Administrator
Rulon House
415 South Arthur
Pocatello, ID 83204

RE: Rulon House, Provider #13G020

Dear Mr. McCoy:

This is to advise you of the findings of the complaint survey of Rulon House, which was conducted on September 7, 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

Russell McCoy, Administrator
September 16, 2016
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **September 29, 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 September 29, 2016. If a request for informal dispute resolution is received after September 29, 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



Promoting Functional Independence Through Person Centered Services

September 27, 2016

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

RECEIVED
SEP 30 2016
FACILITY STANDARDS

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the complaint survey completed September 7, 2016. On the Statement of Deficiencies / Plan of Correction, Form CMS-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed below.

Sincerely,


Russell C. McCoy, M.A. Ed
Executive Director

Enclosures

Russell C McCoy, M.A. Executive Director • russellmccoy415@gmail.com

415 So. Arthur Avenue • Pocatello, Idaho 83204-3303 • Phone (208) 233-6833 • Fax (208) 233-6842 • www.developmentaloptions.com

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

PRINTED: 09/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/07/2016
NAME OF PROVIDER OR SUPPLIER RULON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey conducted from 8/30/16 - 9/7/16. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Autumn Bernal, BSN, RN Common abbreviations used in this report are: ABC - Antecedent Behavior Consequence AOD - Administrator on Duty DCS - Direct Care Staff IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional SIB - Self-Injurious Behavior SIR - Significant Injury Report	W 000			
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 was determined the facility failed to ensure guardians were provided with timely, comprehensive information necessary to make	W 124	W124 483.420(a)(2) For the affected individuals, the Consent to Treat documents will be resent to the appropriate guardian/family member with the correct drug side effect sheet that is thorough in explaining the potential side effect. For Individual #2, the Consent to Treat had expired, so the document will be sent to the family for signature. The facility will devise a procedure that allows for a systematic change to address the drug side effect sheets and timely renewal of each Consent to Treat		

RECEIVED
SEP 30 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Director

09/27/2016

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 124	<p>Continued From page 1</p> <p>informed decisions for 3 of 5 individuals (Individuals, #2, #3 and #5) whose consents were reviewed. This resulted in insufficient information being provided to guardians on which to base consent decisions and a lack of timely consent renewals being completed. The findings include:</p> <p>1. The 2017 Nursing Drug Handbook identified numerous adverse reactions to Risperdal (an antipsychotic drug) that included, but were not limited to, urinary incontinence, increased urination, gynecomastia (enlarged breasts in men), suicide attempt, and neuroleptic malignant syndrome (a life-threatening, neurological disorder most often caused by an adverse reaction to neuroleptic or antipsychotic drugs).</p> <p>Individuals #3 and #5's records were reviewed and documented they received Risperdal. However, comprehensive information regarding the potential side effects of the medication was not provided to their guardians, as follows:</p> <p>a. Individual #3's 7/5/16 IPP documented he was a 15 year old male whose diagnoses included moderate intellectual disability.</p> <p>Individual #3's record included a 11/2/15 physician order for Risperdal 3 mg two times a day. His 8/2016 Medication Record documented he received Risperdal 3 mg as ordered.</p> <p>His 2/23/16 Consent to Treat letter, signed by his guardian on 2/29/16, listed that the side effects of the medication were dizziness, drowsiness, fatigue, nausea, constipation, runny nose, increased appetite, and weight gain. Additionally, an undated patient information leaflet documented some potential side effects of</p>	W 124	<p>document. The QIDP's will be trained on this tracking system so there will be another level of review to prevent any lapses in required information.</p> <p>Corrective Action Completion Date: November 7, 2016</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>		

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W 124	<p>Continued From page 2</p> <p>Risperdal. However, the undated leaflet also documented the side effects were not a complete list of possible side effects.</p> <p>b. Individual #5's 9/15/15 IPP documented he was a 25 year old male whose diagnoses included moderate intellectual disability.</p> <p>Individual #5's record included a 4/29/09 physician order for Risperdal 2 mg two times a day. His 8/2016 Medication Record documented he received Risperdal 2 mg as ordered.</p> <p>His 2/22/16 Consent to Treat letter, signed by his guardian on 2/28/16, listed that the side effects of the medication were fever, stiff muscles, confusion, sweating, fast or uneven heartbeats, tremor, and trouble swallowing. Additionally, an undated patient information leaflet documented some potential side effects of Risperdal. However, the undated leaflet also documented the side effects were not a complete list of possible side effects.</p> <p>When asked during an interview on 9/1/16 from 3:10 - 4:40 p.m., the Program Director and the facility's LPN both stated the undated patient information leaflet was provided by the pharmacy and was the only side effects document given to Individual #3 and Individual #5's guardians.</p> <p>The facility failed to ensure guardians were provided with comprehensive information necessary to make informed decisions.</p> <p>2. Individual #2's 7/19/16 IPP documented he was a 47 year old male whose diagnoses included moderate intellectual disability, impulse control disorder, autism, obsessive compulsive</p>	W 124		

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W 124	Continued From page 3 disorder, and seizure disorder. Individual #2's 8/4/15 Consent to Treat letter was signed by the guardian on 8/4/15. The letter was for Individual #2's behavior management program, dietary modifications, video surveillance system, and medications. The letter documented the Consent to Treat would be considered to be in effect for one year, or until withdrawn. However, Individual #2's record did not include a signed, updated Consent to Treat letter. When asked during an interview on 9/6/16 at 8:58 - 9:25 a.m., the Program Director stated Individual #2's Consent to Treat letter had expired and the facility had not garnered his guardian's signature.	W 124		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation, policy review, record review, review of SIRs, Minor Incident Reports, and staff interview, it was determined the facility failed to ensure all injuries of unknown source and self-injurious behavior were immediately	W 153	W153 483.420 (d)(2) The facility will revise the policy and procedure pertaining to injuries of unknown origin and self-injurious behavior to make the reporting of incidents more thorough and establish a better tracking system to ensure all incidents have been followed up with correctly. This revised policy and procedure will ensure all injuries are immediately reported to the administrator. This corrective approach will address the deficient practice with all individuals in the facility. The QIDP will track and monitor the incidents to	

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W 153	<p>Continued From page 4</p> <p>reported to the Administrator for 1 of 5 individuals (Individual #4) whose records were reviewed. This resulted in an individual engaging in ongoing self-injurious behavior without investigation. The findings include:</p> <p>1. The facility's Policy on Injuries of Unknown Origin, adopted 11/24/03 stated "...Upon the occurrence of such an injury, an investigation will be initiated to attempt to discover the cause of the injury..." A corresponding "Significant Incident Report" policy, dated 3/19/13, stated an SIR was to be completed for injuries of unknown origin and directed staff to notify the AOD, Residential Program Director, and assigned QIDP.</p> <p>Individual #4's 5/10/16 IPP documented she was a 57 year old female whose diagnoses included mild intellectual disability, impulse control disorder, bipolar disorder, history of schizophrenia, borderline personality disorder, and traumatic brain injury.</p> <p>Her record documented injuries of unknown source. However, corresponding SIRs related to the injuries could not be found, as follows:</p> <p>During an observation, on 8/31/16 at 8:31 a.m., Individual #4 was observed with a band-aid on her left forearm. During an interview with Individual #4 on 8/31/16 at 10:12 a.m., the band-aid had been removed and an open sore on the back of her left forearm, which was approximately 1 and 1/2 cm in diameter, was observed.</p> <p>However, a related SIR or Minor Incident Report documenting the source of the injury and that immediate Administrator notification had occurred</p>	W 153	<p>ensure correct follow through and reporting has been completed.</p> <p>Corrective Action Completion Date: November 7, 2016</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>		

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W 153	<p>Continued From page 5 could not be found.</p> <p>When asked during an interview on 8/31/16 at 3:15 p.m., the LPN stated that Individual #4 had been picking her skin and she had multiple open sores. The LPN provided documentation of Individual #4's 8/29/16 Head to Toe Visual Exam that documented the following:</p> <ul style="list-style-type: none"> - "Dime size open area," documented to be on her abdomen in the right upper quadrant. - "Old pick mark," documented to be on her abdomen in the right lower quadrant. - "2 red areas quarter size [sic] under abd. [abdominal] fold," documented to be on the upper most portion of the front of her left thigh. - "8 open pick areas varying sizes from pinpoint to dime," documented to be on her right breast. - "Dime size open area," documented to be on her right lower back. - "Pick area," documented to be on her left posterior hand. <p>However, a related SIR or Minor Incident Report documenting the source of the injury and that immediate Administrator notification had occurred could not be found.</p> <p>During an interview on 9/1/16 from 8:45 - 9:05 a.m. the Program Director stated new injuries should be tracked on injury reports. However, when asked to see the injury reports, no injury reports could be provided for Individual #4's documented skin wounds.</p>	W 153		

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W 153	<p>Continued From page 6</p> <p>When asked during an interview on 9/1/16 at 11:55 a.m., the QIDP stated Individual #4 picked at her skin, usually when staff did not see her do it.</p> <p>During a follow-up interview on 9/1/16 from 3:10 - 4:40 p.m. the Program Director stated Individual #4 did not always tell staff how her skin injuries occurred. Therefore, the injury would be considered an injury of unknown source. Individual #4's skin picking was not considered an unknown injury if she later told staff that the wounds were self-inflicted.</p> <p>The "Client Significant and Minor Incident Reports" section of the facility's 1998 Standard Operating Procedures Manual stated a "Significant Incident is any event that might endanger the individual or other individuals..." The policy stated significant incidents included self-injurious behavior with serious injury. The policy stated an SIR form was to be completed for all Significant Incidents and the Executive Director was to be immediately notified.</p> <p>The policy also stated a "Minor Incident" was one where no serious injury was apparent and directed staff to complete a "Minor Incident Report." The corresponding Minor Incident Report form stated "The Executive Director or AOD MUST be notified IMMEDIATELY of all injuries."</p> <p>The facility's SIRs and Minor Incident Reports from 5/22/16 to 8/30/16 were reviewed. The reports did not include documentation of Individual #4 picking at her skin or further explain the injuries identified in Individual #4's 8/29/16</p>	W 153			

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W 153	Continued From page 7 Head to Toe Visual Exam. Related SIRs and/or minor injury reports documenting the SIB and immediate Administrator notification could not be found.	W 153		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on observation, record review and individual and staff interview, it was determined the facility failed to ensure individual training programs specified the type of data necessary to be able to assess progress toward objectives for 1 of 5 individuals (Individual #4) whose Behavior Management Plans were reviewed. That failure had the potential to prevent the facility from making objective decisions regarding an individual's success or lack of success. The findings include: 1. Individual #4's 5/10/16 IPP documented she was a 57 year old female whose diagnoses included mild intellectual disability, impulse control disorder, bipolar disorder, history of schizophrenia, borderline personality disorder, and traumatic brain injury.	W 237	W237 483.440(c)(5)(iv) For Individual #4, the behavior management plan will be revised to give staff appropriate response on what to do if she has picked her skin when it was not observed or witnessed by staff. This is also tied to the correction at W153 for the revised policy and procedure. The QIDP will identify other individuals in the facility that have a similar or like behavior through the behavior assessments. Should another person be identified, the same corrective action will be implemented. The goal is to make certain each training program is designed to implement the objectives in the individual program plan ensuring the staff understands the type and frequency of data so that assessment toward progress can be obtained. Corrective Action Completion Date: November 7, 2016 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 237	<p>Continued From page 8</p> <p>Individual #4's Behavioral Assessment, conducted between 4/6/16 and 5/9/16 as part of re-assessing her behaviors, documented that she sometimes displayed SIB. The assessment documented another aspect of the SIB was Individual #4 picking at her skin and creating sores on her body (namely on her shins and belly). The assessment also included that some of the reasons that she may be engaging in SIB could have been due to boredom, irritation with staff members and residents. She did heal slowly and bruised easily, so the picking at and creating sores on her body did pose a danger to herself.</p> <p>Individual #4's Behavior Management Program, revised 12/17/15, documented her SIB included, but was not limited to, hitting, trying to bite or scratch herself, deliberately ripping off fingernails or skin, and picking at her skin creating or reopening wounds or scabs. The Documentation Instructions section directed staff to document each incidence of SIB on a Behavior Data Collection Sheet (ABC sheets). Each sore was to be counted as 1 incidence of SIB. If Individual #4 caused any sort of injury (i.e. red mark, bruise/potential bruise, bite mark, open scab), the injury would be documented on the minor illness/injury log and the LPN notified. The Prevention section documented that picking at her skin SIB often happened in her room alone when she felt ignored and sometimes there was no clear antecedent to her behavior of picking at her skin. The Staff Response section documented that staff should verbally redirect Individual #4 to stop picking at her skin because it was harmful and she should be told why it was harmful.</p> <p>However, the Staff Response section did not</p>	W 237			

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W 237	<p>Continued From page 9</p> <p>provide staff interventions of what do to when Individual #4 had been picking at her skin which was not witnessed or observed by staff.</p> <p>During an observation at the facility on 8/31/16 from 8:25 - 8:55 a.m., Individual #4 was observed with a Band-Aid on her left forearm.</p> <p>During an interview with Individual #4 on 8/31/16 at 10:12 a.m., red marks were observed on the inside of her left forearm. The red marks extended from her wrist to the bend in her arm. When asked about the red marks, Individual #4 stated that she tried to hurt herself.</p> <p>When asked during an interview on 8/31/16 at 3:15 p.m., the LPN stated that Individual #4 had been picking her skin and she had multiple open sores. The LPN said she was monitoring Individual #4 and her doctor was made aware.</p> <p>When asked during an interview on 9/1/16 at 11:55 a.m., the QIDP stated Individual #4 picked at her skin, usually when staff did not see her do it. The QIDP also stated Individual #4 picking at her skin was not tracked separately on summaries and the summary data for SIB included both hitting and skin picking. He stated Individual #4's picking at her skin was not incorporated to behavior tracking because the ABC data was only what the staff actually observed. Therefore, most of her skin picking was not tracked. He also stated when staff noticed a sore, they called the LPN.</p> <p>However, the LPN's skin assessments had no corresponding documentation on how each open wound had occurred.</p>	W 237			

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

PRINTED: 09/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/07/2016
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W 237	Continued From page 10 When asked during an interview on 9/6/16 from 8:58 - 9:25 a.m., the Program Director stated the facility was not tracking Individual #4's unwitnessed SIB and there were no further staff directions on what to do for reporting SIB or using the ABC sheets for an unwitnessed injury.	W 237		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 3 of 5 individuals (Individuals #1, #3, and #5) whose behavior interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include: 1. Individual #3's 7/5/16 IPP documented he was a 15 year old male whose diagnoses included moderate intellectual disability, autism,	W 289	W289 483.450(b)(4) For individuals #1, 3, and 4, their behavior management program will be revised to incorporate the missing techniques listed in the citation. The QIDP will review the plans for the other individuals residing in the facility to assess for any missing techniques that could provide a better response to maladaptive behaviors. The RPD will review the plans on an annual basis, tied with the IPP meetings to ensure behaviors are adequately assessed and responses used meet their needs. Corrective Action Completion Date: November 7, 2016 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 289	<p>Continued From page 11</p> <p>oppositional defiant disorder, attention deficit disorder, learning disorder, personality disorders, and complex developmental encephalopathy.</p> <p>The facility's SIRs from 5/22/16 to 8/30/16 were reviewed. The reports documented that on 5/22/16 and 8/28/16, Individual #3 eloped from the facility.</p> <p>Individual #3's behavioral assessment, dated 6/24/16, stated he had several maladaptive behaviors that caused safety concerns for both him and those who work with him. The assessment defined attempted elopement as "attempting to leave the facility or trying to run away with staff following him. He used this behavior as an escape mechanism. He would go into other people's yards looking for items that may be appealing to him." The behavior summary stated that Individual #3 had a frequent tendency to run away or attempt to elope. The facility decided that Individual #3 would be provided with one-on-one staffing from 7:00 a.m. - 9:00 p.m.</p> <p>Individual #3's Behavior Management Plan, revision date 11/10/14, was reviewed. The plan did not include elopement, the definition of elopement, staff interventions related to elopement or what the one-on-one staffing interventions were.</p> <p>On 9/1/16 from 3:10 - 4:40 p.m., the Program Director stated that when she reviewed Individual #3's QIDP summaries, elopement was not listed in his behavior plan. She also stated Individual #3's behavior plan for one-on-one should include instructions to staff regarding what the one-on-one interventions should consist of.</p>	W 289		

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W 289	<p>Continued From page 12</p> <p>The facility failed to ensure systematic approaches for Individual #3's one-on-one staffing and elopements were incorporated into his behavior management plan.</p> <p>2. Individual #4's 5/10/16 IPP documented she was a 57 year old female whose diagnoses included mild intellectual disability, impulse control disorder, bipolar disorder, and history of schizophrenia, borderline personality disorder, and traumatic brain injury.</p> <p>Individual #4's Behavioral Assessment, conducted between 4/6/16 and 5/9/16 as part of re-assessing her behaviors, documented that she sometimes displayed SIB. The assessment documented one aspect of the SIB was Individual #4 picking at her skin and creating sores on her body (namely on her shins and belly). The assessment stated that some of the reasons that she may be engaging in SIB could have been due to boredom, irritation with staff members and residents. She did heal slowly and bruised easily, so the picking at and creating sores on her body did pose a danger to herself.</p> <p>When asked during an interview on 9/1/16 at 11:55 a.m., the QIDP stated Individual #4 did pick at her skin, usually when she was alone and staff did not see her do it.</p> <p>The Prevention section of Individual #4's SIB Behavior Management Program, revised 12/17/15, documented that picking at her skin often happened in her room alone when she felt ignored. However, the Staff Response section did not include instructions to staff regarding how to intervene if they found Individual #4 with open</p>	W 289			

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

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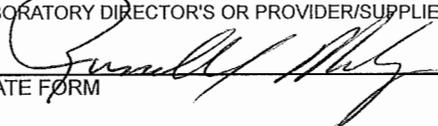
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W 289	<p>Continued From page 13</p> <p>wounds, caused by unwitnessed skin picking.</p> <p>The facility failed to ensure systematic approaches for Individual #4's unwitnessed skin picking were incorporated into her behavior management plan.</p> <p>3. Individual #1's 9/22/15 IPP documented he was a 13 year old male whose diagnoses included mild intellectual disability, attention deficit/hyperactivity disorder, autistic disorder, and unspecified anxiety disorder.</p> <p>Individual #1's 9/28/15 Behavior Management Plan stated SIB was defined as head banging, hitting or slapping himself, biting himself, and throwing himself off of objects to hurt himself.</p> <p>However, the staff responses section of the plan did not include staff interventions when Individual #1 would bite himself.</p> <p>When asked during an interview on 9/6/16 at 8:58 - 9:25 a.m., the Program Director stated the staff intervention for Individual #1 biting himself would be deflection and his behavior plan could be updated to include instructions for biting.</p> <p>The facility failed to ensure comprehensive information was included in Individual #1's behavior management plan.</p>	W 289			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint survey conducted from 8/30/16 - 9/7/16. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Autumn Bernal, BSN, RN	M 000	<p>RECEIVED</p> <p>SEP 30 2016</p> <p>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 W124, W149 and W153.	MM134		MM134 16.03.11200 Refer to W124, W149, and W153
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W237.	MM159		MM159 16.03.11400 Refer to W237
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of	MM162		MM162 16.03.11500 Refer to W289

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Executive Director</i>	(X6) DATE <i>09/16/2016</i>
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Bureau of Facility Standards

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MM162	Continued From page 1 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 W289.	MM162		
MM209	16.03.11705.04 Deodorizers Deodorizers and other products must not be used to cover odors caused by poor housekeeping or unsanitary conditions. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sanitary conditions were maintained in the bedroom of 2 of 6 individuals (Individuals #1 and #3) residing at the facility. This resulted in urine odor and the smell of chemicals permeating from the individuals' shared bedroom. The findings include: 1. During an observation at the facility on 8/30/16 from 3:25 - 4:25 p.m., there was a urine odor permeating from the bedroom shared by Individual #1 and Individual #3. During an observation at the facility on 8/31/16 from 8:25 - 8:55 a.m., there was a chemical odor permeating from the bedroom shared by Individual #1 and Individual #3.	MM209	MM209 16.03.11705.04 The facility had the carpet cleaned recently in an attempt to clean and remove the odor problems in the room shared by Individuals #1 and #3. The facility will have the carpet replaced. Corrective Action Completion Date: November 7, 2016 Person Responsible: Russell C. McCoy, Executive Director	

Bureau of Facility Standards

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MM209	<p>Continued From page 2</p> <p>When asked during an interview on 8/31/16 at 11:27 a.m., the QIDP stated Individual #3 had been urinating and defecating in the shared bedroom. The QIDP also stated the floors had been vacuumed, the carpet spot cleaned, and the carpet was going to be replaced.</p> <p>When asked during an interview on 8/31/16 at 6:45 p.m., Individual #3's guardian stated she had spoken with the facility several times regarding the urine smell in bedroom shared by Individual #1 and Individual #3.</p> <p>When asked during an interview on 9/1/16 from 3:10 - 4:40 p.m., the Program Director stated the facility needed to do something about the urine odor in the bedroom shared by Individual #1 and Individual #3.</p> <p>The facility failed to ensure sanitary conditions were maintained in the bedroom shared by Individual #1 and Individual #3.</p>	MM209		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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September 16, 2016

Russell McCoy, Administrator
Rulon House
415 South Arthur
Pocatello, ID 83204

Provider #13G020

Dear Mr. McCoy:

An unannounced on-site complaint investigation was conducted from August 30, 2016 to September 7, 2016 at Rulon House. The complaint allegation, findings, and conclusions are as follows:

Complaint #ID00007369

Allegation: The facility does not provide sufficient numbers of staff resulting in individuals not receiving appropriate supervision and behavioral intervention.

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

During the entrance conference with the Program Director and the Executive Officer, the Program Director stated there were 2 individuals who required one-on-one staffing. One individual's one-on-one staffing was from 7:00 am. to 5:00 p.m. The other individual's one-on-one staffing was from 7:00 a.m. - 9:00 p.m. The Program Director also stated there should be 4 staff working the day and swing shifts when both individuals, who required one-on-one staffing, were in the facility.

The facility's as worked schedules from 6/1/16 - 8/27/16 were reviewed. The schedules documented the following:

Russell McCoy, Administrator
September 16, 2016
Page 2 of 3

- On 7/7/16 there were 3 staff working the swing shift from 6:00 - 9:00 p.m. During the 3 hour timeframe, there were 6 individuals in the home with 1 individual assigned one-on-one staffing.

- On 7/28/16 there were 2 staff working the swing shift from 7:00 - 8:00 p.m. During the 1 hour timeframe, there were 6 individuals in the home with 1 individual assigned one-on-one staffing.

- On 8/21/16 there were 3 staff working the swing shift from 6:00 - 9:00 p.m. During the 3 hour timeframe, there were 6 individuals in the home with 1 individual assigned one-on-one staffing.

When asked during an interview on 9/1/16, the Program Director stated the facility had made changes to who the home manager was and who managed the staffing schedules due to the timeframes when the facility did not have enough staff coverage. The Program Director stated that she was now managing the staffing schedules. The Program Manager stated the facility's Qualified Intellectual Disabilities Professional was currently the acting home manager until an individual could be found to fill the vacant position. In addition, she stated home managers and staff from other facilities within the company were filling in when needed.

Observations were conducted at the facility on 8/30/16 from 3:25 - 4:25 p.m. and on 8/31/16 from 8:25 - 8:55 a.m., for a cumulative 1 hour and 30 minutes of observation.

During the observations, there was a minimum of 4 staff working the shifts and 2 individuals were noted to be provided with one-on-one staffing.

Nine staff who worked both the day shifts and evening shifts were interviewed. All of the staff stated that when a staff called in and could not work their shift, staff from the previous shift would stay until management had found another staff to work the shift. The staff also stated that when the facility was short staffed, the on call supervisor would be contacted to find staff to help cover the shift. All the staff stated that there had been times when a manager from another facility would fill in or a staff would arrive to cover the shift after the phone calls were made.

One individual was interviewed and stated there were sufficient staff to ensure all individuals had enough help to meet their needs.

Four individuals were selected for in-depth review, including the 2 individuals who required one-on-one staffing.

One individual's Behavior Management Plan stated the he was provided with one-on-one staffing, from 7:00 a.m. - 9:00 p.m., due to attempted elopements and to help support his behavioral needs.

The facility's Significant Event Reports from 5/22/16 to 8/30/16 were reviewed. The reports documented that on 5/22/16 and 8/28/16, the individual had eloped from the facility.

Russell McCoy, Administrator
September 16, 2016
Page 3 of 3

The individual's 2016 behavioral assessment stated he would go into other people's yards looking for items that may be appealing to him. The behavior summary stated that he had a frequent tendency to run away or attempt to elope.

The facility had decided to provide him with one-on-one staffing from 7:00 a.m. - 9:00 p.m.

However, the individual's corresponding 2014 Behavior Management Plan did not include elopement, the definition of elopement, staff interventions related to elopement or what the one-on-one staffing interventions would consist of.

The Program Director was interviewed and stated that when she reviewed the individual's summaries, elopement was not listed in his behavior plan. The Program Director also stated the individual's behavior plan for one-on-one staffing should include instructions to staff regarding what the one-on-one interventions would consist of.

It could not be determined that the facility failed to provide sufficient numbers of staff which resulted in individuals not receiving appropriate supervision and behavioral intervention.

Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated. However, the individuals' behavior plans did not consistently include sufficient instructions to staff regarding how to intervene when individuals engaged in maladaptive behaviors and a deficient practice was identified and cited at W289.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,



NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt