



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](mailto:fsb@dhw.idaho.gov)

October 3, 2016

Steve Young, Administrator  
Yellowstone Group Home #1 Springfield  
560 West Sunnyside  
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #1 Springfield, which was conducted on September 23, 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;

Steve Young, Administrator  
October 3, 2016  
Page 2 of 2

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
6. Include dates when corrective action(s) will be completed. 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 **October 16, 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 October 13, 2016. If a request for informal dispute resolution is received after October 13, 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



10/10/2016

Karen Marshall, MS, RD, LD  
Health Facility Surveyor  
Non-Long Term Care  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009

RECEIVED  
OCT 14 2016  
FACILITY STANDARDS

RE: Springfield, Provider #13G063

Dear Karen Marshall:

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

**W312**

1. Individuals #2 and #3 were seen by the psychiatrist on 10/5/2016. Individual #2 received a medication reduction, whereas, Individual #3, the Dr. decided to wait. The Medication reduction plans have been revised to reflect the change.
2. Aspire Human Services is currently in the process of reviewing all medication reduction plans to ensure that identified criteria for reduction is current and completed.
3. A training is scheduled for the QIDP's at Aspire Human Services to focus on the implementation of individualized medication reduction plans, identified criteria and medication reductions.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review verifies that individualized medication reduction plans are appropriate and criteria is met.
5. Person Responsible: Program Manager, QIDP, & Program Supervisor.
6. Completion Date: 11/30/16

**MM162**

Please see responses under W312.

A handwritten signature in black ink, appearing to read 'Kim Eckstein', with a stylized flourish at the end.

Kim Eckstein  
QIDP

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

PRINTED: 09/30/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/23/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD IDAHO FALLS, ID 83404</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the recertification survey conducted from 9/19/16 - 9/23/16.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Lead Autumn Bernal, BSN, RN</p> <p>Common abbreviations used in this report are:</p> <p>IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional</p>	W 000	<p style="text-align: center;"><b>RECEIVED</b> OCT 14 2016 <i>[Signature]</i> <b>FACILITY STANDARDS</b></p>	
W 312	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</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 behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 1 of 2 individuals (Individual #3) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without a plan that accurately identified how the drugs may change in relation to progress or</p>	W 312		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <b>QIDP</b>	(X6) DATE <b>10/10/16</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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W 312	<p>Continued From page 1 regress. The findings include:</p> <p>1. Individual #3's IPP, dated 6/1/16, documented he was a 57 year old male whose diagnoses included profound intellectual disability and Downs syndrome.</p> <p>His record contained a Medication Reduction Plan, dated 9/1/15, which documented the facility would consider decreasing his Prozac (an antidepressant drug) by 20 mg when his depressive symptoms decreased to 25 incidents or less for three consecutive months.</p> <p>Individual #3's QIDP summaries, dated 9/2015 - 8/2016, were reviewed and documented the following specific incidents or symptoms of depression:</p> <ul style="list-style-type: none"> <li>- 9/2015: 12</li> <li>- 10/2015: 2</li> <li>- 11/2015: 2</li> <li>- 12/2015: 13</li> <li>- 1/2016: 2</li> <li>- 2/2016: 4</li> <li>- 3/2016: 50</li> <li>- 4/2016: 30</li> <li>- 5/2016: 20</li> <li>- 6/2016, 7/2016, and 8/2016: 8 during each month.</li> </ul>	W 312		

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W 312	<p>Continued From page 2</p> <p>Individual #3's psychiatric progress notes and physician's telephone orders, dated 9/2/15 - 9/7/16, included the following:</p> <ul style="list-style-type: none"> <li>- On 9/2/15, his Prozac was increased to 40 mg every morning for depression.</li> <li>- On 1/6/16, his Prozac was increased to 60 mg every morning for depression.</li> </ul> <p>Individual #3's Prozac was increased from 40 mg to 60 mg a day instead of being decreased when he met the medication reduction criteria for 3 consecutive months from 9/2015 - 11/2015 and met criteria again from 12/2015 - 2/2016. Further, his Prozac was not considered for reduction when he met the medication reduction criteria for 3 consecutive months from 6/2016 - 8/2016.</p> <p>When asked during an interview on 9/23/16 from 10:45 - 11:30 a.m., the Program Supervisor and the Administrator both stated the criteria for Individual #3's medication reduction needed to be revised so that it would be more clear as to when the medication would be reduced. The Administrator stated the facility would have to review Individual #3's depression medication and determine why it was not considered for reduction when he met the criteria.</p> <p>The facility failed to ensure Individual #3's medication reduction plan contained accurate and comprehensive information related to his use of behavior modifying drugs.</p> <p>Repeat Deficiency.</p>	W 312			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/23/2016</b>
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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiency was cited during the state licensure survey conducted from 9/19/16 - 9/23/16.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Lead Autumn Bernal, BSN, RN</p>	M 000		
MM162	<p>16.03.11500 Client Behavior and Facility Practices</p> <p>The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W312.</p>	MM162		

RECEIVED  
OCT 14 2016 *AM*  
FACILITY STANDARDS

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

*Karen Eckers*

TITLE

*QIDP*

(X6) DATE

*10/10/16*