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

October 6, 2016

Steve Young, Administrator
Yellowstone Group Home #2 Sunnybrook
560 West Sunnyside Lane
Idaho Falls, ID 83402

RE: Yellowstone Group Home #2 Sunnybrook, Provider #13G064

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #2 Sunnybrook, 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;

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 19, 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 October 19, 2016. If a request for informal dispute resolution is received after October 19, 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,

Dennis Kelly RN on behalf of

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

ASPIRE
HUMAN SERVICES, LLC

10/17/2016

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

RECEIVED
OCT 20 2016
FACILITY STANDARDS

RE: Sunnybrook, Provider #13G064

Dear Karen Marshall:

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

W125

1. For Individuals # 2, #3 and #6, consents to lock knives, sharp objects and/or chemicals temporarily, for their safety, have been obtained and filed.
2. Each individual currently residing in the facility has a consent in their file giving approval for the restriction of sharp objects when necessary.
3. A training is scheduled for the QIDP's at Aspire Human Services. One part of the training will focus on the importance of addressing the restrictive procedures during intake and annual IDT's.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review to verify consents are obtained prior to admission for all restrictive practices and the accuracy of records. Any discrepancies will be addressed immediately.
5. Person Responsible: Program Manager & QIDP.
6. Completion Date: 11/30/16

W149

1. Individual #6's behavioral management plan has been revised to address approved restraints.
2. All individual files are being reviewed to verify that all mental health needs are being addressed and comprehensive interventions are implemented to avoid unnecessary restrictive interventions.
3. A training is scheduled for the Sunnybrook's Direct Support Professional staff. The training will focus on the team approach to the implementation of restrictive interventions and the importance of basing decisions on appropriate assessments to meet the mental health needs of each individual. Additionally, this training will review Therapeutic Options techniques as well as the agency's abuse and neglect policies, including clearly defining and identifying abusive and/or neglectful practices, and the reporting and investigation processes.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review to verify

restrictive interventions are based on a team approach according to corresponding assessments to verify the mental health needs of each individual is met.

5. Person Responsible: Program Manager, QIDP & Program Supervisor.
6. Completion Date: 11/30/16

W214

1. The Sunnybrook IDT is currently in the process of revising Individual #6's assessments to include comprehensive information.
2. All individual charts are currently being reviewed to assure that assessments contain comprehensive information regarding the function of maladaptive behaviors.
3. A training has been scheduled with the QIDP's with Aspire Human Services. The training will focus on the expectation that there is comprehensive information in regards to the function of maladaptive behavior present in the behavior assessments.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. One part of the review verifies that comprehensive information in regards to the function of maladaptive behavior is in the individual assessments.
5. Person Responsible: Program Manager, QIDP & Program Supervisor.
6. Completion Date: 11/30/16

W285

1. Individual #6's behavioral management plans have been revised to ensure techniques to manage inappropriate behaviors are employed with sufficient safeguards to protect the rights of the individual.
2. All files are being reviewed to verify that appropriate assessments have been obtained, guidelines have been generated and staff in the facility are implementing guidelines as they are written.
3. A training is scheduled for the Aspire Human Services Direct Support Professional staff. One part of the training will focus on assuring that before restrictive interventions are implemented that appropriate assessments are completed, guidelines are created from the assessments based on team input and staff training has occurred. This training will also address how body searches are conducted, and under which specific circumstances for which their use is reserved.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review verifies that each individual has the appropriate assessments in the record before restrictive interventions occur.
5. Person Responsible: Program Manager, QIDP & Program Supervisor.
6. Completion Date: 11/30/16

W295

1. Individual #6's behavioral management plans have been revised to ensure physical restraint is only used as specified in the behavior plan.
2. All files are being reviewed to verify that physical restraints are only used as an integral part of the IPP and have been generated and staff in the facility are implementing guidelines as they are written.
3. A training is scheduled for the Direct Support Professionals who work at Sunnybrook. One part of the training will focus on assuring that before restrictive interventions are implemented that appropriate assessments are completed, guidelines are created from the assessments based on team input, and staff training has occurred.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review verifies that each individual has the appropriate

assessments in the record before restrictive interventions occur in order to protect the individual from unnecessary restraints.

5. Person Responsible: Program Manager, QIDP & Program Supervisor.
6. Completion Date: 11/30/16

W303

1. Individual #6's comprehensive record for physical interventions has been reviewed, revised and currently maintained.
2. All files are being reviewed to verify that physical restraints and comprehensive records are maintained for all individuals to help ensure the IDT, HRC and guardians will be able to make informed decisions and/ or recommendations.
3. A training is scheduled for the Direct Support Professionals who work at the Sunnybrook House, at Aspire Human Services. This training will consist of utilizing the comprehensive records of restraints to ensure that informed decisions and recommendation will occur. This training will include a review of how to properly complete an "ABC report," which must include the start and end times for restraints as well as a thorough description of why and exactly how they were used, and what the intervention result was.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review verifies that each individual has the appropriate assessments in the record before restrictive interventions occur in order to protect the individual from unnecessary restraints.
5. Person Responsible: Program Manager, QIDP & Program Supervisor.
6. Completion Date: 11/30/16

W331

1. Individual #2's Blood Pressure monitoring has been clarified and is being followed per physician's guidelines.
2. All files are being reviewed to verify that physician's recommendations and guidelines are in place.
3. Nursing will contact the group homes at the beginning of each month to verify weights and vitals to record. Nursing also attends behavioral meetings monthly with the house to notify DSP's of any changes or concerns
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review verifies that each individual has the appropriate recommendations, orders and guidelines in order to ensure that each individuals health needs are met..
5. Person Responsible: Program Manager, LPN, RN & Program Supervisor.
6. Completion Date: 11/30/16

MM134

Please see response under W125 and W149

MM159

Please see response under W214

MM162

Please see response under W285, W295 and W303

MM166

Please see response under W331

MM183
The facility has ensured that all trash cans currently have lids and is monitored by completing a cleaning schedule placed in the homes. This will be turned into the Program Supervisors at the end of each month for review and address any issues at that time. Program Supervisors will also monitor when completing visits at the homes throughout the month.

MM206
The facility has ensured that all ovens, water heater/water conditioner closets and under the sinks are clean and is currently monitored by completing a cleaning schedule placed in the homes. This will be turned into the Program Supervisors at the end of each month for review and address any issues at that time. Program Supervisors will also monitor when completing visits at the homes throughout the month.

Lisa Kunz
QIDP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G064		09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #2 SUNNYBROOK	3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 9/19/16 - 9/23/16. 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 BP - Blood Pressure DCS - Direct Care Staff HRC - Human Rights Committee I&A - Incident/Accident Report IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 3 of 4 individuals (Individuals #2, #3, and #6) whose consents were reviewed. This resulted in implementation of blanket restrictions not based on individual need, and without assuring due	W 125	RECEIVED OCT 19 2016 DIV OF LIC & CERT RECEIVED OCT 19 2016 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alda Kuns	QIDP	10/17/16

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 125	Continued From page 1 process protections. The findings include: 1. An environmental observation was conducted at the facility on 9/20/16 from 10:41 - 11:45 a.m. During the observation, knives were observed to be locked in the kitchen. At that time a DCS was interviewed about the locked knives. The DCS stated that when an individual was in behavior, the knives were locked to prevent the individual from gaining access to the knives. Individual #1's record was reviewed and included a consent to lock knives/scissors or chemicals temporarily if someone made a threat to hurt themselves or others. The guardian signed the consent on 5/31/16. However, during review of Individuals #2's, #3's, and #6's records guardian consents and HRC approval to lock knives/scissors or chemicals temporarily if someone made a threat to hurt themselves or others could not be found. When asked during an interview on 9/23/16 from 9:15 - 10:45 a.m., the Program Supervisor stated the facility had garnered consents to temporarily lock the knives/scissor or chemicals when necessary. However, the facility did not provide copies of Individual #2's, #3's, or #6's consents. The facility failed to ensure individuals' rights to free access of knives/scissors or chemicals was based on individual need and only employed with the consent of the guardians and approval of the HRC. 2. Refer to W285 as it relates to the facility's failure to ensure techniques to manage inappropriate behavior were employed with	W 125		

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W 125	Continued From page 2 sufficient safeguards to protect the human rights of each individual.	W 125		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, ABC logs, I&A review, and staff interview, it was determined the facility failed to ensure policies and procedures for the detection and prevention of abuse, neglect and/or mistreatment were sufficiently implemented and monitored. This failure directly impacted 1 of 1 individual (Individual #6) for whom physical restraints were used and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in an individual being subjected to ongoing unauthorized physical restraints. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy, revised 10/12/15, included definitions of abuse, neglect and mistreatment, which included "Unapproved Physical Restraint: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body that he/she cannot remove easily and that restricts freedom of movement or normal access to his/her body." The facility's Behavior Support Method Hierarchy and Definitions policy, revised 10/9/14, documented that approved Therapeutic Options	W 149		

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W 149	Continued From page 3 restraints included the following: - Supportive escort - One person body control - One person arm control - Two person body control - One person two arm control - Secure escort - Bite Release - Hand hold Further, the facility's December 2009 Therapeutic Options Instructor Manual stated Therapeutic Options "does not contain prone restraint techniques. Individual #6's 5/1/16 IPP documented she was a 12 year old female whose diagnoses included mild intellectual disability, post traumatic stress disorder, oppositional defiant disorder, reactive attachment disorder and anxiety disorder. She was admitted to the facility on 3/17/16. Individual #6's 4/23/16 - 9/18/16 I&As and ABC Logs were reviewed. The I&As documented Individual #6 was subjected to multiple unauthorized restraints, as follows: - 5/21/16 at 8:10 p.m., Individual #6 was placed in a full prone restraint when she attacked staff, another full prone restraint when she became aggressive, and another full prone restraint when she became agitated. Staff documented "...after I would say about 5 - 10+ mins [minutes] we let her go..." She later became aggressive and was again placed in a full prone restraint. She was released, became aggressive again and was placed in a full prone restraint a third time.	W 149		

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W 149	Continued From page 4 - 8/27/16 at 3:45 p.m., staff employed the use of a 2 person full prone restraint for "5 - 8 min. [minutes]" when Individual #6 hit, punched, attempted to bite staff, and attempted to climb over the gate of the facility's fence. - 8/29/16 from 8:15 - 8:55 a.m., staff employed the use of full prone restraint for "about 5 min [minutes]" due to Individual #6 being aggressive. Individual #6 was released, became aggressive again and was placed in a full prone restraint. - 9/14/16 at 9:45 a.m., staff employed the use of a full body control when she attempted to bite a staff. Staff employed the use of an arm control when Individual #6 attempted to hit a staff. Individual #6 and the staff fell to the floor. A staff then held onto Individual #6's legs to keep her from kicking staff and another staff placed a hand on Individual #6's forehead to keep her from biting the staff. - 9/14/16 at 12:15 p.m., staff employed the use of a 3 person body control restraint when Individual #6 started hitting, biting, and kicking staff. None of the above listed restraints were included as authorized for use per the facility's Behavior Support Method Hierarchy and Definitions policy. However, the facility's documentation did not identify the unauthorized use as potential abuse, neglect and mistreatment per the facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy. When asked, during an interview on 9/23/16 from 9:15 - 10:45 a.m., the Administrator, stated a full restraint was a prone restraint. The Administrator also stated the staff who completed the I&As	W 149		

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W 149	Continued From page 5 were using terminology from a previous restraint program not the current Therapeutic Options manual. The Administrator stated if Individual #6 was on the floor when the restraints were used, it would be an unauthorized use of the restraint. When asked the QIDP who was present during the interview stated, there was no additional information or investigation related to the staff use of restraints with Individual #6. On 10/3/16 at 9:46 a.m., the facility provided via e-mail copies of Therapeutic Options training for staff on 4/28/16 and 5/17/16. However, the e-mail did not state that staff were trained after the use of the unauthorized restraints. The facility failed to ensure the unauthorized use of restraint was identified and investigated in accordance with the facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy.	W 149		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a behavior assessment contained comprehensive information for 1 of 4 individuals (Individual #6) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:	W 214		

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W 214	Continued From page 6 1. Individual #6's 5/1/16 IPP documented she was a 12 year old female whose diagnoses included mild intellectual disability, post traumatic stress disorder, oppositional defiant disorder and anxiety disorder. She was admitted to the facility on 3/17/16. Individual #6's behavior assessment, revised 5/24/16, documented her maladaptive behaviors included disruptive behaviors, socially inappropriate behaviors, self-injurious behaviors, elopement, suicide ideation, and physical aggression. Individual #6's 4/23/16 - 9/18/16 I&As and ABC Logs were reviewed and documented that she was physically restrained at multiple times during maladaptive behaviors. Examples included, but were not limited to, the following: - 5/21/16 at 8:10 p.m., staff employed the use of a 2 person secure escort when Individual #6 attempted a second time to enter a main thoroughfare. - 8/29/16 from 8:15 - 8:55 a.m., staff employed the use of a support escort and then a secure escort to return Individual #6 to the facility. - 9/14/16 at 9:45 a.m., staff employed the use of a full body control when she attempted to bite a staff. Staff employed the use of an arm control when Individual #6 attempted to hit a staff. However, Individual #6's behavior assessment did not include the use of physical restraints for any of her maladaptive behaviors. When asked, during an interview on 9/23/16 from	W 214		

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W 214	Continued From page 7 9:15 - 10:45 a.m., the QIDP reviewed Individual #6's behavior assessment and stated the assessment had not been updated to include the use of physical restraints. The facility failed to ensure Individual #6's behavior assessment contained comprehensive information.	W 214		
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on review of the facility's behavior support policy, restraint policy, record review and staff interview, it was determined the facility failed to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards to protect the human rights of 1 of 1 individuals (Individuals #6) for whom restraint and body searches were used. This resulted in an individual being subjected to physical restraints and a body search which were not approved for use by the facility. The findings include: 1. Individual #6's 5/1/16 IPP documented she was a 12 year old female whose diagnoses included mild intellectual disability, post traumatic stress disorder, oppositional defiant disorder, reactive attachment disorder and anxiety disorder. She was admitted to the facility on 3/17/16.	W 285		

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YELLOWSTONE GROUP HOME #2 SUNNYBROOK	3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402

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W 285	Continued From page 8 Individual #6's functional behavioral assessment, revised 5/24/16, stated she engaged in maladaptive behaviors which included, interrupting others, talked nonsense, pretended to be asleep, purposely fell over or into objects, was rude to others, yelled or screamed, threatening others, taking others personal possessions, pulled out her hair, left the area when she did not get what she wanted or if she felt that she needed more attention, suicide ideation, hit, bit, kicked and scratched staff when she was angry or upset, and attention seeking or not getting her way. a. The facility's records included an I&A dated 5/21/16 at 8:10 p.m., which documented Individual #6 was engaged in maladaptive behaviors. Attached to the report were staff hand-written statements. The hand-written statement documented Individual #6 was picking at her gums with plastic that "...she was pulling out of her panties..." The statement documented the staff called the QIDP who instructed staff to "...do a full body search..." Staff documented "I told [Individual #6] that she needed to show us by pulling down her pants or we would have to do it for her. She ended up showing us..." The facility's Behavior Support Method Hierarchy and Definitions policy, revised 10/9/14, included the use a "Personal Search" intervention. The policy stated the intervention included "...the physical search for items that are not the individual's own or which may be considered dangerous to the individual as specified by guidelines provided in their behavior support plan. May include a body search (being 'pat down' over the clothing and asked to empty pockets)." The facility failed to ensure interventions to	W 285		

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	13G064		09/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #2 SUNNYBROOK	3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402

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W 285	Continued From page 9 manage Individual #6's maladaptive behaviors were implemented with sufficient safeguards necessary to ensure she was not subjected unauthorized, inappropriate body searches. b. The facility's Behavior Support Method Hierarchy and Definitions policy, revised 10/19/14, documented the facility was using Therapeutic Options restraints. The facility's December 2009 Therapeutic Options Instructor Manual stated Therapeutic Options "does not contain prone restraint techniques." However, Individual #6's 4/23/16 - 9/18/16 I&As and ABC Logs were reviewed. The I&As documented Individual #6 was subjected to multiple unauthorized restraints, as follows: - 5/21/16 at 8:10 p.m., Individual #6 was placed in a full prone restraint when she attacked staff, another full prone restraint when she became aggressive, and another full prone restraint when she became agitated. Staff documented "...after I would say about 5 - 10+ mins [minutes] we let her go..." She later became aggressive and was again placed in a full prone restraint. She was released, became aggressive again and was placed in a full prone restraint a third time. - 8/27/16 at 3:45 p.m., staff employed the use of a 2 person full prone restraint for "5 - 8 min. [minutes]" when Individual #6 hit, punched, attempted to bite staff, and attempted to climb over the gate of the facility's fence. - 8/29/16 from 8:15 - 8:55 a.m., staff employed the use of full prone restraint for "about 5 min [minutes]" due to Individual #6 being aggressive. Individual #6 was released, became aggressive	W 285		

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W 285	Continued From page 10 again and was placed in a full prone restraint. - 9/14/16 at 9:45 a.m., staff employed the use of a full body control when she attempted to bite a staff. Staff employed the use of an arm control when Individual #6 attempted to hit a staff. Individual #6 and the staff fell to the floor. A staff then held onto Individual #6's legs to keep her from kicking staff and another staff placed a hand on Individual #6's forehead to keep her from biting the staff. - 9/14/16 at 12:15 p.m., staff employed the use of a 3 person body control restraint when Individual #6 started hitting, biting, and kicking staff. None of the above listed restraints were included as authorized for use per the facility's Behavior Support Method Hierarchy and Definitions policy. When asked, during an interview on 9/23/16 from 9:15 - 10:45 a.m., the Administrator, stated a full restraint was a prone restraint. The Administrator also stated the staff who completed the I&As were using terminology from a previous restraint program not the current Therapeutic Options manual. The Administrator stated if Individual #6 was on the floor when the restraints were used, it would be an unauthorized use of the restraint. The facility failed to ensure interventions to manage Individual #6's maladaptive behaviors were implemented with sufficient safeguards necessary to ensure she was not subjected to unauthorized restraints.	W 285		
W 295	483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as	W 295		

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W 295	Continued From page 11 an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by: Based on review of the facility's behavior support policy, I&As, record review and staff interview, it was determined the facility failed to ensure physical restraints were only used as an integral part of the IPP for 1 of 1 individual reviewed (Individual #6) for whom restraint was used. This resulted in the potential for an individual to be subjected to physical restraints unnecessarily. The findings include: 1. Individual #6's 5/1/16 IPP documented she was a 12 year old female whose diagnoses included mild intellectual disability, post traumatic stress disorder, oppositional defiant disorder, reactive attachment disorder and anxiety disorder. She was admitted to the facility on 3/17/16. Individual #6's revised 5/24/16 functional behavioral assessment stated she engaged in maladaptive behaviors which included, interrupting others, talked nonsense, pretended to be asleep, purposely fell over or into objects, was rude to others, yelled or screamed, threatening others, taking others personal possessions, pulled out her hair, left the area when she did not get what she wanted or if she felt that she needed more attention, suicide ideation, hit, bit, kicked and scratched staff when she was angry or upset, and attention seeking or not getting her way. The facility's Behavior Support Method Hierarchy and Definitions policy, revised 10/9/14,	W 295		

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W 295	Continued From page 12 documented that approved Therapeutic Options restraints included the following: - Supportive escort - One person body control - One person arm control - Two person body control - One person two arm control - Secure escort Individual #6's I&As and ABC Logs from 4/23/16 - 9/18/16 were reviewed and documented repeated "emergency" restraint use, as follows: - A supportive escort was used on 8/29/16 from 8:15 - 8:55 a.m. - A 2 person secure escort was used on 5/21/16 at 8:10 p.m. and twice on 8/29/16 from 8:15 - 8:55 a.m. - A body control restraint was used on 8/29/16 from 8:15 - 8:55 p.m., on 9/14/16 at 9:45 a.m., and on 9/14/16 at 10:30 a.m. - An arm control restraint was used on 9/14/16 at 9:45 a.m. Individual #6's 4/22/16 behavior intervention plans included socially inappropriate behavior, suicide ideation, self-injurious behavior, elopement, and disruptive behavior. Individual #6's 5/24/16 behavior intervention plan included physical aggression. None of the plans incorporated the use of physical restraint. When asked, during an interview on 9/23/16 from 9:15 - 10:45 a.m., the QIDP reviewed Individual #6's behavior intervention plans and stated the	W 295		

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W 295	Continued From page 13 plans did not include the use of physical restraints. The facility failed to ensure physical restraint was only used as specified in Individual #6's behavior plans.	W 295		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review, it was determined the facility failed to ensure a record of restraint was maintained for 1 of 1 individuals (Individual #6) for whom restraint was used. Failure to keep a comprehensive record of restraint usage impeded the ability of the IDT, the facility's HRC, and an individual's guardians to make informed decisions and/or recommendations regarding the use of restraints. The findings include: 1. Individual #6's 5/1/16 IPP documented she was a 12 year old female whose diagnoses included mild intellectual disability, post traumatic stress disorder, oppositional defiant disorder, reactive attachment disorder of infancy or early childhood, eating disorder, anxiety disorder. She was admitted to the facility on 3/17/16. Individual #6's 4/23/16 - 9/18/16 I&As and ABC Logs were reviewed and documented that she was physically restrained at multiple times during maladaptive behaviors. However, the records did not consistently include comprehensive information regarding the	W 303		

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W 303	Continued From page 14 restraint use. Examples include, but were not limited to, the following: - 5/21/16: An I&A and attached ABC Log for the incident documented a 2 person secure escort had been used. However, the ABC log did not document the start and end time, whether the secure escort was 1-arm or 2-arm and whether the intervention was effective. The incident also contained a handwritten narrative from a DCS that documented a full prone restraint had been used on Individual #6 and documented the duration of the restraint as "5-10+ mins [minutes]." However, the ABC Log did not document the use of a full prone restraint or the start and end time of the restraint. - 8/27/16: An I&A documented a full prone restraint was used for "5-8 min." However, the attached ABC Log did not document the start and end time for the incident. - 8/29/16: An I&A documented 2 full prone restraints were used. A handwritten narrative from a DCS documented the first restraint was used "until [Individual #6] was calm enough to get up after about 5 minutes..." However, the attached ABC Log did not document the use of the 2 full prone restraints or the start and end times of the restraints. - 9/14/16: An I&A contained a hand written narrative from a DCS which documented an arm control restraint and a body control restraint had been used. The attached ABC Log also documented an arm control restraint and a body control restraint had been used. However, the attached ABC Log did not document the start and	W 303		

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W 303	Continued From page 15 end time of either restraint. The facility failed to ensure a comprehensive record of restraint usage was maintained for Individual #6.	W 303		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided for 1 of 3 individuals (Individual #2) whose medical records were reviewed. This resulted in a lack of nursing follow-up necessary to ensure an individual's health needs were met. The findings include: 1. Individual #2's 9/17/15 IPP documented she was a 28 year old female whose diagnoses included moderate intellectual disability. Individual #2's record included the following: - Her physician ordered clonazepam (an anticonvulsant drug) 15 mg each day on 3/7/14 and clozapine (an antipsychotic drug) 300 mg each day on 3/6/13. Her 8/2016 Medication Record documented she received the medications as ordered. - A 5/18/16 Consultant Pharmacist's Progress Note documented in the drug interaction reminder section that "taking clonazepam and clozapine together increases the risk of orthostatic	W 331		

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W 331	Continued From page 16 hypotension (a form of low blood pressure that happens when standing up from a sitting or lying position), dizziness, lethargy, confusion, etc. Monitor BP regularly..." However, BP monitoring could not be found in her record. When asked during an interview on 9/21/16 at approximately 2:00 p.m., the facility's LPN stated she would obtain clarification about monitoring Individual #2's BP from her physician. When asked during a follow-up interview on 9/23/16 from 9:15 - 10:45 a.m., the facility's LPN stated Individual #2's physician's expectation was that her BP would be monitored on a monthly basis, which had not been done. The facility failed to ensure adequate nursing follow-up occurred to meet Individual #2's health needs.	W 331		

Bureau of Facility Standards

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	13G064		09/23/2016

NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #2 SUNNYBRC

STREET ADDRESS, CITY, STATE, ZIP CODE: 3245 SUNNYBROOK LANE, IDAHO FALLS, ID 83402

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the state licensure survey conducted from 9/19/16 - 9/23/16. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Autumn Bernal, BSN, RN	M 000		
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W125 and W149.	MM134	RECEIVED OCT 19 2016 DIV OF LIC & CERT RECEIVED OCT 19 2016 FACILITY STANDARDS	
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 W214.	MM159		
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of	MM162		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Kunz | TITLE: QIDP | (X6) DATE: 10/17/16

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 W285, W295, and W303.	MM162		
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		
MM183	16.03.11702.05(c) Refuse Storage Containers All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and must not leak. Containers must be provided with tight fitting lids unless stored in a vermin-proof room or enclosure; This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all	MM183		

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MM183	Continued From page 2 containers used for storage of garbage were provided with tight-fitting lids for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to be exposed to contaminated items. The findings include: 1. An environmental observation was conducted at the facility on 9/20/16 from 10:41 - 11:45 a.m. During the observation, the garbage can in the kitchen did not have a lid. When asked a DCS, who accompanied the surveyor during the environmental review, stated that the kitchen garbage can had never had a lid. The facility failed to ensure all garbage containers had tight fitting lids.	MM183		
MM206	16.03.11705.01 Facility Interior Floors, walls, ceilings, and other interior surfaces, equipment, and furnishings must be maintained in a clean and sanitary manner. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility's interior was maintained in a clean manner for 6 of 6 individuals (#1 - #6) residing at the facility. This resulted in the accumulation of trash and debris, and surfaces that were not clean. The findings include: 1. An environmental observation was conducted at the facility on 9/20/16 from 10:41 - 11:45 a.m. During the observation, the following was noted:	MM206		

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MM206	Continued From page 3 - The bottom inside and the door of the kitchen stove both had an accumulation of black and brown debris. The DCS who accompanied the surveyor during the observation stated, the graveyard staff should have cleaned the stove. - There was an accumulation of sheetrock and insulation debris in the furnace/air conditioner/water heater/water conditioner closet and a cardboard box had been placed on top of the water conditioner unit. - The shelf under the kitchen sink was discolored, brown/black and white in appearance. When asked during an interview on 9/20/16 at 12:05 p.m., the maintenance man stated there should not be anything located on or near the furnace or hot water heater in the furnace closet. He stated the water conditioner unit should not have a cardboard box placed on top of it. He also stated there may have been water damage under the kitchen sink. The facility failed to ensure the interior was maintained in a clean and sanitary manner.	MM206		