



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 17, 2016

Valentina Reudter, Administrator
Belmont Care Center 5th Street
444 Hospital Way Suite 701
Pocatello, ID 83201-2744

RE: Belmont Care Center 5th Street, Provider #13G079

Dear Ms. Reudter:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center 5th Street, which was conducted on October 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

Valentina Reudter, Administrator
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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 **October 31, 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 31, 2016. If a request for informal dispute resolution is received after October 31, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

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

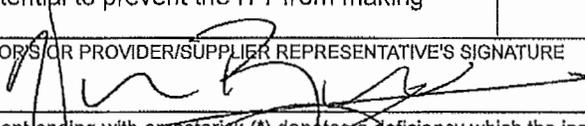
PRINTED: 10/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2016
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NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER 5TH STREET	STREET ADDRESS, CITY, STATE, ZIP CODE 6150 SOUTH 5TH STREET POCATELLO, ID 83204
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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	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 10/4/16 - 10/7/16. The surveyors conducting your survey were: Trish O'Hara, RN, Team Lead Autumn Bernal, RN Common abbreviations used in this report are: AED - Anti-epileptic Drugs IPP - Individualized Program Plan ITT - Interdisciplinary Treatment Team MAR - Medication Administration Record PRN - as needed PTSD - Post Traumatic Stress Disorder RN - Registered Nurse QIDP - Qualified Intellectual Disabilities Professional	W 000	<p>Please see attached Plan of Correction</p>  <p>RECEIVED OCT 31 2016 FACILITY STANDARDS</p>	
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 record review and staff interview, it was determined the facility failed to ensure training programs specified the type of data necessary to assess progress toward objectives for 2 of 4 individuals (Individuals #1 and #4) whose records were reviewed. That failure had the potential to prevent the ITT from making	W 237		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Director	(X6) DATE 10/31/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 237	<p>Continued From page 1</p> <p>objective decisions regarding individuals' success or lack of success. The findings include:</p> <p>1. Individuals #1 and #4's training programs and data collection summaries were reviewed and did not have adequate data collection to assess progress towards goals as follows:</p> <p>a. Individual #1's 3/16/16 IPP stated he was a 28 year old male whose diagnoses included mild intellectual disability, bipolar disorder and depression.</p> <p>Individual #1's IPP included a formal training program, titled Coping Skills, which stated, "[Individual #1] has limited coping skills when he experiences anger, insomnia, depressive type symptoms, alcohol cravings, and/or suicidal ideations. Learning ways to better cope when experiencing any of these would benefit [Individual #1]."</p> <p>The plan included instructions to follow accompanying handouts. These handouts included instructions for coping skills for various objectives including, depression, anger, insomnia, sobriety, and suicidal ideations. Each objective listed different skills for that particular situation. Examples, included, but were not limited to:</p> <p>- For anger, coping skills were listed as: exercise, talk to someone you're not angry with, distract yourself, count 10 breaths, write about it, and deal with it when you feel calm.</p> <p>- For insomnia, coping skills were listed as: exercise and stay active, avoid or limit naps, stick to a sleep schedule, avoid large meals and beverages before bed, use your bed and</p>	W 237			

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W 237	<p>Continued From page 2 bedroom only for sleeping, make your bedroom comfortable for sleep, etc.</p> <p>The plan stated staff were to record the prompt level necessary for Individual #1 to be successful in completing a coping skill 12 times per month.</p> <p>Individual #1's September 2016 raw data was reviewed. The data collection sheet documented 9 probes, including 7 self-initiations, one gestural prompt and one refusal. No other information was included indicating which objective coping skills were being practiced (e.g. for depression, anger, insomnia, etc.) or which skill was being completed (e.g. distraction, counting 10 breaths, writing, etc.). Without such information, it would not be possible for the ITT to determine which of the targeted objectives Individual #1 was able to use coping skills for or which coping skills were effective. Further, the ITT would not be able to determine if Individual #1 was demonstrating progress or regression for each specific skill.</p> <p>b. Individual #4's 5/16/16 IPP stated he was a 30 year old male whose diagnoses included mild intellectual disability, schizoaffective disorder, borderline personality disorder, PTSD and depression.</p> <p>Individual #4's IPP included a formal training program, titled Coping Skills, which stated, "[Individual #4] has limited coping skills when he experiences anger, insomnia, depressive type symptoms, psychosis type symptoms, difficulty communicating emotions and/or suicidal ideations. Learning ways to better cope when experiencing any of these would benefit [Individual #4]."</p>	W 237		

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W 237	<p>Continued From page 3</p> <p>The plan included instructions to follow accompanying handouts. These handouts included instructions for coping skills for various objectives including, depression, anger, insomnia, reorientation to reality, communication skills and suicidal ideations. Each scenario listed different skills for that particular objective. Examples, included, but were not limited to:</p> <ul style="list-style-type: none"> - For anger, coping skills were listed as: exercise, talk to someone you're not angry with, distract yourself, count 10 breaths, write about it, and deal with it when you feel calm. - For insomnia, coping skills were listed as: exercise and stay active, avoid or limit naps, stick to a sleep schedule, avoid large meals and beverages before bed, use your bed and bedroom only for sleeping, make your bedroom comfortable for sleep, etc. <p>The plan stated staff were to record the prompt level necessary for Individual #4 to be successful in completing the coping skill 12 times per month.</p> <p>Individual #4's May 2016 raw data was reviewed. The data collection sheet documented 12 probes, including 6 self-initiations, 4 specific-verbal prompts and 2 refusals. No other information was included indicating which objective coping skills were being practiced (e.g. for depression, anger, insomnia, etc.) or which skill was being completed (e.g. distraction, counting 10 breaths, writing, etc.). Without such information, it would not be possible for the ITT to determine which of the targeted objectives Individual #4 was able to use coping skills for or which coping skills were effective. Further, the ITT would not be able to determine if Individual #4 was demonstrating</p>	W 237			

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W 237	Continued From page 4 progress or regression for each specific skill. During an interview on 10/6/16 starting at 4:30 p.m., the QIDP and Senior Clinician stated there was no way to distinguish which objective or coping skill was being successfully practiced according to the data collection on Individual #1 and #4's training programs. Therefore they could not accurately identify which coping skill was effective or ineffective. The facility failed to ensure the type of data collected for Individual #1 and #4's coping skills training program provided sufficient information to adequately assess the efficacy of the intervention strategies.	W 237			
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in individuals not receiving bone density studies, as recommended in accordance with their medication use. The findings include: 1. Individual #1's 3/16/16 IPP stated he was a 28 year old male whose diagnoses included mild intellectual disability, bipolar disorder and depression. His 9/2016 physician orders	W 326			

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W 326	Continued From page 5 documented he received Depakote (an anticonvulsant drug) 500 mg once daily for mood stabilization. An article, published by the American Epilepsy Society in March 2009, stated AED therapy was associated with metabolic bone disease and a high risk for fractures, with a reduction in bone mineral density reported in 20% - 75% of individuals taking AEDs. The article further recommended assessment of bone mineral density 3-5 years after initiation of AED therapy. The facility's Policy for Bone Density Testing on Patients, revised 4/17/2015, stated, a radius bone scan (a test to measure bone mineral density) should be done for individuals under 50 years old who have risk factors, but don't meet criteria for a DEXA scan (a test to measure bone mineral density). Risk factors included taking the medication valproic acid (the generic name for Depakote). However, documentation of any bone mineral density assessment was not present in Individual #1's records. During an interview on 10/6/16 beginning at 4:30 p.m., the RN and Nurse's Aide confirmed Individual #1 had not received a baseline bone density study. The RN further stated she had not discussed the possibility of Individual #1 receiving a bone density study with his physician. The facility failed to ensure Individual #1 received a bone density study as recommended.	W 326			
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368			

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W 368	<p>Continued From page 6</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to administer drugs as ordered by the physician for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in an individual not receiving medications in a manner consistent with physician orders. The findings include:</p> <p>1. Individual #2's 4/27/16 IPP documented a 20 year old male whose diagnoses included mild intellectual disability, autism and anxiety disorder. Individual #2's MARs reflected that his medications and topical prescriptions were not administered as ordered by his physician on several occasions. Examples included, but were not limited to, the following:</p> <p>a. Individual #2's 7/25/2016 physician's recap orders documented he was to receive QVAR (a corticosteroid inhaler) 80 mcg twice daily.</p> <p>Individual #2's September 2016 MAR documented he had received QVAR on 9/7/16 at 6:37 p.m. as a PRN dose for a "problem breathing" and again at his regularly scheduled time at 8:00 p.m.</p> <p>However, no additional physician's orders for receiving an additional PRN administration of QVAR could be found.</p> <p>When asked during an interview on 10/6/16, beginning at 4:30 p.m., the RN stated Individual</p>	W 368			

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W 368	<p>Continued From page 7</p> <p>#2's QVAR inhaler should not have been administered as a PRN medication.</p> <p>b. Individual #2's MAR documented that some topical prescriptions were not administered as ordered due to a lack of availability as follows:</p> <p>i. Individual #2's 8/24/16 physician's order prescribed foot soaks for his right foot twice daily, following a podiatry appointment for a toenail removal. On 10/13/16 at 9:10 a.m., the RN stated the physician gave verbal instructions to use Epsom salt for the prescribed foot soaks during the 8/24/16 appointment.</p> <p>However, Individual #2's MAR did not reflect the Epsom salt orders were consistently followed as prescribed. Examples, included, but were not limited to, the following:</p> <p>The MAR for August had no documentation that Epsom salt soaks were administered from 8/25/16 - 8/31/16, for a total of 7 days.</p> <p>Individual #2's MAR for September documented the Epsom salt soaks were not administered on multiple occasions due to being out of supply. Examples included the following dates:</p> <ul style="list-style-type: none"> - 9/6/16 at 8:00 p.m. - 9/7/16 at 8:00 a.m. and 8:00 p.m. - 9/8/16 at 8:00 a.m. - 9/11/16 at 8:00 a.m. - 9/12/16 at 8:00 a.m. - 9/13/16 at 8:00 a.m. <p>ii. Individual #2's physician's recap orders documented Stridex pads (a medicated cleansing product) were to be given twice daily, for acne.</p>	W 368			

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W 368	Continued From page 8 However, Individual #2's MAR for August documented the Stridex pads were not administered on multiple occasions due to being out of supply. Examples included the following dates: - 8/26/16 at 8:50 p.m. - 8/27/16 at 10:15 a.m. and 8:00 p.m. - 8/28/16 at 8:00 a.m. and 8:00 p.m. - 8/29/16 at 8:00 a.m. - 8/30/16 at 8:00 a.m. When asked about the medications, during an interview on 10/6/16 beginning at 4:30 p.m., the RN confirmed the doses were missed and stated she was not aware the facility did not have an adequate supply of the topical prescriptions.	W 368		
W 390	483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all outdated drugs were removed from use for 11 of 11 individuals (Individuals #1 - #11) whose drug supplies were reviewed. This placed individuals residing at the facility at risk of being treated with ineffective medications. The findings include: 1. An environmental review was conducted on 10/5/16 from 11:00 a.m. - 12:30 p.m. The review	W 390		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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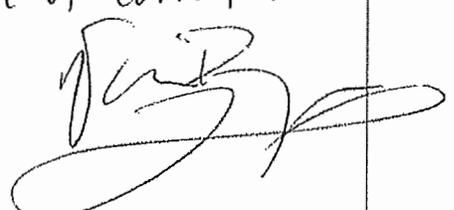
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W 390	<p>Continued From page 9</p> <p>included a medication cabinet inspection where the following expired drugs were found:</p> <ul style="list-style-type: none"> - 2 bottles of Mucus Relief Guaifenesin 400 mg tablets, expired on 11/15 and 2/16. - 1 bottle of Diphenhydramine HCL 25 mg tablets, expired on 4/16. - 1 bottle of Loperamide Hydrochroid Anti-diarrheal, 2 mg tablets, expired on 6/16. - 1 can of Antifungal Powder Spray Tolnaftate, expired on 9/16. <p>The Home Supervisor, who was present at the time of the medication cabinet review, confirmed the presence of the expired drugs and set them aside to be disposed of.</p> <p>The facility failed to remove expired drugs from use.</p>	W 390			

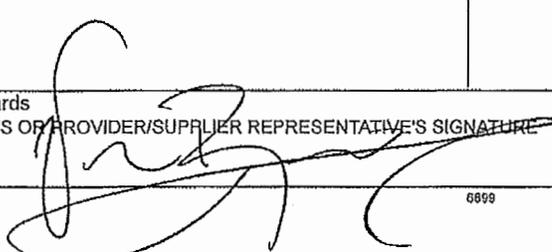
Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the state licensure survey conducted from 10/4/16 - 10/7/16. The surveyors conducting your survey were: Trish O'Hara, RN, Team Lead Autumn Bernal, RN	M 000	<p><i>Please see attached Plan of Correction.</i></p>  <p>RECEIVED OCT 31 2016 FACILITY STANDARDS</p>	
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		
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 W326, W368 and W390.	MM166		

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



TITLE
Program Director (X6) DATE
10/31/16



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

October 31, 2016

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

Dear Ms. Wisenor, Ms. O'Hara and Ms. Bernal

I would like to thank you for your recent visit to 5th Street Care Center (Provider #13G079). Please see the following for a list of corrections for the deficiencies found in our recent survey.

Abbreviations used in this document:

RN – Registered Nurse

QIDP – Qualified Intellectual Disabilities Professional

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

W237

1. Individual #1 and #4's programs were assessed and revised to ensure data was collected for each coping skill and the program is no longer a routine.
2. All individual's programs were assessed and revised as needed to ensure adequate data collection is collected in order to assess progression towards goal.
3. Aspire Human Services has record reviews for all the homes. One part of the record review will be to assess data collection methods and effectiveness.
4. Aspire Human Services will follow a schedule to review all records. After records are reviewed the Clinical Director will coordinate the correction of any identified errors.
5. Person Responsible: Qualified Intellectual Disabilities Professional (QIDP), Clinical Director, Program Director
6. Completion Date: 11/15/2016

W326

1. Individual #1 is scheduled for a radial scan to identify his risk for osteoporosis. Upon results, individual will receive appropriate treatment.
2. All individuals residing at the facility have had their medications reviewed by Facility Nurse. Any individual whose medications put them at risk for developing osteoporosis will receive a radial scan or a DEXA scan depending on dynamic risk factors.
3. Aspire Human Services will complete record reviews for all the individuals in the home. One part of the record reviews will be to review each individual for risk factors that may contribute to developing osteoporosis.
4. Aspire Human Services will follow a schedule to review all records. After records are reviewed the Facility Nurse will coordinate the correction of any identified errors.
5. Person Responsible: Facility Nurse (Registered Nurse (RN) oversight)
6. Completion Date: 12/1/2016

W368

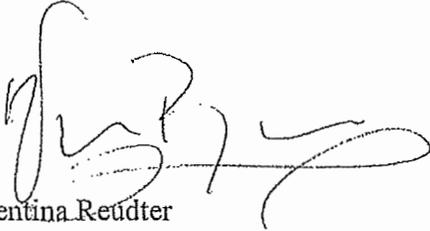
1. Staff member who made a critical error was immediately suspended from passing medications.
2. MARS were reviewed to ensure no other medication errors had occurred and safety was maintained for all individuals in the home.
3. Identified medication errors will be reported to the Facility Nurse. Recommendations for retraining will be given to the Program Supervisor by the Facility Nurse. The Program Supervisor will ensure completion of recommendations.
4. Medication passer delegation will be evaluated annually to ensure medication passing competency. Correction of medication passing deficiencies will be coordinated by the Facility Nurse and Program Supervisor.
5. Person Responsible: Facility Nurse (RN oversight), Program Supervisor, Program Director
6. Completion Date: 11/15/16

W390

1. All expired medications were immediately removed from the facility.
2. Facility medication cart and all individuals' medications were inventoried to ensure all expired medications were removed from the home.
3. Prior to medications being delivered to the facility, facility nurse will highlight the expiration date to assist staff in identifying outdated medications. Staff members will receive additional training on the weekly medication check form which includes a section to check for outdated medication.
4. Medication check forms will be reviewed weekly by the Program Supervisor. The facility nurse will coordinate the correction expired medication identified in the review.
5. Person responsible: Program Supervisor, Facility Nurse (RN oversight)
6. Completion Date: 12/1/2016

Please contact me if you have any further questions regarding this Plan of Correction.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valentina Reudter', with a long horizontal flourish extending to the right.

Valentina Reudter

Program Director | Aspire Human Services

444 Hospital Way Suite 701 Pocatello, Idaho 83201

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10/31/2016

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

MM159

Please see response to W237

MM166

Please see response to W326, W368 and W390

Please contact me if you have any further questions regarding this Plan of Correction.

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