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

March 9, 2017

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 Medicaid/Licensure survey of Rulon House, which was conducted on March 2, 2017.

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 **March 22, 2017,** 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:

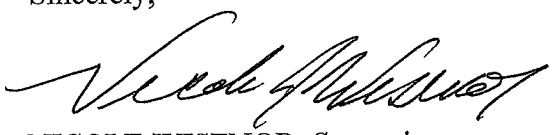
www.icfmr.dhw.idaho.gov

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 March 22, 2017. If a request for informal dispute resolution is received after March 22, 2017, 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

Developmental Options

Promoting Functional Independence Through Person Centered Services

March 16, 2017

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
MAR 20 2017
FACILITY STANDARDS

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the survey completed March 2, 2017. 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. Ed • Executive Director • russellmccoy415@gmail.com
415 So. Arthur Avenue • Pocatello, Idaho 83204-3303 • Phone (208) 233-6833 • Fax (208) 233-6842 • www.developmentaloptions.org

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G020		03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	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 recertification survey conducted from 2/27/17 to 3/2/17. The survey was conducted by: Karen Marshall, MS, RD, LD, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactivity Disorder AED - Anti-Epileptic Drug ATS - Active Treatment Specialist DEXA - Dual-energy X-ray absorptiometry ER - Extended Release HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse PD - Program Director SIB - Self-Injurious Behavior	W 000	RECEIVED MAR 20 2017 FACILITY STANDARDS	
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 a guardian was provided with comprehensive	W 124	**W124 483.420(a)(2)** For the individual found to have been affected by the deficient practice, as well as all other individuals residing in the facility, the Licensed Practical Nurse will review each residents' consents to insure guardians have been provided with adequate information necessary to make an informed decision regarding recommended medical screening and testing. Adequate information will be based on recommendations from the Center for Disease Control and or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 03/16/2017

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	Continued From page 1 information necessary to make informed decisions for 1 of 4 individuals (Individual #3) whose consents were reviewed. This resulted in insufficient information being provided to a guardian on which to base consent decisions. The findings include: 1. An article, published by the American Epilepsy Society in March 2009, stated AED therapy (e.g. Depakote) 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. Individual #3's 7/19/16 IPP documented he was a 47 year old male with diagnoses including moderate intellectual disability and a seizure disorder. His record contained a Physician's Orders, dated 2/13/17, that documented he was receiving Tegretol (an antiepileptic drug) 200 mg three times a day and Depakote ER (an antiepileptic drug) 1000 mg each evening. His record did not contain documentation of a DEXA scan as recommended by the American Epilepsy Society. When asked during an interview on 3/2/17 from 10:00 - 11:47 a.m., the LPN stated Individual #3 had been on antiepileptic drugs for at least 5 years and that the DEXA scan had been discussed with his physician, but it was decided it would not be done due to his age and because he was weight bearing.	W 124	other nationally recognized health organizations. To ensure the deficient practice does not recur, the facility will require the LPN to review this information now and annually to insure that all guardians have received adequate information to make decisions to offer or withhold consent and that this is appropriately documented. Corrective Action Completion Date: May 1, 2017 Person Responsible: Christy Day, Lead LPN	

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W 124	Continued From page 2 However, his record did not contain evidence of his guardian being provided with information related to the risk and benefits of the DEXA scan. When asked during the same interview if informed consent had been provided to the guardian related to the DEXA scan, the LPN stated the guardian had not been provided with the information. The facility failed to ensure Individual #3's guardian had received informed consent related to the risks and benefits of a DEXA scan.	W 124		
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 4 of 4 individuals (Individuals #1 - #4) residing at the facility. This resulted in the implementation of restrictions not based on individual need and without assuring due process protections. The findings include: 1. During an environmental review on 2/28/17 from 11:15 a.m. - 12:15 p.m., an alarm was noted to be on the downstairs exit door. There was also a motion sensor that activated a light by the door and upstairs by the living room. The ATS, who	W 125	**W125 483.420(a)(3)** For the individuals found to have been affected by the deficient practice, as well as all other individuals residing in the facility, the Residential Program Director will audit each Consent to Treat Document to ensure all restrictive elements are accounted for including the use of alarms and locking up knives. To ensure the deficient practice does not recur, the facility will require the assigned QIDP to obtain written consent from each individual's guardian prior to implementation of any restrictive procedure/intervention in the home. Once the Residential Program Director has received written consent, then authorization for implementation will be provided	

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W 125	Continued From page 3 was present, stated it was used to alert staff if Individual #7 tried to elope. The records of Individuals #1 - #4 were reviewed. However, none of the records contained evidence of the individuals' guardians being provided with information related to the use of door alarms being used on the downstairs exit door. Additionally, knives were noted to be locked in boxes located on the kitchen counter. Individuals #1, #3 and #4's records did not contain documentation of the individuals' guardians being provided with information related to locking the facility's knives. When asked during an interview on 3/2/17 from 10:00 - 11:47 a.m., the PD stated there should have been consent given for locking the knives and the use of the alarm. The facility failed to ensure guardians for Individuals #1 - #4 were provided with information related to the use of a door alarm and locking knives prior to implementation.	W 125	through the interdisciplinary treatment team. A tracking form will be created to monitor successful implementation of this practice. Corrective Action Completion Date: May 1, 2017 Person Responsible: Nik Maier, QIDP and Jamie L. Anthony, Residential Program Director	
W 129	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure personal privacy was provided for 1 of 7	W 129	**W129 483.420(a)(7)** For individual #4, the Active Treatment Specialist will purchase and install proper window coverings for his windows. To ensure the deficient does not recur, the facility will do revise the Monthly Home Inspection to include assessing the window coverings for each bedroom ensuring proper privacy. The Active Treatment Specialist will complete the inspection	

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W 129	Continued From page 4 individuals (Individual #4) residing at the facility. This resulted in the potential for an individual's right to privacy being violated. The findings include: Individual #4's IPP, dated 8/30/16, documented a 26 year old male whose diagnoses included moderate intellectual disability and autism. During an environmental review on 2/28/17 from 11:15 a.m. - 12:15 p.m., Individual #4's bedroom window was noted to have one-half of the window drape missing. His bedroom window was also noted to be facing the street, allowing anyone passing by to see in the uncovered side of the window. The ATS, who was present during the environmental review, stated she would replace the missing drape. The facility failed to ensure Individual #4's bedroom window had sufficient coverings to provide privacy.	W 129	and submit it to the Residential Program Director for review. Corrective Action Completion Date: May 1, 2017 Person Responsible: Heather Facer-Nichols, Active Treatment Specialist and Jamie L. Anthony, Residential Program Director	
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed. This failure resulted in a lack of sufficient QIDP coordination, monitoring and oversight necessary to ensure individuals' rights	W 159	**W159 483.430(a)** In regards to the data collection, the QIDP and Active Treatment Specialist will review the group books on a weekly basis to ensure adequate and correct data collection. The Residential Program Director will review the q-sums each month assessing for any shortcomings on the data collection. Should problems with data collection continue, the Residential Program Director will work	

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W 159	Continued From page 5 were upheld and their needs were met. The findings include: 1. Individual #2's IPP, dated 5/10/16, documented a 58 year old female whose diagnoses included mild intellectual disability and bipolar disorder. Individual #2's 2016 data for her sleep hygiene program was reviewed. The data sheet required at least 20 trials per month. Her data was reviewed with the following concerns: - February: "[Individual #2] had only 1 trial..." - March: "[Individual #2] had only 9 trials this months, missing 11 trials...Will continue to monitor." - April: "[Individual #2] had barely one 1 trial this month..." - May: "[Individual #2] had 6 trials this month." - June: "[Individual #2] had 9 trials this month. Will continue to monitor." - July: "[Individual #2] had 4 trails [sic] this month. Will continue to monitor." - August: "[Individual #2] had 3 trials this month. Will continue to monitor." - September: "Staff training was done mid-month, should see improvement for October data." September's data was 6 trials. - October: There were improvements in this months documentation..." October's data was 6 trials.	W 159	hand-in-hand with the home managers to remedy the problem with the staff members ensuring a speedy correction. The assigned QIDP for Rulon House will receive addition training in regards to QIDP responsibilities, oversights and regulatory guidelines. The QIDP will meet with the RPD on a bi-monthly basis to complete trainings and review progress on implementation of trainings provided. Refer to W124 Refer to W125 Refer to W129 Refer to W262 Refer to W312 Corrective Action Completion Date: May 1, 2017 Person Responsible: Nik Maier, QIDP and Jamie L. Anthony, Residential Program Director	

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W 159	Continued From page 6 - November: Individual #2 had 21 trials. - December: "[Individual #2] was very close to meeting this objective." December's data was 16 trial. When asked during an interview on 3/2/17 from 10:00 - 11:47 a.m., the PD stated the data was insufficient for program decisions. The QIDP failed to ensure timely action was taken necessary to ensure Individual #2's sleep hygiene data was taken as specified in his plan. 2. Refer to W124 as it relates to the facility's failure to ensure the QIDP ensured comprehensive information, necessary to make informed decisions, was provided to each individual's guardian. 3. Refer to W125 as it relates to the facility's failure to ensure the QIDP ensured individuals' rights were not restricted without assuring due process protections. 4. Refer to W129 as it relates to the facility's failure to ensure the QIDP ensured each individual's right to privacy was upheld. 5. Refer to W262 as it relates to the facility's failure to ensure the QIDP ensured HRC approval was obtained prior to implementation of restrictive programming. 6. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured behavior modifying drugs were used only as a comprehensive part of each individual's IPP that	W 159		

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W 159	Continued From page 7 was directed specifically towards the reduction and eventual elimination of the behaviors for which the drug was employed.	W 159		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of restrictive interventions. The findings include: 1. Individual #1's 1/12/17 IPP documented a 14 year old male whose diagnoses included mild intellectual disability, autism and ADHD. Individual #1's record was reviewed. A Consent for Treatment form, with a 12/15/16 date of request and a 12/15/17 expiration date, documented he received Trazadone (an antidepressant drug), Methylphenidate (a central nervous system stimulant), Haldol (an antipsychotic drug), Valium (an anxiolytic drug), Saphris (an antipsychotic drug) and Clonidine (an antihypertensive drug).	W 262	**W262 483.440 (f)(3)(i)** For Individual #1, written consent from the Human Rights Committee will be obtained for the use of psychotropic medications. To ensure programs are not implemented prior to approval from the Human Rights Committee, verbal consent will be obtained prior to implementation with written consent obtained within 30 days of implementation. To ensure the deficient practice does not recur, the Residential Program Director will complete an audit of resident charts reviewing the Human Rights Committee documents for approvals of all restrictive elements in the individual's plan. Corrective Action Completion Date: May 1, 2017 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 262	Continued From page 8 The Consent for Treatment form was signed by Individual #1's guardian on 12/15/16. However, the form did not include HRC consent for the use of the medications. The HRC consent section of the form was blank. During an interview on 3/2/17 from 10:00 - 11:47 a.m., the facility's LPN stated she obtained verbal consent from the HRC but did not document on the Consent for Treatment form when she obtained the HRC verbal consents. She stated she had not obtained the HRC members' written consents for Individual #1's Consent for Treatment. The facility failed to ensure programs were not implemented prior to approval from the HRC.	W 262		
W 312	483.450(e)(2) DRUG USAGE 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. 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 individuals' IPPs for 2 of 4 individuals (Individuals #1 and #2) whose psychotropic medications were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that accurately identified how the drugs may change in relation to progress or regress. The findings include:	W 312	**W312 483.450(e)(2)** For all individuals residing in the facility, the Residential Program Director will provide further training to the QIDP on how to properly research and obtain information regarding the use of psychotropic medications for each individual. The training will also include accurately reviewing notes from physicians, properly writing medication reduction plans and review of medication reduction plans. The revised medication reduction plans will be presented to the interdisciplinary team for review. Corrective Action Completion Date: May 1, 2017	

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NAME OF PROVIDER OR SUPPLIER RULON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201	

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W 312	Continued From page 9 1. Individual #2's IPP, dated 5/10/16, documented a 58 year old female whose diagnoses included mild intellectual disability and bipolar disorder. a. Her record contained documentation from [name of facility providing care], dated 5/16/16, stated that Individual #2 was receiving Seroquel (an antipsychotic drug) 300 mg at bedtime to help with sleep. It further documented the bedtime dose of Seroquel was to be discontinued because it was not effective. However, her Medication Reduction Plan, dated 10/10/16, documented there would be a recommendation made to the physician to reduce the Seroquel if Individual #2 had 8 consecutive hours of sleep for 16% or more nights (4.8 nights) in one month for 11 of 12 consecutive months. The criteria to reduce section documented a reduction criteria for the reduction of Seroquel given for assaults, tantrum, suicide threats/attempts and refusing medication and not sleeping. It was not clear why a medication being used for sleep was tied into the reduction plan related to assaults, tantrums, suicide threats/attempts and refusing medication. Her Medication Reduction Plan also had the same reduction criteria for the reduction of Thorazine (an antipsychotic drug) given for assaults, tantrums, suicide threats/attempts and refusing medication. During an interview on 3/2/17 from 10:00 - 11:47 a.m., the PD stated Individual #2's Medication	W 312	Person Responsible: Nik Maier, QIDP and Jamie L. Anthony, Residential Program Director	

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 03/02/2017
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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
W 312	Continued From page 10 Reduction Plan should be revised. b. Individual #2's Medication Reduction Plan documented the use of Effexor (a drug for treating depression) would be decreased if she met criteria for a reduction in suicide attempts, suicide threats or tantrums. However, there was no documentation she was receiving Effexor. During an interview on 3/2/17 from 10:00 - 11:47 a.m., the LPN stated Individual #2's Effexor had been discontinued in August 2016. The facility failed to ensure Individual #2's Medication Reduction Plan contained comprehensive information. 2. Individual #1's 1/12/17 IPP documented a 14 year old male whose diagnoses included mild intellectual disability, autism and ADHD. Individual #1's 1/15/17 Medication Reduction Plan documented the use of Clonidine (an antihypertensive drug), Methylphenidate (a central nervous system stimulant), Haldol (an antipsychotic drug) and Saphris (an antipsychotic drug) for assaults and SIB. The "Order of Decrease" documented "1. Saphris" and "2. Haldol." The Order of Decrease in the Medication Reduction Plan did not include Clonidine and Methylphenidate. During an interview on 3/2/17 from 10:00 - 11:47 a.m., both the QIDP and the PD stated Individual #1's Medication Reduction Plan should be	W 312		

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

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	13G020		03/02/2017

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RULON HOUSE	2369 RULON POCATELLO, ID 83201

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W 312	Continued From page 11 updated to include in what order Clonidine and Methylphenidate would be decreased. The facility failed to ensure Individual #1's Medication Reduction Plan contained comprehensive information.	W 312		

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 2/27/17 - 3/2/17. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Jim Troutfetter, QIDP	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 W124, W125 and W129.	MM134	**MM134 16.03.11200** Refer to W124, W125, W129 RECEIVED MAR 20 2017 FACILITY STANDARDS	
MM155	16.03.11300 Facility Staffing The requirements of Sections 300 through 399 of these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Refer to W159.	MM155	**MM155 16.03.11300** Refer to W159	
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of	MM159	**MM159 16.03.11400** Refer to W262	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 03/15/2017

Bureau of Facility Standards

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 03/02/2017

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MM159	Continued From page 1 these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W262.	MM159		
MM162	16.03.11500 Client Behavior and Facility Practices 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. This Rule is not met as evidenced by: Refer to W312.	MM162	**MM162 16.03.11500** W312	
MM239	16.03.11711.10(c) Hot Water The temperature of hot water at plumbing fixtures used by individuals in the facility must be between one hundred (100) degrees and one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for individuals to be scalded. The	MM239	**MM239 16.03.11711** Water temperature logs are completed on a nightly basis by the graveyard staff. From this information the Active Treatment Specialist will review this logs on a weekly basis to ensure the water temperatures are between the required 100 degrees and 120 degrees Fahrenheit. Should the temperatures be outside of the required range, the ATS will report	

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MM239	Continued From page 2 findings include: 1. An environmental review was conducted on 2/28/17 from 11:15 a.m. - 12:15 p.m. During that time, the water temperature at the kitchen sink was noted to be at 124 degrees Fahrenheit. The ATS, who was present, stated she would have the maintenance man adjust the temperature to a lower setting. The temperature of the water at the kitchen sink was rechecked on 3/1/17 at 12:30 p.m. and found to be at 106.5 degrees Fahrenheit. The facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit.	MM239	this to the physical facilities manager for adjustment. Corrective Action Completion Date: May 1, 2017 Person Responsible: Jamie L. Anthony, Residential Program Director	
MM243	16.03.11712.02(a) Shades or Drapes Suitable window shades or drapes must be provided to control lighting in the room. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure suitable window shades or drapes were provided for 1 of 7 individuals (Individual #4) residing at the facility. This resulted in a lack of sufficient window coverings to provide privacy. The findings include: 1. An environmental review was conducted on 2/28/17 from 11:15 a.m. - 12:15 p.m. During that time, the following was noted: Individual #4's bedroom window had one-half of the window drape missing.	MM243	**MM243 16.03.11712.02(a)** For individual #4, the Active Treatment Specialist will purchase and install proper window coverings for his windows. To ensure the deficient does not recur, the facility will do revise the Monthly Home Inspection to include assessing the window coverings for each bedroom ensuring proper privacy. The Active Treatment Specialist will complete the inspection and submit it to the Residential Program Director for review. Corrective Action Completion Date: May 1, 2017 Person Responsible:	

Bureau of Facility Standards

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MM243	Continued From page 3 The ATS, who was present during the environmental review, stated she would replace the missing drape. The facility failed to ensure Individual #4's bedroom window had sufficient coverings to provide privacy.	MM243	Heather Facer-Nichols, Active Treatment Specialist and Jamie L. Anthony, Residential Program Director	