



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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January 23, 2014

Eric Russell, Administrator
Yellowstone Group Home #4 Hollow
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #4 Hollow, Provider #13G066

Dear Mr. Russell:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #4 Hollow, which was conducted on January 13, 2014.

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; and,
5. Include dates when corrective action 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

Eric Russell, Administrator
January 23, 2014
Page 2 of 2

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 **February 4, 2014**, 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 February 4, 2014. If a request for informal dispute resolution is received after February 4, 2014, 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 our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 10/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2014
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 HOLLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID 83402
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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 1/6/14 - 1/13/14.

The survey was conducted by:
Michael Case, LSW, QIDP, Team Leader
Trish O'Hara, RN

Common abbreviations used in this report are:

AQIDP - Assistant Qualified Intellectual Disability Professional
CM - Consecutive Months
DCS - Direct Care Staff
IEP - Individualized Education Program
IPP - Individual Program Plan
OCD - Obsessive Compulsive Disorder
PBSP - Positive Behavior Support Plan
QIDP - Qualified Intellectual Disability Professional
SIB - Self Injurious Behavior
WIC - Written Informed Consent

W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure outside services met the needs for 2 of 2 individuals (Individuals #2 and #3) who attended a public school. This resulted in a lack of coordination of services and communication with the school. The findings include:

W 000

W 120

Please see attached of Plan of correction for all Deficiencies

Juan J. Wicks NHA
City Director

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FEB - 4 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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2/4/14

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.

**Hollow Plan of Correction
Survey January 13, 2014**

*Per phone call 2/6/14 11:00/Am with
Ferrer Weeks: W120 Responsibility for
communication with schools will be placed
with QIDP/Program Supv. Monitoring for
this activity & documentation to be done
by Ferrer Weeks. T.O. Alaska*

W120. QIDP/Program supervisor will observe classroom activities monthly. The Class instructor will be provided with current IPP and PSBP as well as be invited to any meetings and be documented. The facility will work with the Guardian to ensure that the school will release the IPP and other information concerning this individual. Staff will note behavior trends/relevant data in behavior log going back to the school so that it is a two way form of communication. The log will be reviewed monthly by the QIDP/program supervisor. The implementation date will be completed by 3/1/14

W149

Hollow will ensure development and implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of the clients.

Retraining will be completed with all staff regarding the Abuse, Neglect, Mistreatment and Injuries of an Unknown Source. In addition, Training will be completed with all staff regarding the updated behavior logs.

A new data base will be used to track all incidents of Abuse, Neglect, Mistreatment, and Injuries of Unknown Source.

Person Responsible: QIDP/ Program Supervisor, LPN and City Director.

Monitor: Daily incident/accidents/behavior logs will be taken to the main office and given to the LPN. The LPN will enter those incidents into the data tracking system. The Program Supervisor will review them daily. Quarterly the City Director will review the tracking information to ensure Abuse, Neglect, Mistreatment, Injuries of Unknown Source are being appropriately documented and tracked. Will be completed by 3/23/14.

W159

The Hollow home will ensure each client's active treatment program will be integrated, coordinated and monitored by a qualified mental retardation professional.

A QIDP was hired to take over the individual program plans and monitoring. This will help ensure the QIDP oversight of programming by spreading the workload.

Refer to W120

Refer to W214

Refer to W227

Refer to W 237

Refer to W239

Refer to W289

Refer to W249

Refer to W312

Refer to W313

Refer to W480

Refer to W481

Responsible persons: QIDP/program supervisor and City Director
Monitor: Monthly an audit of each individual's documents will be completed by the QIDP. Quarterly a QIDP peer review will be completed to ensure documents are being completed and monitored by a qualified mental retardation professional. Will be completed by 3/23/14.

W214

The Hollow Home will ensure the comprehensive functional assessment identifies the client's specific developmental and behavioral management needs.

The comprehensive functional assessments, to include the PBSP for all individuals will be reviewed and additional information included in the documents. In addition, implementation or updates will be made to the programming based on the comprehensive functional assessment.

The positive behavior support plans are currently being reviewed and new tracking sheets implemented. In addition, staff are being trained on these changes and the implementation of this programming.

Person Responsible: QIDP/program supervisor, Behavior Specialist, and City Director.

Monitor: Quarterly a review of all comprehensive functional assessments will be completed by an in-house peer review. Program objectives will be reviewed to ensure they reflect the individual's current functioning level and need. The corporate QA will ensure that this is being done. Annually the Treatment Team will review the comprehensive functional assessment in their interdisciplinary Team Meeting. Objectives for programming will be determined based on the comprehensive functional assessment. Will be completed by 3/23/14.

W227

The Hollow Home will ensure individual program plans state the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. All individual program plans will be reviewed to ensure the plan includes objective to meet their needs.

Person Responsible: QIDP, Program Supervisor, and City Director

Monitor: Monthly QIDP and Program Supervisor will review all program objectives and individual program plans to ensure the objective necessary to meet their needs are incorporated into the individual's plans. Quarterly a review of the individual's plans will be completed by the facilities in-house QA team. Corporate QA team will audit these reviews to ensure completion and documentation. Annual or as need the Treatment Team will review the individual's plans.

Will be completed by 3/23/14

W237

The Hollow Home will ensure individual program plans state the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.

All individual program plans and PBSPs will be reviewed to ensure the plan includes objectives to meet their needs and are clearly measurable. All staff will be trained on the necessity to accurately measure progress or lack of. Corrections will be made according.

Person Responsible: QIDP/ Program Supervisor, and City Director

Monitor: Monthly QIDP / Program Supervisor will review all program objectives and individual program plans to ensure the objective necessary to meet their needs are incorporated into the individual's plans. Quarterly a review of the individual's plans will be reviewed quarterly by the facilities internal QA. Annual or as needed the Treatment Team will review the individual's plans. The corporate QA will ensure that the internal audits are being completed and program changes are being made.

Will be completed by 3/23/14

W239

The Hollow Home will ensure individual program plans state the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. All individual program plans will be reviewed to ensure the plan includes clear objectives to meet their needs. Replacement behaviors will be included in the revisions to provide clear comprehensive instructions to all staff. All staff will be trained on the concept of replacement behaviors.

Person Responsible: QIDP/ Program Supervisor, and City Director

Monitor: Monthly QIDP / Program Supervisor will review all program objectives and individual program data to ensure the lead necessary revisions to meet their needs are incorporated into the individual's plans. A quarterly in-house QA review of the individual's plans will be completed and documented. These audits will be reviewed by the corporate QA to ensure that this is being followed through with. Annual or as need the Treatment Team will review the individual's plans.

Will be completed by 3/23/14

W249

The Hollow Home will ensure that once the interdisciplinary team has formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified.

Staff will be trained on data collection and the implementation of programming based on the criteria within the program. All materials and the environment needs will be provided and included in monitoring.

Monitor: The program supervisor/QIDP will monitor the implementation of programming monthly. The Program Supervisor/QIDP will complete on-going training with the staff regarding changes in individual's programming strategies, supplies needed and data collection. A quarterly peer review will be completed to ensure ongoing proper

follow through. Corporate QA will review these audits to ensure they are completed and documented. Will be completed by 3/23/14

W289. The Hollow Home will ensure individual program plans and PBSPs state clear as specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.

All individual program plans and PBSPs will be reviewed to provide staff necessary instructions

Person Responsible: QIDP, Program Supervisor, and City Director

Monitor: Monthly QIDP and Program Supervisor will review all program objectives and individual program plans to ensure the objective necessary to meet their needs are incorporated into the individual's plans. Quarterly review of the individual's plans will be completed by the facilities in-house QA. The corporate QA will do audits to ensure the reviews are completed and documented. Annual or as need the Treatment Team will review the individual's plans.

Will be completed by 3/23/14

W312

The Hollow Home will ensure drugs used to control inappropriate behavior will be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of an eventual elimination of the behaviors for which the drugs are employed.

All medication reduction plans will be reviewed or implemented to ensure they accurately reflect and define the criteria for reduction.

Data collection documents will be implemented or reviewed to ensure accurate information based on the individuals plan is being collected.

All individual program plans will be reviewed to ensure objectives related to each diagnosis with a medication to control inappropriate behavior are implemented.

Person Responsible: Program Supervisor/ QIDP, LPN, and City Director

Monitor: Monthly the QIDP will review all individual program plans and documentation related to the number of incidents for medications used to control inappropriate behaviors. These will be cross referenced monthly with the medication reduction plans. Quarterly or as needed a review of medication reduction plans will be reviewed by the LPN.

Will be completed by 3/23/14

W313

The Hollow Home will ensure drugs used for control of inappropriate behavior are gradually withdrawn at least annually in a carefully monitored med reduction program.

This will be conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

staff to write down any food or drink item consumed that was not on the menu. In addition, all staff will be retrained on the importance of following the dietitian's menu, the new form and the facilities expectations.

Person Responsible: Program Supervisor/QIDP Dietician, and City Director.

Monitor: Weekly the Supervisor will review the forms to ensure staff are documenting correctly on the form. Monthly the Dietician will review the documents to ensure 30 days of actual meals served are recorded. The QIDP will file all menus and meals served.

Quarterly the City Director will review the forms and menus. Will be completed by 3/23/14

MM177 – Refer to W 149

MM191 – Refer to W 313

MM197 – Refer to W 289 and W313

MM212 – refer to W 249

MM672 – Refer to W481

MM673 – Refer to W480

MM725 – Refer to W159

MM729 – Refer to W227

MM730 – Refer to W214

MM731 – Refer to W237

MM855 – refer to W239

MM859 – refer to W120

Ferran Weeks
Idaho Falls City Director

2/4/14

A review of all contraindicated medications will be completed. Records will be updated with current information regarding any contraindicated medications.

Person Responsible: Program Supervisor/ QIDP, LPN and City Director.

Monitor: Quarterly or as needed the QIDP and the LPN will review all contraindicated medications. In addition, a quarterly QIDP peer review will be completed to ensure follow through. Will be completed by 3/23/14.

W334

The Part time LPN assigned to do the quarterly assessments will divide the number of residents into 4 week periods of time and nursing assessments will be done on a weekly basis within quarterly month. Example: 40 residents = 10 assessments done per week this will make the work load more feasible and trackable. The full time nurse will review and complete a portion of the monthly narrative nursing notes based on assessment info. This would be a double check. All assessments will be given to the full time LPN Barb when completed. Will be completed by 3/23/14.

W440

The missing fire drill is contributed to a lack of follow through by the program supervisor/AQIDP who recently quit. The new program supervisor/QIDP and the shift supervisors will be inserviced on this process and the schedule laid out to follow and ensure the drills are completed for each shift each quarter. This will be completed by 3/1/14. The City Director will be responsible for the training and the program supervisor/QIDP will be responsible for reviewing each fire drill monthly. The city director will review fire drills quarterly

W480

The Hollow home will ensure that menus for food actually served are kept on file for 30 days and reviewed monthly by the dietitian.

Menus will include portion sizes that will provide instructions to individuals and staff. All staff will be trained on the newly noted portion sizes, the menus, and the facilities expectations.

Person Responsible: Program Supervisor/QIDP, Dietician, and City Director.

Monitor: Weekly the Supervisor will review the staff to ensure portion sizes are being considered and followed. Monthly the Dietician will review the documents to ensure 30 days of actual meals served and portion sizes are included. The program supervisor/QIDP will file all menus and meals served. Quarterly the City Director will review the forms and menus. Will be completed by 3/23/14.

W481

Hollow will ensure that menus for food actually served are kept on file for 30 days. The current form for tracking anything outside of the menu will be revised to include additional instructions on what should be tracked on the form. The form will instruct

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FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/13/2014
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 HOLLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE IDAHO FALLS, ID, 83402
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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) COMPLETE DATE
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 1/6/14 - 1/13/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN	M 000		
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MM177	16.03.11 075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177		
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MM191	16.02.11 075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W313.	MM191		
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Please see attached of Plan of correction for all Deficiencies

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James J. Weeks NHA
City Director

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	DATE
		2/13/14