



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 22, 2014

Nick Schmidt, Administrator
Yellowstone Group Home #5 Burke
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #5 Burke, Provider #13G067

Dear Mr. Schmidt:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #5 Burke, 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

Nick Schmidt, Administrator
January 22, 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 **January 30, 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 January 30, 2014. If a request for informal dispute resolution is received after January 30, 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,



MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/pmt
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G067	(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 #5 BURKE	STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83406
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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 annual recertification survey conducted from 1/6/14 - 1/13/14. The survey was conducted by: Monica Nielsen, QIDP, Team Leader Jim Troutfetter, QIDP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactivity Disorder CD - Compact Disc CFA - Comprehensive Functional Assessment HRC - Human Rights Committee IEP - Individual Education Program IPP - Individual Program Plan LPN - Licensed Practical Nurse PBSP - Positive Behavior Support Plan QIDP - Qualified Intellectual Disability Professional	W 000		
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 interviews it was determined the facility failed to ensure outside services met the needs for 1 of 1 individual (Individual #1) who attended a local high school. This resulted in a lack of communication and information being shared between the school and the facility. The findings include: 1. Individual #1's IPP, dated 11/15/13,	W 120	Please see attached of Plan of correction for all Deficiencies	

RECEIVED
FEB 04 2014
FACILITY STANDARDS

Jessica J. White NHA
City Director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	City Director	1/30/14

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.

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W 120	<p>Continued From page 1</p> <p>documented a 15 year old male diagnosed with mild mental retardation and autism. He was admitted to the facility on 10/18/13.</p> <p>An observation was conducted at Individual #1's school on 1/7/14 from 9:10 - 9:47 a.m. During that time, Individual #1 had a one-to-one aid and was using a picture schedule. Individual #1's teacher was present during the observation and was interviewed with the following results:</p> <p>a. Individual #1 had been in his current classroom since 9/2013. The teacher reported no one from the facility had been to the school to meet with the teacher or to observe Individual #1 since he was admitted to the facility in October 2013. The teacher reported if Individual #1 was late to school, he (the teacher) called the facility. The teacher reported there had not been any other communication from the facility until 1/6/14 when the QIDP called the teacher to inquire about scratches and bruises on Individual #1 that were reported to the facility on 12/18/13.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he had not been to the school and had not met with Individual #1's teacher.</p> <p>b. The teacher reported he had not been invited to Individual #1's 11/15/13 IPP and he had not received a copy of the IPP or Individual #1's 10/17/13 PBSP. The teacher reported Individual #1 had a Behavior Intervention Plan at school that incorporated Mandt (a physical restraint system) for physical aggression.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., the school had</p>	W 120		
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W 120	Continued From page 2 not requested the IPP or PBSP and he was not sure if Individual #1 had a behavior plan at school. c. The teacher reported a communication log was completed by school personnel on a daily basis and sent home with Individual #1 each day. The teacher reported no information had been entered in the log from the facility. When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he did not know the facility was supposed to use the communication log. d. Individual #1's IEP, dated 9/20/13, was reviewed and included objectives for adding money with a calculator, telling time, using a daily picture schedule, and requesting a break. However, similar objectives in his IPP could not be found. When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., Individual #1 did not have similar objectives in his IPP because he (the QIDP) did not want to duplicate training programs. The facility failed to ensure Individual #1's educational services were coordinated and monitored.	W 120			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		3/23/14	

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W 159	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 3 of 3 individuals (Individuals #1 - #3), and had the potential to impact all individuals residing at the facility (Individuals #1 - #6). This failure resulted in a lack of sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of outside services, assessments, programing, and dietary services. The findings include:</p> <p>1. Individual #1's IPP, dated 11/15/13, documented a 15 year old male diagnosed with mild mental retardation and autism.</p> <p>Individual #1's Occupational Therapy Evaluation, dated 11/16/13, recommended he be provided deep pressure and resistive items due to his "significant sensory issues."</p> <p>However, resistive items were not observed during observations conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. Additionally, Individual #1's 11/15/13 IPP and active treatment schedule, undated, did not include information related to deep pressure.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., the recommendations had not been implemented.</p> <p>2. Individual #2's IPP, dated 4/18/13, documented a 23 year old male diagnosed with moderate</p>	W 159			

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W 159	<p>Continued From page 4</p> <p>mental retardation and diabetes mellitus Type II. He was admitted to the facility on 3/25/13.</p> <p>Individual #2's Occupational Therapy Evaluation, dated 4/2013, recommended he be provided with a wedge when eating and a slanted work surface at his day program due to postural concerns.</p> <p>However, Individual #2 was not observed using a wedge during meal observations conducted in the facility on 1/6/14 from 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m. Additionally, Individual #2 was not observed using a slanted work surface during an observation at the day program on 1/7/14 from 10:17 - 11:04 a.m.</p> <p>When asked about the wedge, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., Individual #2 did not have a wedge when eating. When asked about the slanted surface, the day program supervisor stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., Individual #2 did not have a slanted work surface at the day program.</p> <p>The facility failed to ensure the QIDP ensured individuals had supplies to meet their needs in each environment.</p> <p>3. Refer to W120 as it relates to the facility's failure to ensure the QIDP ensured an individual's educational services were coordinated and monitored.</p> <p>4. Refer to W186 as it relates to the facility's failure to ensure the QIDP ensured there were sufficient direct care staff to meet individuals' needs.</p>	W 159		

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W 159	<p>Continued From page 5</p> <p>5. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' developmental and behavior assessments were accurate and included comprehensive information.</p> <p>6. Refer to W230 as it relates to the facility's failure to ensure the QIDP ensured program completion dates were varied based upon an individual's rate of learning.</p> <p>7. Refer to W249 as it relates to the facility's failure to ensure the QIDP ensured individuals' training programs were implemented in accordance with their program plans.</p> <p>8. Refer to W250 as it relates to the facility's failure to ensure the QIDP ensured individuals had an active treatment schedule that outlined the active treatment program staff were to implement.</p> <p>9. Refer to W276 as it relates to the facility's failure to ensure the QIDP ensured all behavioral interventions were included in the facility's behavior policy.</p> <p>10. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured techniques used to manage inappropriate behavior were sufficiently incorporated into an individual's behavior program.</p> <p>11. Refer to W455 as it relates to the facility's failure to ensure the QIDP ensured infection control procedures were followed to prevent and control infection and/or communicable diseases.</p> <p>12. Refer to W480 as it relates to the facility's</p>	W 159		

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W 159	Continued From page 6 failure to ensure the QIDP ensured menus included average portion sizes.	W 159			
W 186	13. Refer to W481 as it relates to the facility's failure to ensure the QIDP ensured a record of food served was kept for 30 days. 483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to provide sufficient direct care staff to manage and supervise individuals in accordance with their IPPs for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This had the potential to impede staffs' ability to consistently meet individuals' identified active treatment needs. The findings include: 1. During the entrance meeting on 1/6/14 at 1:57 p.m., the QIDP stated 3 direct care staff were required on the morning and evening shifts and 2 direct care staff were required on the graveyard shifts. The facility's as-worked schedules, dated 10/18/13 - 12/31/13, were reviewed and documented shifts were worked with less than the required number of direct care staff when	W 186		3/1/14	

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W 186	Continued From page 7 Individuals #1 - #6 were in the facility, as follows: October 18th - 31st: - A.M. Shift: 2 shifts were worked with 2 staff - P.M. Shift: 7 shifts were worked with 2 staff - Graveyard Shift: 3 shifts were worked with 1 staff November: - A.M. Shift: 8 shifts were worked with 2 staff - P.M. Shift: 14 shifts were worked with 2 staff - Graveyard Shift: 11 shifts were worked with 2 staff December: - A.M. Shift: 5 shifts were worked with 2 staff - P.M. Shift: 8 shifts were worked with 2 staff - Graveyard Shift: 5 shifts were worked with 2 staff Out of 75 A.M. shifts reviewed, 15 shifts were worked with 2 staff. Out of the 75 P.M. shifts reviewed, 29 shifts were worked with 2 staff. Out of the 75 graveyard shifts reviewed, 19 shifts were worked with 2 or less staff. When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he was aware shifts were worked with less than the required number of direct care staff. The facility failed to ensure the individuals' were provided with sufficient direct care staff as required by the facility.	W 186			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and	W 214		3/23/14	

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W 214	<p>Continued From page 8 behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure developmental needs were accurately and comprehensively assessed for 2 of 3 individuals (Individuals #1 and #2) whose CFAs were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #1's IPP, dated 11/15/13, documented a 15 year old male diagnosed with mild mental retardation and autism. He was admitted to the facility on 10/18/13.</p> <p>Individual #1's CFA, dated 10/29/13, was reviewed and was not accurate and did not contain comprehensive information. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's CFA stated he had no facial hair and did not shave. However, his IPP included an objective to shave his face.</p> <p>b. Individual #1's CFA stated he did not rush eating and relaxed and enjoyed the meal. However, his IPP included an objective to take one bite and swallow, take another bite and swallow, set the utensil down, and take a drink while keeping his left hand on the table with a specific verbal cue.</p> <p>c. Individual #1's CFA stated he was independent in identifying all coins and paper money up to \$20.00. However, his IPP included an objective to identify all coins and the \$1.00 bill with a</p>	W 214		
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W 214	<p>Continued From page 9 nonspecific verbal cue.</p> <p>d. Individual #1's CFA stated he exhibited attention seeking behavior and extreme anxiety. However, his IPP did not include objectives related to the maladaptive behaviors.</p> <p>e. Individual #1's CFA stated he independently expressed concern about others and was able to hold a conversation on the phone. However, under the section titled Basic Rights within the CFA, it stated he was non-verbal and was not able to report abuse.</p> <p>f. Sections of Individual #1's CFA were not complete including money management and shopping, identification and naming skills, time management, math and numbers, reading, prevocational skills, home leisure, community leisure, privacy, and treatment and habilitation.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., all sections of the CFA were to be completed. The QIDP stated Individual #1's CFA was not accurate and needed revised.</p> <p>2. Individual #2's IPP, dated 4/18/13, documented a 23 year old male diagnosed with moderate mental retardation and diabetes mellitus Type II. He was admitted to the facility on 3/25/13.</p> <p>Individual #2's CFA, dated 3/26/13, was reviewed and did not contain accurate information. Examples included, but were not limited to, the following:</p> <p>a. Individual #2's CFA stated he had no maladaptive behavior. However, his IPP included</p>	W 214		

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W 214	Continued From page 10 objectives related to aggression, property destruction, non-compliance, and socially offensive behavior. b. Individual #2's CFA stated he was independent in turning on the water, adjusting the temperature, closing the shower curtain, shampooing and rinsing his hair. However, his IPP included an objective to turn on the water, and wet and shampoo his hair with a specific verbal cue. c. Individual #2's CFA stated he did not rush eating and relaxed and enjoyed the meal. However, his IPP included an objective to take one bite and swallow, take another bite and swallow, set the utensil down, and take a drink while keeping his left hand on the table with a specific verbal cue. d. Individual #2's CFA stated he was independent in adding single and double digit numbers. However, his IPP included an objective to add single digit numbers with a nonspecific verbal cue. e. Individual #2's CFA stated he was independent in identifying all coins and paper money up to \$20.00. However, his IPP included an objective to identify coins and a \$1.00 dollar bill with a nonspecific verbal cue. When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., Individual #2's CFA was not accurate. The facility failed to ensure developmental needs were accurately and comprehensively assessed.	W 214			
W 230	483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN	W 230			3/3/14

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W 230	<p>Continued From page 11</p> <p>The objectives of the individual program plan must be assigned projected completion dates.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to assign individualized projected completion dates to objectives for 1 of 3 individuals (Individual #3) whose IPPs were reviewed. This resulted in the potential for an individual to receive training on objectives for extended periods of time without his rate of learning, strengths, and abilities being taken into consideration. The findings include:</p> <p>1. Individual #3's IPP, dated 2/21/13, documented a 20 year old male whose diagnoses included mild mental retardation and ADHD.</p> <p>Individual #3's IPP contained 28 priority training objectives. All 28 program objectives had a target completion date of 2/2014. The objectives included, but were not limited to eating, communication, tooth brushing, showering, money management, and grooming.</p> <p>When asked on 1/10/14 from 8:03 - 9:53 a.m. the QIDP stated the objectives should not have the same completion dates and it was an oversight.</p> <p>The facility failed to ensure active treatment objective completion dates accurately reflected Individual #3's rate of learning.</p>	W 230		
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has</p>	W 249		3/23/14

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W 249	<p>Continued From page 12</p> <p>formulated a client's individual program plan, each client must 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 in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in individuals' training programs not being implemented. The findings include:</p> <p>1. Individual #1's IPP, dated 11/15/13, documented a 15 year old male diagnosed with mild mental retardation and autism. He was admitted to the facility on 10/18/13.</p> <p>Individual #1's PBSP, dated 10/17/13, stated he engaged in aggression (defined as hitting, kicking, grabbing, and scratching), disruptive behavior (defined as yelling), and property destruction (defined as throwing and breaking objects, hitting walls, and tearing objects off walls).</p> <p>a. Under the section titled Prevention Strategies, it stated Individual #1 was to use a daily picture schedule to allow him choice in the order of required tasks, an electronic tablet was to be used to assist him with communication, a timer was to be used when transitioning from one task</p>	W 249			

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W 249	<p>Continued From page 13</p> <p>to another, staff were to encourage him to participate in social groups, and social stories were to be used to prepare him for planned tasks and activities.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. A daily picture schedule, an electronic tablet, and a timer were not observed to be used.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., Individual #1 did not have a daily picture schedule or an electronic tablet. The lead worker stated Individual #1 was not interested in social groups and the facility did not have a timer or social stories.</p> <p>b. Under the section titled Replacement Behaviors, it stated Individual #1 was to participate in sensory activities multiple times throughout each shift. The listed activities included swinging and manipulating play dough and different textured items.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. A swing and different textured items were not observed to be used.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., Individual #1 did not like play dough and the facility did not have a swing and different textured items.</p>	W 249		

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W 249	<p>Continued From page 14</p> <p>c. Under the section titled Replacement Behaviors, it stated Individual #1 was to sit with staff at the start of each shift to create his daily schedule by pairing words with pictures. The plan stated the schedule was to be used throughout the shift and was to be accessible at all times. The facility's morning shift started at 6:00 a.m. and the evening shift started at 2:00 p.m.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. No visual schedule was observed to be used.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., Individual #1 did not have a visual schedule.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he was not aware the facility did not have the items necessary to implement Individual #1's PBSP.</p> <p>2. Individual #2's IPP, dated 4/18/13, documented a 23 year old male diagnosed with moderate mental retardation and diabetes mellitus Type II.</p> <p>Individual #2's PBSP, dated 12/1/13, stated he engaged in aggression (defined as hitting and biting), property destruction (defined as throwing and breaking objects, hitting walls, and tearing objects off walls), uncooperative behavior (defined as refusing to engage in activities and programs), and socially offensive behavior (defined as swearing, telling staff to shut up, and name calling).</p>	W 249		

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W 249	<p>Continued From page 15</p> <p>a. Under the section titled Prevention Strategies, it stated Individual #2 was to use a daily picture schedule to allow him choice in the order of required tasks, a timer was to be used when transitioning from one task to another, staff were to encourage him to participate in social groups, and social stories were to be used to prepare him for planned tasks and activities.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m. A daily picture schedule and a timer were not observed to be used.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., Individual #2 did not have a daily picture schedule and he was not interested in social groups. The shift leader stated the facility did not have a timer or social stories.</p> <p>b. Under the section titled Replacement Behaviors, it stated Individual #2 was to sit with staff at the start of each shift to create his daily schedule by pairing words with pictures. The plan stated the schedule was to be used throughout the shift and was to be accessible at all times. The facility's morning shift started at 6:00 a.m. and the evening shift started at 2:00 p.m.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. No visual schedule was observed to be used.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10</p>	W 249			

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W 249	<p>Continued From page 16 p.m., Individual #2 did not have a visual schedule.</p> <p>c. Under the section titled Replacement Behaviors, it stated Individual #2 was to use "emotional faces cards" to identify his emotions.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. Emotional face cards were not observed to be used.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., the facility did not have any emotional face cards.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he was not aware the facility did not have the items necessary to implement Individual #2's PBSP.</p> <p>3. Individual #3's IPP, dated 2/21/13, documented a 20 year old male whose diagnoses included mild mental retardation and ADHD.</p> <p>Individual #3's PBSP, dated 2/1/13, stated he engaged in uncooperative behavior (defined as refusing to participate in programs and not listening or ignoring others), attention seeking behavior (defined as swearing, inappropriately touching others, calling people names, yelling, and interrupting), property destruction (defined as hitting objects), and harming others (defined as threatening others).</p> <p>a. Under the section titled Prevention Strategies, it stated Individual #3 was to use a daily picture schedule to allow him choice in the order of</p>	W 249			

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W 249	<p>Continued From page 17</p> <p>required tasks, a timer was to be used when transitioning from one task to another, and social stories were to be used to prepare him for planned tasks and activities.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m. A daily picture schedule, a timer, and social stories were not observed to be used.</p> <p>When asked on 1/8/14 from 12:15 - 1:10 p.m., the evening shift leader stated Individual #3 did not have a picture schedule, a timer, or social stories.</p> <p>b. Under the section titled Teaching/Training Supports & Replacement Skills, it stated Individual #3 was on a behavior bonus system.</p> <p>When asked on 1/8/14 from 12:15 - 1:10 p.m., the evening shift leader stated she did not know what the bonus system was.</p> <p>c. Under the section titled Replacement Behaviors, it stated Individual #3 was to sit with staff at the start of each shift to create his daily schedule and when each task was complete, the task could be removed from the schedule. The plan stated the schedule was to be used throughout the shift and was to be accessible at all times. The facility's morning shift started at 6:00 a.m. and the evening shift started at 2:00 p.m.</p> <p>However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. No schedule</p>	W 249		

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W 249	Continued From page 18 with removable tasks was observed to be used. When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., Individual #3 did not have a schedule with tasks that could be removed. d. Under the section titled Replacement Behaviors, it stated Individual #3 was to use "emotional faces cards" to identify his emotions. However, observations were conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. and 5:30 - 6:17 p.m. and on 1/7/14 from 6:13 - 8:05 a.m., for a cumulative 3 hours 57 minutes. Emotional face cards were not observed to be used. When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., the facility did not have any emotional face cards. When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he was not aware the facility did not have the items necessary to implement Individual #3's PBSP. The facility failed to ensure items were available such that Individuals #1 - #3 received training consistent with their PBSPs.	W 249			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 250		3/23/14	

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W 250	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop active treatment schedules which were consistent and reflective of individuals' needs for 3 of 3 individuals (Individuals #1 - #3) whose active treatment schedules were reviewed. This had the potential to impede the implementation of individuals' active treatment plans and services. The findings include:</p> <p>1. Individual #1's IPP, dated 11/15/13, documented a 15 year old male diagnosed with mild mental retardation and autism. He was admitted to the facility on 10/18/13.</p> <p>Individual #1's IPP contained 28 priority training objectives and 10 non-priority needs. His active treatment schedules from the facility were reviewed. Both his morning and evening schedules were undated and were not reflective of the objectives stated in his 11/15/13 IPP.</p> <p>Current active treatment schedules that were reflective of Individual #1's priority and non-priority needs could not be found.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., the undated schedules for Individual #1 were the most current and were not sufficient.</p> <p>2. Individual #2's IPP, dated 4/18/13, documented a 23 year old male diagnosed with moderate mental retardation and diabetes mellitus Type II.</p> <p>Individual #2's IPP contained 29 priority training objectives and 7 non-priority needs. His active</p>	W 250			

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W 250	<p>Continued From page 20</p> <p>treatment schedules from the facility and day program were reviewed. His morning and day schedules were dated 11/1/13 and his evening schedule was undated. None of the schedules were reflective of the objectives stated in his 4/18/13 IPP.</p> <p>Current active treatment schedules that were reflective of Individual #2's priority and non-priority needs could not be found.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., the schedules for Individual #2 were the most current and were not sufficient.</p> <p>3. Individual #3's IPP, dated 2/21/13, documented a 20 year old male whose diagnoses included mild mental retardation and ADHD.</p> <p>Individual #3's IPP contained 28 priority training objectives and 6 non-priority needs. His active treatment schedules from the facility and the day program were reviewed. His morning schedule and day treatment schedules were dated 11/1/13 and his evening schedule from the facility was undated. None of his schedules were reflective of the objectives stated in his 2/21/13 IPP.</p> <p>Current active treatment schedules that were reflective of Individual #3's priority and non-priority needs could not be found.</p> <p>When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., the undated schedules for Individual #3 were the most current and were not sufficient.</p> <p>The facility failed to ensure active treatment</p>	W 250			

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W 250	Continued From page 21 schedules, reflective of current priority and non-priority needs, were developed for Individuals #1 - #3.	W 250			
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on observation, record review, policy review, and staff interviews it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior, which directly impacted 1 of 3 individuals (Individual #4) whose restrictive interventions were reviewed and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in the implementation of a behavioral intervention that had not been approved by the facility. The findings include: 1. Individual #4's PBSP, dated 12/1/13, documented he was diagnosed with moderate mental retardation and autism. An observation was conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. During that time, 2 large blocking pads were noted to be leaning against a living room wall. Each blocking pad measured 3 feet by 2 feet and the front and sides were covered with a black washable fabric. The back of each blocking pad was exposed and showed hard foam from yoga mats had been	W 276		3/23/14	

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #5 BURKE			STREET ADDRESS, CITY, STATE, ZIP CODE 4541 EAST BURKE DRIVE AMMON, ID 83406	
(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 276	Continued From page 22 glued and taped together. The back of each blocking pad also contained handles which consisted of 2 plastic pipes inserted and taped to the foam. The evening shift leader was present during the observation and at 4:33 p.m., she was asked about the blocking pads. The shift leader stated the blocking pads were used to block Individual #4 from hitting his head on the wall. The shift leader stated the blocking pads were homemade and they had been in place for about two months on a "trial and error" basis. However, the facility's behavior policy, titled Behavior Support Method Hierarchy & Definitions, dated 1/3/14, was reviewed and did not include the use of blocking pads. When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., blocking pads were not incorporated in the policy. The facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior.	W 276		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by:	W 289		3/23/14

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W 289	<p>Continued From page 23</p> <p>Based on observation, record review, and staff interview it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 3 individuals (Individual #4) whose restrictive interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include:</p> <p>1. Individual #4's PBSP, dated 12/1/13, documented he was diagnosed with moderate mental retardation and autism.</p> <p>An observation was conducted in the facility on 1/6/14 from 3:45 - 5:05 p.m. During that time, 2 large blocking pads were noted to be leaning against a living room wall. Each blocking pad measured 3 feet by 2 feet and the front and sides were covered with a black washable fabric. The back of each blocking pad was exposed and showed hard foam from yoga mats had been glued and taped together. The back of each blocking pad also contained handles which consisted of 2 plastic pipes inserted and taped to the foam.</p> <p>The evening shift leader was present during the observation and at 4:33 p.m., she was asked about the blocking pads. The shift leader stated the blocking pads were used to block Individual #4 from hitting his head on the wall. The shift leader stated the blocking pads were homemade and they had been in place for about two months on a "trial and error" basis. When asked, the shift leader stated the blocking pads were not incorporated in Individual #4's PBSP.</p> <p>Individual #4's PBSP, dated 12/1/13, stated he</p>	W 289		

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W 289	Continued From page 24 engaged in self-abuse (defined as hitting himself on the head and biting). The only information related to the blocking pad was one sentence which stated "The blocking pads usually are enough to ensure safety for [Individual #4]." The PBSP did not contain any additional information related to the use of the blocking pads (e.g. when to use the blocking pads, how to use the blocking pads, etc.). When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., the blocking pads were not comprehensively incorporated in the PBSP. The facility failed to ensure the blocking pads, used to manage self-abusive behavior, was sufficiently incorporated into Individual #4's PBSP.	W 289			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases for 5 of 6 individuals (Individuals #1, #2, and #4 - #6) residing at the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:	W 455		2/15/14	

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W 455	<p>Continued From page 25</p> <p>1. During an observation on 1/6/14 from 3:45 - 5:05 p.m., toothbrushes were noted to be uncovered and stored in the same container with grooming supplies, as follows:</p> <ul style="list-style-type: none"> - Individual #1's toothbrush was noted to be uncovered and stored in the same container with his hairbrush, deodorant, body wash, shampoo, toothpaste, and dental floss. - Individual #2's grooming container had 2 uncovered toothbrushes stored with deodorant, personal cleanser, Q-Tips, 2 containers of lotion, and toothpaste. - Individual #4's toothbrush was noted to be uncovered and stored in the same container with 2 electric razors, lotion, cologne, 2 packs of baby wipes, personal cleanser, and toothpaste. - Individual #5's grooming container had 3 uncovered toothbrushes stored with a hairbrush, a CD, a dog collar, an electric charger, and toothpaste. - Individual #6's toothbrush was noted to be uncovered and stored in the same container with his comb, deodorant, Axe body spray, and dental floss. <p>When asked about infection control practices, the LPN stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., toothbrushes were to be covered and stored separately from grooming supplies.</p> <p>The facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases.</p>	W 455		

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W 480	<p>483.480(c)(1)(iv) MENUS</p> <p>Menus must include the average portion sizes for menu items.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure menus included the average portion sizes for 6 of 6 individuals (Individuals #1 - #6) observed during meals. This resulted in the potential for individuals to not be provided with adequate well balanced meals necessary to maintain their nutritional status. The findings include:</p> <p>1. During an observation on 1/6/14 from 5:30 - 6:17 p.m., dinner was observed. The meal consisted of fish sticks, corn, and white rice. The menu, titled Fall/Winter Week Two, was posted on the front of the refrigerator and did not contain portion sizes for the food items. Two direct care staff, who were present during the observation, were asked about the menu. Both staff stated the menu did not contain portion sizes so they (the staff) typically followed the serving sizes identified on the food packages.</p> <p>However, when the food items were placed on the table at 5:47 p.m., it was noted the bowl of rice contained a ¼ cup measuring cup and the bowl of corn contained a ½ cup measuring cup. The measuring cups were used by the individuals to place the rice and corn on their plates. The food package for the rice stated the serving size was 1 cup and the corn package stated the serving size was 2/3 cup.</p> <p>Additionally, during an observation on 1/7/14 from</p>	W 480		3/23/14	

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W 480	Continued From page 27 6:13 - 8:05 a.m., breakfast was observed. The meal consisted of French toast and sausage patties. At 6:53 a.m., a direct care staff looked at the menu and asked Individual #5, who was in the kitchen, how many pieces of toast were to be served. Individual #5 stated "I think it's 2 pieces." Individual #6 was also present and stated "I'm confused, 1 or 2, I don't know." When asked, the QIDP stated during an interview on 1/10/14 from 8:03 - 9:53 a.m., he was not aware the menu did not contain average portion sizes. The facility failed to ensure the menu included average portion sizes.	W 480		
W 481	483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include: 1. During an observation on 1/6/14 from 5:30 - 6:17 p.m., dinner was observed. The meal consisted of fish sticks, corn, and white rice. However, the menu for 1/6/14 stated the dinner meal was to include fish, seasoned mixed vegetables, and steamed rice.	W 481		3/23/14

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W 481	<p>Continued From page 28</p> <p>An observation was conducted on 1/7/14 from 6:13 - 8:05 a.m. During that time, the morning shift leader and Individual #5 were observed packing lunches for all individuals, as follows:</p> <p>The lunch meal for Individual #1:</p> <ul style="list-style-type: none"> - A Michelina's Salisbury steak frozen dinner - A package of Cheddar cheese crackers - A baggie of potato chips - A 12 ounce bottle of Gatorade <p>The lunch meal for Individuals #2 - #6:</p> <ul style="list-style-type: none"> - 2 lettuce leaves - 3 celery sticks - 2 pieces of wheat bread - 1 tablespoon of peanut butter - A baggie of potato chips - Approximately 1 cup of chicken salad (made by Individual #5 and included chicken, mayonnaise, salt and pepper). <p>However, the menu for 1/7/14 stated the lunch meal was to include the following:</p> <ul style="list-style-type: none"> - Chicken salad with chopped grapes - Cucumber salad - Apple slices with caramel - Choice of beverage <p>No documentation of the food actually served at dinner and lunch could be found.</p> <p>When asked, the evening shift leader stated during an interview on 1/8/14 from 12:15 - 1:10 p.m., she did not know food substitutions were to be documented.</p> <p>The facility failed to ensure documentation of food actually served was kept.</p>	W 481		

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 1/6/14 - 1/13/14. The survey was conducted by: Monica Nielsen, QIDP, Team Leader Jim Troutfetter, QIDP	M 000		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	Please see attached of Plan of correction for all Deficiencies	
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W249.	MM212		
MM238	16.03.11.080.03(h) Access to Resident's Records To be given access to all of the resident's records that pertain to his active treatment; subject to the requirements specified in Idaho Department of Health and Welfare Rules, Section 05.01.300 through Subsection 05.01.301.06, and Sections 05.01.310 through 05.01.339, "Rules Governing Protection and Disclosure of Department Records."	MM238		

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James J. Winters NHA
TITLE
City Director

1/30/14 DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/13/2014
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MM238	Continued From page 1 This Rule is not met as evidenced by: Refer to W250.	MM238		
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the environment not being clean and being kept in ill-repair. The findings include:</p> <p>1. During an environmental review conducted 1/8/14 from 11:40 a.m. - 12:30 p.m., the following was noted:</p> <ul style="list-style-type: none"> - There were food splatters inside the top and on the glass tray of the microwave. - There was food debris in the bottom drawer of the oven. - There was a build up of dust on the back side of the floor fan in the living room. - There were loose handles on 7 of the 14 drawers in the kitchen. - There was a 1 foot by 1 foot area of unpainted 	MM380		3/1/14

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MM380	Continued From page 2 wall next to the light switch in Individuals #2 and #5's bedroom. - There was a 1 foot by 1 foot area of unpainted wall near the closet and an area approximately 8 inches by 8 inches of unpainted wall near the bathroom in Individuals #1 and #6's bedroom. - There were 2 uncovered electrical outlets in Individuals #1 and #6's bedroom. - There was rust on the toilet brush and unidentified brown matter down one side of the brush holder in Individuals #1 and #6's bathroom. The facility failed to ensure the facility was kept clean and in good repair.	MM380		
MM520	16.03.11.200.03(a) Establishing and Implementing policies The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520		3/23/14
MM672	16.03.11.07(a) Menu Preparation Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty	MM672		3/23/14

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MM672	Continued From page 3 (30) days. This Rule is not met as evidenced by: Refer to W480 and W481.	MM672		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		3/23/14
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		3/23/14
MM732	16.03.11.270.01(d)(iii) Date Objective Achieved Time limited, giving dates when the objective is to be achieved. This Rule is not met as evidenced by: Refer to W230.	MM732		3/3/14
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to	MM769		2/15/14

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YELLOWSTONE GROUP HOME #5 BURKE

**4541 EAST BURKE DRIVE
AMMON, ID 83406**

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MM769	Continued From page 4 medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		
MM857	16.03.11.270.08(e) Qualified Training There must be sufficient appropriately qualified training and habilitation personnel and necessary supporting staff available to carry out the residents' training and habilitation program. This Rule is not met as evidenced by: Refer to W186.	MM857		3/1/14
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859		3/1/14

Plan of correction for the Burke home survey 1/13/ 2014

W120. QIDP 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. 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 Q IDP. The implementation date will be completed by 3/1/14

W159. Facility will undergo a quarterly internal QA process to ensure all QIDP functions are being performed as required. Quarterly QA's will be reviewed by the corporate QA officer and will inspect both the resident files and the QA logs to ensure the QA process is being completed. The corporate quality assurance team has developed a QA assessment to be used to document all review process. The psychologist who is retired from the Air Force will provide general training on QA, which he is very knowledgeable. To be completed by 3/23/14. The city director will be responsible.

Also refer to: W120, W186, W214, W230, W249, W250, W276, W289, W455, W480, and W481.

W186. The staff sign in logs will be modified to reflect the additional staff providing services and ensure that they sign in. The previous form did not clearly designate when Day treatment staff were staying over to provide services or when additional staff were taking clients to movies, class, school, etc. In addition any resident activities that don't require staff supervision will be properly noted, such as school and home visits. Examples listed in this deficiency, regarding shifts worked by the grave yard shift is confusing as it refers to only having two people on that particular shift, that's what we staff this shift for.

The HR person will also be trained on this tag to recognize the importance of replacing/hiring staff promptly. To be completed by 3/1/14.

W214. The CFA process will be reviewed and staff trained on properly completing the CFAs in the future. No CFA's will be completed by untrained staff. As part of the QA process, CFA's will be evaluated quarterly to see if they match objectives and to see if they need revised. The facility is also involved with the Idaho ICF providers to gain greater knowledge in this area. Administrative staff participated in the training in Twin Falls recently and actively participated, and will continue to do so. This will be completed by 3/23/14. The city director will be responsible to see that this is accomplished. Corporate quality assurance will also provide oversight.

W230. This has been completed. This sample individual's IPP was the last one yet to be completed to the new facility standards. Our new QA processes will ensure that this is reviewed quarterly. Implementation of the reviews will be completed by 3/3/14. The program supervisor/Q IDP will make sure that this is completed. The city director will oversee the QA process.

W249. Behavior specialist and QIDP shall go through all PBSP's and ensure that only the interventions that are applicable for a particular client are in place for the plan. All objectives will be reviewed and proper materials obtained. Staff will be trained on the use and strategies to utilize the items. The noted

QA process in this survey will ensure that all of the resources for successful plan implementation are available and staff have been trained how to utilize. This will be completed by 3/23/14.

W250. QIDP will go through each clients schedule and customize so that it accurately outlines the current active treatment program and is readily available for review by relevant staff. Internal monthly QA reviews and corporate quarterly reviews will ensure that schedules are in place. This will be completed by 3/23/14 and monitored by the city director

W276. Policy, Informed consents and PBSP's will be revised to include detailed descriptions of blocking pads as well as directions for use. The blocking pads were a short term less restrictive alternative to prior methods. Our goal is to obtain some are less menacing boards. Our ultimate goal per corporate is to minimize the use of the boards by building our skills to therapeutic options. The creator of therapeutic options and our behavior specialist will be utilized to achieve this. This area will be completed by 3/23/14.

W289. See W276

W455. All residents will be provided with new toothbrush covers and trained in their use. In addition, staff will responsible to ensure proper infection control procedures will be taken as part of their shift cleaning log process. The shift supervisors will be responsible and will be completed by 2/15/14

W480. New menus will be built and customized for the current residents at Burke by the dietician and her team. The menus will have clear portion sizes as dictated by the assessed needs of the individual clients. Staff will be trained on following the menus. Program supervisors/Q IDP will be responsible for this. It will be completed by 3/23/

W481. All Staff will be trained on following the menus and using the replacement food log which is kept in a drawer in the kitchen. The program supervisor/Q IDP will be responsible for reviewing this monthly. It will be completed by 3/23/14.

MM 197 refer to W2 89

MM 212 refer to W2 49

MM 238 refer to W2 50

MM 380. The cleaning schedules will be reviewed with the graveyard shift and the expectations of accurately following and documenting them. Lack of follow through will be grounds for disciplinary action. All other staff will also be trained as to what is expected and what to report to the maintenance person for prompt repair. These cleaning schedules will be reviewed by program supervisor/Q IDP and city director. This will be completed by 3/1/14.

MM520 refer to W276

MM 672 refer to W 480 and W481

MM 725 refer to W159

MM 730 refer to W2 14

MM732 refer to W230

MM 769 refer to W455

MM 857 refer to W186

MM859 refer to W120

Frederic J. Weeks NHA
City Director

1130 114

Yellowstone Burke home survey 1/13/14 **addendum** to plan of correction

W186- for clarification the Burke home program supervisor/QIDP Nick Schmitt will be the responsible party to ensure that this deficiency in its entirety is corrected.

Jerrin Weeks
Yellowstone Park City Director

2/5/14

RECEIVED *PNT*
FEB - 4 2014
FACILITY STANDARDS

RECEIVED
FEB - 5 2014
FACILITY STANDARDS