



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
Coise, ID 83720-0009
PHONE 208-334-8628
FAX 208-364-1888

March 28, 2014

Susan Broetje, Administrator
Southwest Idaho Treatment Center
1660 Eleventh Avenue North
Nampa, ID 83687

RECEIVED

MAR 31 2014

SWITC-ADMINISTRATION

RE: Southwest Idaho Treatment Center, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure survey of Southwest Idaho Treatment Center, which was conducted on March 17, 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

Susan Broetje, Administrator
March 28, 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 **April 10, 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 April 10, 2014. If a request for informal dispute resolution is received after April 10, 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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

ROBERT B. LUCE – Administrator
DIVISION OF FAMILY AND COMMUNITY SERVICES
SUSAN BROETJE – Administrative Director
SOUTHWEST IDAHO TREATMENT CENTER
1660 11th Avenue North
Nampa, Idaho 83887-5000
PHONE 208-442-2812
Fax 208-467-0965
EMAIL broetjes@dhw.idaho.gov

April 9, 2014

Nicole Wisenor
Michael Case
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720 – 0009

RE: Southwest Idaho Treatment Center, Provider #13G001
Annual Survey – March 17, 2014

Dear Ms. Wisenor,

Attached please find the plan of correction for the annual survey conducted on March 17, 2014 at the Southwest Idaho Treatment Center as identified in the Statement of Deficiencies. If you have any questions, please contact me at 442-2812 ext 482.

Sincerely,

Susan Broetje
Administrator
Southwest Idaho Treatment Center

SB/ejw

RECEIVED
APR 11 2014
FACILITY STANDARDS

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

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2014
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST IDAHO TREATMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification and complaint survey conducted from 3/10/14 - 3/17/14.</p> <p>The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN Ashley Henscheid, QIDP Jim Troutfetter, QIDP Paul Rowe, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>DCS - Direct Care Staff DD - Developmental Disabilities HPV - Human Papilloma Virus HRC - Human Rights Committee IED - Intermittent Explosive Disorder LPN - Licensed Practical Nurse MAR - Medication Administration Record OCD - Obsessive Compulsive Disorder ODD - Oppositional Defiant Disorder PCP - Person Centered Plan QIDP - Qualified Intellectual Disability Professional RN - Registered Nurse SIB - Self Injurious Behavior</p>	W 000		
W 125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p>	W 125	<p style="text-align: right;">RECEIVED APR 11 2014 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>S. Boetz</i>	TITLE Administrative Director	(X6) DATE 4/9/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	Continued From page 1 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 29 of 29 individuals (Individuals #1 - #29) residing at the facility. This resulted in implementation of blanket restrictions to knives and glass baking dishes, not based on individual need, and without assuring due process protections. The findings include: 1. On 3/10/14 at 10:50 a.m., an observation was conducted of the kitchen of the Aspen 2 living unit. All the drawers as well as the upper and lower cabinets were equipped with locks. DCS D, who was present during the observation, reported all the drawers and cabinets had the potential to be locked, but only two cabinets in the kitchen were actually locked. When asked to view the inside of the locked cabinets, DCS D unlocked the first locked lower cabinet, the contents of which included glass baking dishes. When asked if the glass baking dishes were locked for a specific person, she said, "No, it's just a general safety precaution...not for any person who currently lives here." DCS D stated an individual who used to reside at the facility engaged in cutting behavior by using broken glass or any sharp object to cut her arms. As a safety precaution, the glass baking dishes were locked to prevent her from smashing them on the kitchen floor and using the glass shards to cut herself. DCS D unlocked the second locked cabinet revealing spices. When asked about the locked spices, DCS D stated an individual who used to live at the facility sometimes ingested large	W 125		

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W 125	<p>Continued From page 2</p> <p>amounts of spices to make himself sick in order to obtain medical attention. However, DCS D showed the surveyor other spices stored in the kitchen that were not locked. When asked if any other kitchen items were locked, DCS D stated the sharp knives and other sharp food preparation implements were locked in another cabinet. She reported the knives and other sharp food preparation implements were initially locked because of the former individual who cut herself. When asked if there was anyone currently living at the facility who used sharp objects in an unsafe manner, DCS D stated Individual #12 had threatened to stab another individual with a butter knife, but had not actually done so.</p> <p>On 3/12/14 at 4:15 p.m., DCS B was asked where the sharp knives and other sharp food preparation implements were stored. He unlocked a storage room and moved to a locked Plexiglas cabinet mounted on the wall with a variety of knives and food processing blades visible inside. DCS B reported the knives and sharp food preparation implements were kept locked to prevent access by individuals as a general safety precaution rather than for any specific individual. He said individuals could use knives under direct staff supervision if staff obtained the knife from the locked cabinet and stayed close to the individual who was using the knife. DCS B added the knives could only be used for meal preparation.</p> <p>On 3/11/14 at 10:10 a.m., an environmental review was conducted on the Birch 1 living unit. At that time, all knives were noted to be locked in a cabinet in a locked storage room.</p> <p>On 3/11/14 at 11:15 a.m., an environmental</p>	W 125			

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W 125	Continued From page 3 review was conducted on the Birch 2 living unit. At that time, all knives were noted to be locked in a cabinet in a locked storage room. On 3/14/14 beginning at 9:00 a.m., an interview was initiated with the DD Program Manager. She verified the facility restricted access to knives in all living units without determining individual need for the restriction, without obtaining consent for the restriction and without review and approval from the HRC. The facility failed to ensure individuals' rights to free access of knives and glass baking dishes was ensured.	W 125			
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was completed for 1 of 5 individuals (Individual #3) who were of age to be involved in vocational training. Without a comprehensive assessment, the facility would be unable to assist an individual with vocational training needs through the development of objectives designed to optimize the individual's abilities. The findings include: 1. Individual #3's 12/3/13 PCP stated he was a 22 year old male whose diagnoses included moderate mental retardation, impulse control disorder and seizure disorder.	W 225			

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W 225	Continued From page 4 Individual #3's record contained a Comprehensive Functional Assessment for vocational needs, dated 11/26/13. The assessment was blank with the exception of a statement at the end, which stated "[Individual #3's] vocationally-related skills were not assessed as his general functioning does not indicate that vocational assessment is warranted." No additional information was provided. During an interview on 3/14/14 from 9:00 - 11:40 a.m., the DD Program Manager and QIDP both stated Individual #3's vocational needs and abilities should have been assessed. The facility failed to ensure a vocational assessment had been completed for Individual #3.	W 225			
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals' PCPs included objectives to meet their needs for 4 of 8 individuals (Individuals #1, #2, #3 and #6) whose PCPs were reviewed. This resulted in a lack of program plans designed to address the behavioral needs of individuals. The findings include:	W 227			

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W 227	<p>Continued From page 5</p> <p>1. Individual #2's PCP, dated 1/28/14, documented a 23 year old male whose diagnoses included Prader-Willi syndrome, OCD, bipolar disorder, anxiety disorder and mild cognitive impairment.</p> <p>His PCP did not include specific objectives necessary to meet his identified behavioral needs, as follows:</p> <p>Individual #2's Comprehensive Functional Assessment for behavior, dated 2/2013, documented he engaged in assault, inappropriate touch, rubbing and picking, rectal digging, inappropriate elimination, smearing feces, hoarding excrements and taking others' property.</p> <p>a. Individual #2's Medication Management Plan, dated 1/24/14, documented Prozac (an antidepressant drug) was prescribed for multiple uses, including treating Individual #2's OCD and anxiety disorder.</p> <p>Individual #2's Comprehensive Functional Assessment documented under the "Anxiety Stage of Crisis Development" section that "anxiety is defined as a noticeable increase or change in behavior that is manifested by a non-directed expenditure of energy." The assessment documented "For [Individual #2] this is characterized by: 1. Protesting or expressing frustration by crying, whining or using inappropriate language. 2. Making demands & arguing. His tone of voice & volume will increase. 3. Over apologizes for small mistakes."</p> <p>However, Individual #2's PCP did not include an objective related to anxiety or the corresponding symptoms.</p>	W 227		

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W 227	<p>Continued From page 6</p> <p>b. Individual #2's Medication Management Plan, dated 1/24/14, documented Zyprexa (an antipsychotic drug) and Prozac (an antidepressant drug) were both prescribed for multiple uses, including treating the depressive symptoms of Individual #2's bipolar disorder.</p> <p>However, Individual #2's PCP did not include an objective related to his depressive symptoms.</p> <p>c. Individual #2's Medication Management Plan, dated 1/24/14, documented Zyprexa (an antipsychotic drug) and Trileptal (an anticonvulsant drug) were both prescribed for multiple uses, including reducing Individual #2's assaultive behavior.</p> <p>Behavior Reporting Forms from 11/2013 - 3/2014 related to Individual #2's assaultive behavior were reviewed. The forms documented incidents including, but not limited to, the following:</p> <ul style="list-style-type: none"> - 11/3/13: "Assault x1 (one) punched staff on [left] thigh. Att. [assault] x11 (eleven) punches to [left] thigh." - 11/24/13: Slapped another resident "on the right side of the face. x1." - 12/1/13: Hit staff one time. - 2/27/14: "...assaulted staff (x2)." <p>However, Individual #2's PCP did not include an objective related to assaults.</p> <p>When asked, the DD Program Manager stated during an interview on 3/14/14 from 9:00 - 11:40</p>	W 227		

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W 227	<p>Continued From page 7</p> <p>a.m., Individual #2's PCP did not include objectives to address the maladaptive behaviors.</p> <p>The facility failed to ensure Individual #2's PCP included specific objectives necessary to meet his identified behavioral needs.</p> <p>2. Individual #6's PCP, dated 7/31/13, documented a 30 year old male whose diagnoses included mental retardation, unspecified.</p> <p>His PCP did not include specific objectives necessary to meet his identified behavioral needs, as follows:</p> <p>Individual #6's Comprehensive Functional Assessment for behavior, dated 8/2012, documented he engaged in assault, injury cause by self, destruction of property, throwing or swiping objects and low intensity injury to self.</p> <p>a. Individual #6's Comprehensive Functional Assessment under the "Anxiety Stage of Crisis Development" section that for Individual #6 anxiety included "1. [increased] verbalizations that are negative in nature (e.g. 'no,' '[Individual #6] don't want to,' etc.) 2. [increased] movement when rocking. His rocking will became [sic] faster & more intense in its movement. 3. injury to self behaviors 4. [increased] non-compliance or resistance to redirection."</p> <p>Beyond the objective for injury to self, Individual #6's PCP did not include an objective related to anxiety or the corresponding symptoms.</p> <p>b. Individual #6's Comprehensive Functional Assessment, dated 8/2012, documented Individual #6 exhibited maladaptive behaviors</p>	W 227			

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W 227	<p>Continued From page 8 including non-compliance. Further, Individual #6's PCP documented "If presented with choices, [Individual #6] almost universally will decline or refuse the first time."</p> <p>Individual #6's record included a QIDP Progress Note Narrative, dated 1/2014, which documented Individual #6 had refused multiple trials of training programs, as follows:</p> <ul style="list-style-type: none"> - Self-Administration of Medication: "Only 6 trials did not meet minimum # of trials...Refused - 33." - Put Towels in Laundry Basket: "Only 1 trial. 20 refusals." - Get Hands Wet: "Only 9 trials. 46 refusals." - Place Deodorant by the Sink after Applied: "16 refusals. Will continue to monitor." <p>However, Individual #6's PCP did not include an objective related to non-compliance.</p> <p>When asked, the DD Program Manager stated during an interview on 3/14/14 from 9:00 - 11:40 a.m., Individual #6's PCP did not include objectives to address the maladaptive behaviors.</p> <p>The facility failed to ensure Individual #6's PCP included specific objectives necessary to meet his identified behavioral needs.</p> <p>3. Individual #1 PCP, dated 5/7/13, documented a 15 year old male whose diagnoses included mild mental retardation, ODD, and IED.</p> <p>His record contained a behavioral assessment, dated 5/9/13. The recommendations section</p>	W 227		

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W 227	<p>Continued From page 9</p> <p>stated "Implement a Behavior Support Plan (BSP) starting with addressing targeted maladaptive behaviors including physical assault, psychological assault, destruction of property, injury caused by self, and suicide ideation/threat."</p> <p>His record also contained nursing notes documenting the following incidents of SIB:</p> <ul style="list-style-type: none"> - 12/27/13: "...client banging upper forehead resulting in 3 cm x 3 cm lt. [light] purplish discolored 'goose egg'." - 11/13/13: "Client reportedly hit self in face..." - 11/22/13: "SIB to mid hair line of forehead x 3 resulting in sl [slight] red 1-5 cm area." - 11/9/13: "Client had hit self in face/eyes but ref. [refused] skin check and observation." - 9/2/13: "...[Individual #1] was having behaviors again + he slapped himself in the face and throat..." <p>However, his record did not contain an objective related to SIB.</p> <p>When asked on 3/14/14 from 9:00 - 11:40 a.m., the QIDP stated he was not sure why an objective for SIB was not included in his program.</p> <p>The facility failed to ensure Individual #1's PCP contained an objective related to SIB.</p> <p>4. Individual #3's 12/3/13 PCP stated he was a 22 year old male whose diagnoses included moderate mental retardation, impulse control disorder and seizure disorder.</p>	W 227		

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W 227	Continued From page 10 Individual #3's record documented he received melatonin (a hormonal drug) 4 mg each night to assist with sleep. His medication reduction plan documented the drug would be considered for reduction when he was averaging 10 hours of sleep per night for one month. However, Individual #3's plan did not include an objective related to his sleeping needs. During an interview on 3/14/14 from 9:00 - 11:40 a.m., the DD Program Manager stated sleep was tracked for all individuals residing at the facility, but stated Individual #3 did not have a specific objective or plan related to sleep. The DD Program Manager stated Individual #3's melatonin was being discontinued.	W 227		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on environmental review, record review and staff interview, it was determined the facility failed to ensure behavior assessments contained updated comprehensive information for 3 of 8 individuals (Individuals #1, #2 and #6) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:	W 259		

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W 259	<p>Continued From page 11</p> <p>1. Individual #2's PCP, dated 1/28/14, documented a 23 year old male whose diagnoses included Prader-Willi syndrome, bipolar disorder, anxiety disorder and mild cognitive impairment.</p> <p>Individual #2 was admitted to the facility on 1/31/13. Individual #2's Comprehensive Functional Assessment for behavior, dated 2/2013, documented he engaged in assault, inappropriate touch, rubbing and picking, rectal digging, inappropriate elimination, smearing feces, hoarding excrements and taking others' property. The assessment, under the section Antecedents/Triggers/Setting Events, documented "No concrete data was found in [Individual #2's] admission packet. This will continue to be monitored in hopes of identifying precursor behaviors to provide intervention and decrease engagement in maladaptive behaviors."</p> <p>Individual #2's PCP was completed on 1/28/14. However, Individual #2's Comprehensive Functional Assessment for behavior was not updated to include assessment information related to Individual #2's maladaptive behavior precursors or antecedents since his 2/2013 assessment.</p> <p>Additionally, Individual #2's Comprehensive Functional Assessment for behavior did not include accurate, comprehensive assessment information, as follows:</p> <p>a. Individual #2's Comprehensive Functional Assessment for behavior documented "For safety, provide [Individual #2] 24 hour supervision using Enhanced Supervision" at close proximity, arm's length in the restroom. Individual #2's</p>	W 259		

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W 259	<p>Continued From page 12</p> <p>Behavior Support Plan Overview & Written Consent, dated 1/24/14, documented the plan was updated to be "less restrictive as [Individual #2] will no longer be on enhanced supervision [sic] in common areas or in bed after he has fallen asleep."</p> <p>However, Individual #2's assessment was not updated to reflect the new supervision guidelines.</p> <p>b. Individual #2's Medication Management Plan, dated 1/24/14, documented Zyprexa (an antipsychotic drug) and Prozac (an antidepressant drug) were both prescribed for multiple uses, including treating Individual #2's bipolar symptoms. Additionally, Individual #2's Comprehensive Functional Assessment for behavior documented "Symptoms relating to [Individual #2's] mental health diagnoses along with cognitive limitations may increase the likelihood of him engaging in challenging maladaptive behaviors."</p> <p>However, Individual #2's assessment did not include information related to individual #2's bipolar disorder, specifically depressive symptoms and hypomania.</p> <p>c. Individual #2's Medication Management Plan, dated 1/24/14, documented Zyprexa (an antipsychotic drug) and Trileptal (an anticonvulsant drug) were both prescribed for multiple uses, including reducing Individual #2's assaultive behavior.</p> <p>Behavior Reporting Forms from 11/2013 - 3/2014 related to Individual #2's assaultive behavior were reviewed. The forms documented incidents including, but not limited to, the following:</p>	W 259		

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W 259	<p>Continued From page 13</p> <ul style="list-style-type: none"> - 11/3/13: "Assault x1 (one) punched staff on [left] thigh. Att. [assault] x11 (eleven) punches to [left] thigh." - 11/24/13: Slapped another resident "on the right side of the face. x1." - 12/1/13: Hit staff one time. - 2/27/14: "...assaulted staff (x2)." <p>However, Individual #2's assessment did not include information related to Individual #2's assaultive behavior.</p> <p>When asked, the DD Program Manager stated during an interview on 3/14/14 from 9:00 - 11:40 a.m., Individual #2's Comprehensive Functional Assessment for behavior did not include the information noted above and the assessment needed to be updated.</p> <p>The facility failed to ensure Individual #2's Comprehensive Functional Assessment contained updated, comprehensive information.</p> <p>2. Individual #6's PCP, dated 7/31/13, documented a 30 year old male whose diagnoses included mental retardation, unspecified.</p> <p>Individual #6's Comprehensive Functional Assessment for behavior, dated 8/2012, documented he engaged in assault, injury caused by self, destruction of property, throwing or swiping objects and low intensity injury to self. Individual #2's PCP was completed on 7/31/13. However, Individual #2's Comprehensive Functional Assessment for behavior was not</p>	W 259		

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W 259	<p>Continued From page 14 updated to include comprehensive assessment information, prior to his 7/31/13 PCP as follows:</p> <p>a. Individual #6's Comprehensive Functional Assessment for behavior documented Individual #6 exhibited maladaptive behaviors including non-compliance. Further, Individual #6's PCP documented "If presented with choices, [Individual #6] almost universally will decline or refuse the first time."</p> <p>Individual #6's record included a QIDP Progress Note Narrative, dated 1/2014, which documented Individual #6 had refused multiple trials of training programs, as follows:</p> <ul style="list-style-type: none"> - Self-Administration of Medication: "Only 6 trials did not meet minimum # of trials...Refused - 33." - Put Towels in Laundry Basket: "Only 1 trial. 20 refusals." - Get Hands Wet: "Only 9 trials. 46 refusals." - Place Deodorant by the Sink after Applied: "16 refusals. Will continue to monitor." <p>However, Individual #6's assessment did not include information (i.e. causes) related to his non-compliance.</p> <p>b. On 3/11/14 at 10:10 a.m., an environmental review was conducted on the Birch 1 living unit. It was noted that there was not any clothing in Individual #6's bedroom. A direct care staff, who was present during the environmental review, stated Individual #6's clothing was kept in a closet at the end of the hall because Individual #6 tended to tear up items. Individual #6's PCP</p>	W 259		

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W 259	<p>Continued From page 15</p> <p>documented Individual #6's property destruction "is most often characterized by him intentionally breaking or destroying his personal property, specifically his clothing..."</p> <p>However, Individual #6's record did not include assessment information related to the removal of Individual #6's clothing.</p> <p>When asked, the DD Program Manager stated during an interview on 3/14/14 from 9:00 - 11:40 a.m., Individual #6's Comprehensive Functional Assessment for behavior did not include the information noted above and the assessment needed to be updated.</p> <p>The facility failed to ensure individual #6's Comprehensive Functional Assessment contained updated, comprehensive information.</p> <p>3. Individual #1's PCP, dated 5/7/13, documented a 15 year old male whose diagnoses included mild mental retardation, ODD, and IED.</p> <p>Individual #1 was admitted to the facility on 4/16/13. Individual #1's Comprehensive Functional Assessment for behavior, dated 5/9/13 and signed by the Clinician on 5/19/13, documented he engaged in maladaptive behaviors including physical assault, psychological assault, destruction of property, injury caused by self, and suicide ideation/threat.</p> <p>The assessment, under the Antecedents section, stated "No concrete data was found in [Individual #1's] admission packet. His behaviors have not been of great enough frequency to fully evaluate and determine trends for antecedents at this time. This will continue to be monitored."</p>	W 259			

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W 259	Continued From page 16 The Precursor Behaviors section documented "No concrete data was found in [Individual #1's] admission packet. This will continue to be monitored in hopes of identifying precursor behaviors to provide intervention and decrease engagement in maladaptive behaviors." The Maintaining Consequences section documented "No concrete data was found in [Individual #1's] admission packet. His behaviors have not been of great enough frequency to fully evaluate and determine trends for consequences at this time. This will continue to be monitored." When asked about the assessment on 3/14/14 from 9:00 - 11:40 a.m., the QIDP stated the Comprehensive Functional Assessment for behavior needed to be updated. The facility failed to ensure Individual #1's Comprehensive Functional Assessment for behavior was updated as needed.	W 259		
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 environmental review, record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC	W 262		

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W 262	Continued From page 17 for 1 of 8 individuals (Individual #6) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #6's 7/31/13 PCP stated he was a 30 year old male whose diagnoses included autism and mental retardation, unspecified. On 3/11/14 at 10:10 a.m., an environmental review was conducted on the Birch 1 living unit. It was noted that there was not any clothing in Individual #6's bedroom. A direct care staff, who was present during the environmental review, stated Individual #6's clothing was kept in a closet at the end of the hall because Individual #6 tended to tear up items. However, Individual #6's record did not include HRC approval for removing the clothing from Individual #6's bedroom. During an interview on 3/14/14 from 9:00 - 11:40 a.m., the DD Program Manager stated Individual #6's clothing removal had not been incorporated into his behavior assessment or behavior plan. She stated if the intervention was not in his plan, there would not be consent. The facility failed to ensure HRC approval was received prior to the removal of Individual #6's clothing.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed	W 263		

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W 263	<p>Continued From page 18</p> <p>consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on environmental review, record review and staff interview, it was determined the facility failed to ensure guardian consent was obtained prior to the implementation of restrictive interventions for 1 of 8 individuals (Individual #6) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior consent of restrictive interventions. The findings include:</p> <p>1. Individual #6's 7/31/13 PCP stated he was a 29 year old male whose diagnoses included autism and mental retardation, unspecified.</p> <p>On 3/11/14 at 10:10 a.m., an environmental review was conducted. It was noted that there was not any clothing in Individual #6's bedroom. A direct care staff, who was present during the environmental review, stated individual #6's clothing was kept in a closet at the end of the hall because individual #6 tended to tear up items.</p> <p>However, Individual #6's record did not include written guardian consent for removing the clothing from Individual #6's bedroom.</p> <p>During an interview on 3/14/14 from 9:00 - 11:40 a.m., the DD Program Manager stated Individual #6's clothing removal had not been incorporated into his behavior assessment or behavior plan. She stated if the intervention was not in his plan, there would not be consent.</p> <p>The facility failed to ensure written informed</p>	W 263			

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W 263	Continued From page 19	W 263		
W 264	consent was received prior to the removal of individual #8's clothing. 483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. 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 HRC reviewed and approved facility practices that restricted individuals' free access to household items for 29 of 29 individuals (Individuals #1 - #29) residing at the facility. This resulted in access to knives and glass baking dishes being restricted without cause. The findings include: 1. On 3/10/14 at 10:50 a.m., an observation was conducted of the kitchen of the Aspen 2 living unit. During that time, it was noted all glass baking dishes were locked. DCS D, who was present during the observation, stated the glass baking dishes were locked up as a safety precaution due to the self cutting behavior of an individual no longer living at the facility. DCS D also stated knives and sharp food preparation items were also locked due to the self cutting behavior of the former individual, and because	W 264		

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W 264	<p>Continued From page 20</p> <p>Individual #12, who lived on the Aspen 1 living unit, had threatened to stab another individual with a butter knife. DCS D stated Individual #12 had not actually stabbed anyone.</p> <p>On 3/12/13 at 4:15 p.m., DCS B was interviewed and stated knives and sharp food preparation implements were locked as a general safety precaution and not due to any one individual. DCS B opened a locked storage room and showed the surveyor a locked Plexiglas cabinet in which a variety of knives and food processor blades were stored.</p> <p>On 3/11/14 at 10:10 a.m., an environmental review was conducted on the Birch 1 living unit. At that time, all knives were noted to be locked in a cabinet in a locked storage room.</p> <p>On 3/11/14 at 11:15 a.m., an environmental review was conducted on the Birch 2 living unit. At that time, all knives were noted to be locked in a cabinet in a locked storage room.</p> <p>On 3/13/14, the facility's HRC meeting minutes were reviewed. No evidence existed of the HRC's review of the facility practice to restrict access to knives and glass baking dishes.</p> <p>On 3/14/14, beginning at 9:00 a.m., an interview was initiated with the DD Program Manager. She verified the agency restricted access to knives in all residences without obtaining review and approval of the practice by the HRC.</p> <p>The facility failed to ensure all practices resulting in potential rights violations were reviewed and approved by the HRC.</p>	W 264		

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W 322 W 322	<p>Continued From page 21</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 2 of 8 individuals (Individuals #1 and #7) whose medical records were reviewed. This resulted in an individual not receiving a recommended bone density study and an individual not receiving recommended immunizations. The findings include:</p> <p>1. Individual #7 was a 58 year old male with diagnoses including profound intellectual disability, osteoporosis, and unspecified epilepsy.</p> <p>Individual #7's record documented he received a bone density study in November, 2010. This study identified a diagnosis of osteoporosis for Individual #7 and it was recommended the study be repeated in 2-3 years.</p> <p>Review of Individual #7's record showed no documentation the bone density study had been repeated as recommended.</p> <p>In an interview on 3/14/14 from 9:00 - 11:40 a.m., the facility RN confirmed no repeat bone density study had been performed.</p> <p>The facility failed to ensure a repeat bone density study, as recommended, was performed for Individual #7.</p>	W 322 W 322		

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W 322	Continued From page 22 2. The Centers for Disease Control and Prevention (CDC) Pink Book, which contains the recommendations for vaccination needs and schedules, stated HPV can cause genital warts, laryngeal papillomas (tumors that form on the larynx or other parts of the respiratory tract, and cancer of the cervix, vulva, vagina, penis, and anus. The Pink Book stated "HPV is transmitted by direct contact, usually sexual, with an infected person. Transmission occurs most frequently with sexual intercourse but can occur following nonpenetrative sexual activity." The CDC recommends all females between age 9 and 26, and all males between 9 and 21, should receive the HPV vaccination series, and males between 22 and 26 may receive the series unless contraindications exist. Individual #1's PCP, dated 5/7/13, documented a 15 year old male whose diagnoses included mild mental retardation, ODD, and IED. His record did not contain evidence an HPV vaccine series had been received or discussed with his physician. During an interview on 3/14/14 from 9:00 - 11:40 a.m., the RN stated Individual #1 had not received the HPV vaccine and she was not aware if the issue had been discussed with Individual #1's physician.	W 322		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382		

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

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2014
NAME OF PROVIDER OR SUPPLIER SOUTHWEST IDAHO TREATMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1660 ELEVENTH AVENUE NORTH NAMPA, ID 83607	
{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 382	<p>Continued From page 23</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 1 of 6 individuals (Individual #6) residing on the living unit. This resulted in the potential for harm in the event individuals accessed and ingested medication not intended for their use. The findings include:</p> <p>1. During a meal observation on 3/10/14 from 5:30 - 6:25 p.m., the following was observed:</p> <p>At 6:10 p.m. the LPN brought an unmarked paper cup to the kitchen area and placed it in an open cupboard where individuals' dinner dishes were being kept prior to the meal. The LPN then left the unit. The cup was observed to contain a brown substance as well as 3 small orange tablets with the marking "5" on each tablet. The cup remained on the open cupboard shelf until 6:25 p.m., at which time staff mixed the content of the paper cup into a plate of food and served the plate to Individual #6.</p> <p>During an interview at 6:25 p.m. on 3/10/14, DCS E said the paper cup contained two laxative medications. He said mixing the medications with food was the only way Individual #6 would take the medications. When asked, the staff said nursing would be contacted if Individual #6 did not eat all of the food the medication had been mixed with and it would be marked as a refusal.</p> <p>During an interview on 3/10/14 at 6:30 p.m., the facility LPN said the paper cup contained "only bowel prep meds." Individual #6's MAR showed the medications were Naturalax, Miralax, and</p>	W 382		

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W 382	Continued From page 24 Bisacodyl, all laxative medications. The LPN said he had already documented in the MAR that the medications had been taken. He also stated staff would let him know if Individual #6 did not take the medications but "history and experience" showed Individual #6 would take the medications. In an interview on 3/17/14 at 8:40 a.m., the facility RN said leaving medications unattended on the kitchen shelf was not acceptable.	W 382			
W 460	The facility failed to ensure all medications were maintained under locked conditions. 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure diet orders were followed for 1 of 4 individuals reviewed (Individual #4) who required a modified diet. This resulted in an individual not receiving a modified diet texture as ordered. The findings include: 1. Individual #4's 11/19/13 PCP stated he was a 49 year old male whose diagnoses included severe intellectual disability, seizure disorder, osteopenia, osteoarthritis, chronic right lung scarring and a "History of presumed dysphagia but tolerating mechanical soft diet well at the present time."	W 460			

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W 460	<p>Continued From page 25</p> <p>On 3/10/14 beginning at 5:20 p.m., Individual #4 was observed sitting at the dining room table. DCS A stood at the counter in the adjacent kitchen (open to the dining room) and spread a soft flour tortilla with a mix of spices, fried ground hamburger meat, diced onions, lettuce and tomatoes, rolled it into a burrito shape and placed it on a plate. DCS A identified the item as a taco and carried the plate to the dining table where he assisted Individual #4 in adding food to the plate from common bowls sitting on the table. The food in the common bowls consisted of boiled peas, boiled carrots and mashed potatoes. Individual #4 used a spoon to eat the peas, carrots and potatoes from his plate.</p> <p>Individual #4 picked up the taco and took bites from it, placing it back on the plate in between bites. He ate the entire taco. Individual #4 dined relatively independently, moving the food items to his mouth with his hands and a spoon for the small soft items (peas, carrots and potatoes). During the meal observation, DCS A did not cue or assist Individual #4 in cutting his taco into bite sized pieces.</p> <p>Individual #4's PCP included "Mealtime Guidelines," which stated "[Individual #4] receives a heart-healthy mechanical-soft diet with regular fluid consistency. He eats and drinks independently, however, he does require some assistance from staff to ensure that his food is cut up and that he eats at a slow pace to prevent choking." The "Instructions to Staff" section stated "Staff will cue [Individual #4] to cut his food into bite-sized pieces and provide assistance as needed."</p> <p>Individual #4's record included an X-Ray report,</p>	W 460		

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W 460	<p>Continued From page 26 dated 7/12/13, documenting "Choked on Medication, Question Aspiration."</p> <p>On 3/12/14 at 4:00 p.m., DCS B was interviewed regarding the observation on 3/10/14. DCS B said it would be acceptable for Individual #4 to be served a taco that was not cut into smaller pieces because Individual #4 had teeth and could chew up bites taken from a taco. He said "mechanical soft" could mean different things for different people, and that there was a notebook in the kitchen that identified more individualized details of prescribed diets for each individual. DCS B stated DCS C could answer additional questions as she was the staff member on duty who was most knowledgeable about altered textured diets.</p> <p>On 3/12/14 at 4:10 p.m., the special diet notebook maintained on a shelf in the kitchen of the facility was reviewed. The notebook contained a copy of Individual #4's "Mealtime Guidelines," dated 11/19/13, identical to the mealtime guidelines included in his PCP. No information was included documenting Individual #4 could to eat a taco or any other food that had not been altered in texture to mechanical soft or cut up into bite sized pieces.</p> <p>On 3/12/14 at 4:15 p.m., DCS C was interviewed regarding staff training and understanding of mechanical soft diets. DCS C reported all staff were trained on maintaining mechanical soft diets and all Mealtime Guidelines were supposed to be implemented at every meal and snack. She stated Individual #4 should not have been served a taco without it having been altered in texture to "mechanical soft." She described mechanical soft for a taco as "cut into dime sized pieces."</p>	W 460		

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W 460	<p>Continued From page 27</p> <p>On 3/12/14 at 4:30 p.m., an interview was initiated with the RN. The observation, interview and record review information identified above was shared with her. The RN verified the requirement for a mechanical soft diet for Individual #4 via computer. She verified it was not an acceptable practice for Individual #4 to be served and allowed to eat a taco which had not been cut into bite sized pieces.</p> <p>The facility failed to ensure Individual #4's meal texture requirements were followed.</p>	W 460			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure and complaint survey conducted from 3/10/14 - 3/17/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN Ashley Henscheid, QIDP Jim Troutfetter, QIDP Paul Rowe, QIDP	M 000		
MM168	16.11.03.075.07(a) Rights as a Citizen Rights as a citizen refer to all the rights of citizens of this country and any particular state or locality. These include, but are not limited to, voting, marriage, divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not practice a religion. This Rule is not met as evidenced by: Refer to W125.	MM168		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262 and W264.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		

RECEIVED
APR 11 2014
FACILITY STANDARDS

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

SBuettner Administrative Director 4/9/14

Bureau of Facility Standards

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MM678	16.03.11.250.08(c) Individual Resident's Needs Foods must be served in a form to meet individual resident's needs: This Rule is not met as evidenced by: Refer to W460.	MM678		
MM724	16.03.11.270.01(a) Assessments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225 and W259.	MM724		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by:	MM735		

Bureau of Facility Standards

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MM735	Continued From page 2 Refer to W322.	MM735		
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753		

April 9, 2014

Plan of Correction for Southwest Idaho Treatment Center, Provider #13G001
For survey completed *March 17, 2014*

<p>W125</p>	<p><i>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.</i></p> <p>POC: The facility will ensure that cooking and food preparation items are unlocked and clients have free access to them. Any restrictions or limitations to this would require due process including guardian consent and HRC approval.</p> <p>Supervisors will provide training to their staff that our clients have the right to free access to these types of items and that restriction of this access requires due process including guardian consent and HRC approval.</p> <p>CS Manager will do a monthly review/observation to ensure that clients have free access cooking and food preparation items. The results of this review/observation along with any corrective actions taken will be forwarded to the DD Program Manager. The DD Program Manager will compile a summary report each quarter which will include any additional concerns noted and any additional corrective actions that needed to be taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014.</p>
<p>W225</p>	<p><i>The comprehensive functional assessment must include, as applicable, vocational skills.</i></p> <p>POC: The vocational assessment for Individual #3 will be completed.</p> <p>The QIDP will review all clients' comprehensive functional assessments to ensure that all required sections are completed.</p> <p>DD Program Manager will complete quarterly record reviews for a sample client on each unit to ensure that objectives have been developed to meet all identified needs from the PCP. The DD Program Manager will complete a summary report of the reviews which includes any concerns noted and corrective action taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014</p>
<p>W227</p>	<p><i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c) (3) of this section.</i></p> <p>POC: The functional behavioral assessments for Individuals #1, #2, #3, and #5 will be revised and updated as needed.</p> <p>The QIDP will review all clients' assessments/PCPs to ensure that there are objectives to meet the needs or clear justification why an identified need was not prioritized.</p> <p>DD Program Manager will complete quarterly record reviews for a sample client on each unit to</p>

	<p>ensure that objectives have been developed to meet all identified needs from the PCP. The DD Program Manager will complete a summary report of the reviews which includes any concerns noted and corrective action taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014</p>
W259	<p><i>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</i></p> <p>POC: The functional behavioral assessments for Individuals #1, #2, and #6 will be revised and updated as needed.</p> <p>When a significant status change results in a program change or addition, the QIDP, during each monthly review will check the applicable client's assessment to ensure it has been updated to reflect the change.</p> <p>DD Program Manager will complete quarterly record reviews for a sample client on each unit to ensure that objectives have been developed to meet all identified needs from the PCP. The DD Program Manager will complete a summary report of the reviews which includes any concerns noted and corrective action taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014</p>
W 262	<p><i>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.</i></p> <p>POC: The team reviewed the issue of locked clothing for Individual #6 and has decided to return clothing to his room. If there are issues that arise, the team knows that he has a right to due process and before access can be restricted to his clothing that a program to do such needs to be developed and HRC approval needs to be obtained.</p> <p>The CS Manager will review all client restrictions and notify the QIDP to ensure that HRC approval has been obtained.</p> <p>DD Program Manager will complete quarterly record reviews for a sample client on each unit to ensure that all restrictive interventions have the appropriate approvals. The DD Program Manager will complete a summary report of the reviews which includes any concerns noted and corrective action taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014</p>
W263	<p><i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</i></p> <p>POC: The team reviewed the issue of locked clothing for Individual #6 and has decided to return clothing to his room. If there are issues that arise, the team knows that he has a right to due process and before access can be restricted to his clothing that a program to do such needs to be developed and written informed consent needs to be obtained</p> <p>The CS Manager will review all client restrictions and notify the QIDP to ensure that HRC approval has been obtained.</p>

	<p>DD Program Manager will complete quarterly record reviews for a sample client on each unit to ensure that all restrictive interventions have the appropriate approvals. The DD Program Manager will complete a summary report of the reviews which includes any concerns noted and corrective action taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014</p>
W264	<p><i>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</i></p> <p>POC: The facility will ensure that cooking and food preparation items are unlocked and clients have free access to them. Any restrictions or limitations to this or other common items would require due process including guardian consent and HRC approval.</p> <p>Supervisors will provide training to their staff that our clients have the right to free access to these types of items and that restriction of this access requires due process including guardian consent and HRC approval.</p> <p>CS Manager will do a monthly review/observation to ensure that clients have free access cooking and food preparation items. The results of this review/observation along with any corrective actions taken will be forwarded to the DD Program Manager. The DD Program Manager will compile a summary report each quarter which will include any additional concerns noted and any additional corrective actions that needed to be taken. The report will be submitted to the Administrator.</p> <p>Completion Date: May 15, 2014.</p>
W322	<p><i>The facility must provide or obtain preventative and general medical care.</i></p> <p>POC: Individual #1 HPV vaccination series was ordered on 3/20/14. He is scheduled to receive the first HPV vaccination (series of 3) on 4/7/14. Individual #7 has a Dexa scan scheduled for 4/17/14.</p> <p>Immunizations are currently tracked and current guidelines are to follow CDC recommendations. New admissions are screened for immunizations and added to our tracking mechanism (Excel spreadsheet). Nursing will ensure that each year, at the time of the individual's annual history and physical, the physician will be updated on current CDC recommended immunizations and this will be documented in the physician's note of the medical chart.</p> <p>All clients currently taking antiepileptic medications will be tracked and new admissions will be added to our tracking mechanism. New admissions will be added to the tracking mechanism. Nursing will ensure that each year, at the time of the individual's annual history and physical, the physician will be updated current recommendations related to bone density issues and screenings and this will be documented in the physician's note of the medical chart.</p> <p>QIDP will review recommendations from History and Physical to ensure follow-up.</p> <p>Completion Date: May 15, 2014.</p>
W382	<p><i>The facility must keep all drugs and biologicals locked except when being prepared for administration.</i></p> <p>POC: Immediate corrective action taken on 3/12/14 with the LPN involved with verbal counseling that it is unacceptable to leave medications out in a common area and that they are to be locked and/or under constant visual until they are administered to the client.</p>

	<p>Individual #6's self-administration of medication program was revised and includes specific instructions for staff to keep a constant visual on the person and on his prepared medications until they have been completely administered and/or wasted, if refused.</p> <p>RN will provide training for all nurses and medication certified staff on this expectation.</p> <p>Quarterly nursing observations (nursing to nursing and nursing to medication certified staff) observations will be completed which will include observing to ensure medications are kept locked between medication passes.</p> <p>RN will provide a quarterly report to the Administrator outlining the number of observations completed for the previous quarter and a summary what was done to address any issues identified in those observations.</p> <p>Completion Date: May 15, 2014.</p>
W460	<p><i>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</i></p> <p>POC: The facility will provide (at a minimum) yearly training to staff on what each of the diet textures (i.e., puree, mechanical soft, regular) entail and how to get food to that desired texture, along with how to modify diets for those who need it.</p> <p>The facility will add observations related to following prescribed diets to our Risk Management Observations. Staff doing the observations will provide direct support staff working with the clients just in time feedback and corrective action for issues they see.</p> <p>DD Program manager reviews the Risk Management Observations quarterly and provides a report to the Administrator on trends.</p> <p>Completion Date: May 15, 2014</p>
MM168	Refer to W125
MM194	Refer to W262 and W264
MM196	Refer to W263
MM678	Refer to W460
MM724	Refer to W225 and W259
MM729	Refer to W227
MM735	Refer to W322

MM753 Refer to W382 - open + make change per DD program manager.
by M. Case, MD @IDF



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 208-334-6826
FAX 208-364-1888

March 28, 2014

Susan Broetje, Administrator
Southwest Idaho Treatment Center
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Southwest Idaho Treatment Center, Provider #13G001

Dear Ms. Broetje:

On **March 17, 2014**, a complaint survey was conducted at Southwest Idaho Treatment Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006418

Allegation #1: An individual was able to injure themselves while on a suicide precautions and the failure of the staff to intervene was not reported as potential neglect as staff did not know how to report.

Findings #1: An on-site recertification and complaint survey was conducted from 3/10/14 - 3/17/14. During that time, observations were conducted, investigations and significant event reports were reviewed, and individual and staff interviews were conducted with the following results:

Observations were conducted across shifts throughout the survey for no less than a cumulative 20 hours and 13 minutes. During those times, no issues related to lack of staff supervision or intervention were observed.

The facility Abuse, Neglect and Mistreatment policy, dated 11/1/13, was reviewed. The policy stated allegations of abuse, neglect and mistreatment were to be immediately reported by calling switchboard.

Five individuals residing at the facility and various facility staff, including direct care staff across all shifts, para-professional and professional staff were interviewed on multiple occasions throughout the survey. None of the individuals or facility staff reported concerns that staff were not monitoring individuals during suicide precautions. Further, none of the individuals or facility staff reported concerns of not knowing how to report an allegation of abuse, neglect and/or mistreatment.

Additionally, the facility's significant event reports (SERs) from 12/1/13 to 3/17/14 and the facility's investigations from 8/5/13 - 3/17/14 were reviewed. The SERs and investigations included documentation of allegations of abuse, neglect, and mistreatment which were immediately reported and

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thoroughly investigated. None of the SERs or investigations included allegations of individuals not being properly monitored while on suicide precautions, or allegations of staff failing to intervene for individuals who were engaging in self injurious behavior while on suicide precautions.

Further, the facility's Suicide Precautions Policy, dated 1/22/14, stated any individual who made attempts or threatens to harm themselves were to be immediately placed on arm's length supervision. The policy stated if the individual attempted to engage in any dangerous behavior or retrieve a dangerous item, the staff were to immediately intervene, including physical restraining the individual if necessary.

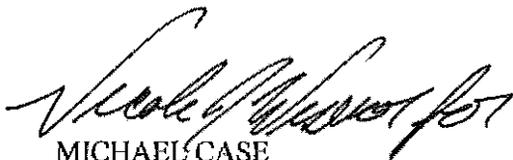
Facility records documented the policy was being implemented. For example, the facility's documentation showed only one individual was placed on suicide precautions on 3/17/14, after making threats to poison himself. The individual's room was cleared of all potentially harmful items and increased supervision was implemented in all areas where the individual was present. Additionally, suicide assessments were completed on 3/17/14 and 3/18/14. There was no documentation of injury or attempts at injury during that time the individual was on suicide precautions.

Therefore, due to a lack of sufficient evidence the allegation was unsubstantiated and no deficient practice was cited.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt