



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

May 13, 2014

Susan Broetje, Administrator  
Southwest Idaho Treatment Center - Kyler  
1660 11th Avenue North  
Nampa, ID 83687-5000

RE: Southwest Idaho Treatment Center - Kyler, Provider #13G081

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure survey of Southwest Idaho Treatment Center - Kyler, which was conducted on May 1, 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Susan Broetje, Administrator  
May 13, 2014  
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **May 25, 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](http://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 May 25, 2014. If a request for informal dispute resolution is received after May 25, 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,



ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pmt  
Enclosures



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTTER - Governor  
Richard M. Armstrong - Director

CHAD CARDWELL, Program Manager  
DIVISION OF FAMILY AND COMMUNITY SERVICES  
DEVELOPMENTAL DISABILITIES - NORTH HUB  
Timothy F. Voz - Clinical Supervisor  
1120 Ironwood Drive  
Coeur d'Alene, Idaho 83814  
PHONE: 208-665-6013 CELL: 208-277-7543  
FAX: 208-769-1473

May 28, 2014

Nicole Wisenor  
Program Supervisor  
Licensing and Certification  
P. O. Box 83720  
Boise, ID 83720-0036

RE: Southwest Idaho Treatment Center-Kyler, Provider 13G081

Dear Ms. Wisenor:

Enclosed is the Plan of Correction for the annual Southwest Idaho Treatment Center - Kyler licensure survey conducted on May 1, 2014.

Please feel free to contact me at 208-277-7543 with any questions.

Timothy F. Voz  
Clinical Supervisor  
Developmental Disabilities Crisis Prevention Team  
Acting Administrator  
SWITC/Kyler Residential Program

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MAY 28 2014  
FACILITY STANDARDS

**W 125 483.420 (a)(3) PROTECTION OF CLIENT RIGHTS**

Corrective Action: All knives have been removed from the locked cabinet and placed in locations where residents have access to use these items as needed.

Identify Others at Risk: This affected all individuals at the Kyler house and the corrective actions above will address the issue for them.

Changes Made: The CS Manager will review all interventions and evaluate for restrictive interventions/procedures. HRC approval will be obtained for all restrictive interventions/procedures.

Monitoring: The CS Manager will review (when doing monthly progress reviews) all interventions utilized by the facility to ensure that client rights are protected and HRC approval has been obtained for restrictive interventions.

Completion Date: May 27, 2014

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MAY 28 2014

**W 129 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS**

**FACILITY STANDARDS**

Corrective Action: All clients will be provided complete privacy while taking their medications.

Identify Others at Risk: All Kyler clients taking medications are at risk for privacy violations during medication administration times without a clearly defined process for communication that a medication pass is in progress.

Changes made: The facility will ensure that all Medication Certified Staff are trained in providing privacy to all of our clients while taking medications. "Privacy" signs have been made and will be placed on the outside of each of the medication room doors to alert other individuals that a medication pass is in progress. Individuals will go around to the front door of the home to enter or exit while the "Privacy" sign is in place.

Monitoring: The LPN/RN will review the practice of placing the "Privacy" signs during quarterly and as needed medication observations to ensure privacy of all clients during medication pass times. Additional staff training will be provided as needed during actual medication pass/observations to ensure proper use of "Privacy" signs.

Completion Date: Privacy signs put into place immediately. Staff training on privacy and use of "Privacy signs" will be provided as needed for current and new Medication Certified Staff members.

**W 154 483.420 (d)(3) STAFF TREATMENT OF CLIENTS**

Corrective Action: The incident was investigated. All staff were re-trained on the Abuse Prevention policy at a staff meeting on 5/22/14. CS Manager will review all allegations to determine if they meet criteria for investigation per policy and conduct a thorough investigation following the investigation protocol.

Identify Others at Risk: This had the potential to affect all individuals at the Kyler house and the corrective actions above will address the issue for them.

Changes Made: All staff were re-trained on the Kyler Abuse Prevention policy.

Monitoring: The CS Manager will review all allegations per policy and conduct investigations if they meet the criteria for abuse or neglect.

Completion Date: May 22, 2014

### **W 227 483.440 (c)(4) INDIVIDUAL PROGRAM PLAN**

Corrective Action: The Comprehensive Functional Assessment, Person Centered Plan, and Behavior Reporting Forms will be updated and revised to ensure objectives are written and address maladaptive behaviors and meet the needs of the individual.

Identify Others at Risk: All residents at the Kyler House had the potential to be affected by the deficient practice. CFA's, PCP's and BRF's for all individuals will be reviewed and updated to meet their needs.

Changes Made: The DSS revised the CFA, PCP and BRF. Objectives were added to the individuals plan to address the maladaptive behaviors stated in the CFA, PCP, and BRF.

Monitoring: The DSS will monitor each individual's files to ensure information is current and addressing the needs of the individual.

Completion Date: May 21, 2014

### **W 259 483.440 (f)(2) PROGRAM MONITORING AND CHANGE**

Corrective Action: The Comprehensive Functional Assessment will be reviewed and revised to meet the current needs of the individual. The PCP and BRF will also be reviewed and revised to reflect the updated CFA.

Identify Others at Risk: All residents at the Kyler House may be affected by the deficient practice.

Changes Made: The DSS reviewed individual #1's files and removed the PRN, food hoarding and fecal manipulation references. The CFA was updated. The PCP and BRF were revised to meet the current needs of the individual reported on the updated CFA.

Monitoring: The DSS will monitor each individual's files and ensure documents are updated when client's needs change.

Completion Date: May 21, 2014

**W 264 483.440 (f)(3)(iii) PROGRAM MONITORING AND CHANGE**

Corrective Action: All knives have been removed from the locked cabinet and placed in locations where residents have access to use these items as needed.

Identify Others at Risk: This affected all individuals at the Kyler house and the corrective actions above will address the issue for them.

Changes Made: The CS Manager will review all interventions and evaluate for restrictive interventions/procedures. HRC approval will be obtained for all restrictive interventions/procedures.

Monitoring: The CS Manager will review (when doing monthly progress reviews) all interventions utilized by the facility to ensure that HRC approval has been obtained for restrictive interventions.

Completion Date: May 27, 2014

**W290 483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR**

Corrective Action: The Intervention Plan will be reviewed and updated to ensure the plan meets the current needs of the individual.

Identify Others at Risk: All residents at the Kyler House may be affected by the deficient practice and their files will be reviewed to ensure information is current.

Changes Made: The DSS reviewed the Intervention Plan and removed the physical restraint from the plan. Other documents were also reviewed to ensure they were current.

Monitoring: The DSS will monitor documents and ensure they are updated and address the current needs of the individual.

Completion Date: May 21, 2014

**W 312 483.450(e)(2) DRUG USAGE**

Corrective Action: The Medication Management Plan for individual #1 will be updated to ensure that criteria for medication increase and reductions are directly correlated to the behaviors for which the drugs were prescribed.

The YMRS score tracking has been removed from the Medication Management Plan for individual #1.

Identify Others at Risk: All clients' Medication Management Plans will be reviewed to ensure that all behavior modifying drugs are used only as a comprehensive part of the individuals' PCP that is directed specifically towards the reduction or eventual elimination of the behaviors for which the drugs were prescribed.

Changes Made: It will be the facility protocol for the Pharmacist to review the Medication Management Plan to ensure that information is accurate and that all behavior modifying drugs

are used only as a comprehensive part of the individuals' PCP that is directed specifically towards the reduction or eventual elimination of the behaviors for which the drugs were prescribed.

Monitoring: Any time there is a change or addition in medication, the Medication Plan will be written and reviewed by the Pharmacist to ensure that all behavior modifying drugs are used only as a comprehensive part of the individuals' PCP that is directed specifically towards the reduction or eventual elimination of the behaviors for which the drugs were prescribed.

Completion Date: 6/6/14

#### **W 361 483.460(i) PHARMACY SERVICES**

Corrective Action: All medication orders have been started.

Identify Others at Risk: This had the potential to affect all individuals at the Kyler house and the corrective actions above will address the issue for them.

Changes Made: All prescribed drugs and biologicals will be provided as prescribed. Orders will clearly define when the medication or treatment will start. If a medication or treatment is unable to be obtained by pharmacy or implemented by the specified start date, the physician will be notified.

Monitoring: The LPN will review all new orders and ensure that medications and treatments are received from pharmacy and implemented as prescribed.

Completion Date: Immediately (May 13, 2014)

#### **MM 167 16.03.11.075.07 EXERCISE OF RIGHTS**

Refer to W125

#### **MM 170 16.03.11.075.07 (b)(ii) METHOD FOR INVESTIGATING GRIEVANCES**

Refer to W154

#### **MM 191 16.03.11.075.09 (c) LAST RESORT**

Refer to W290

#### **MM 194 16.03.11.075.10 (a) APPROVAL OF HUMAN RIGHTS COMMITTEE**

Refer to W264

#### **MM 197 16.03.11.075.10 (d) WRITTEN PLANS**

Refer to W312

#### **MM 203 16.03.11.075.12 (a) TREATED WITH CONSIDERATION**

Refer to W129

**MM 380 16.03.11.120.03 (a) BUILDING AND EQUIPMENT**

Corrective Action: A flooring specialist assessed the state of the linoleum and tile at Kyler on May 20<sup>th</sup>, 2014. The landlord will be replacing the flooring on both sides. All windows were checked and screens replaced. The couch will be fixed or replaced.

Identify Others at Risk: This affected all individuals at the Kyler house and the corrective actions above will address the issue for them.

Changes Made: A building checklist will be developed to ensure the building and equipment are kept in good repair. Kyler lead staff or night shift staff will complete this check weekly or as issues arise.

Monitoring: The CS Manager will review the building checklist each week and work with the landlord to ensure items are replaced or repaired in a timely manner.

Completion Date: June 28, 2014

**MM 724 16.03.11.270.01 (a) ASSESSMENTS**

Refer to W259

**MM 729 16.03.11.270.01 (d) TREATMENT PLAN OBJECTIVES**

Refer to W227

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

PRINTED: 05/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - KYLER			STREET ADDRESS, CITY, STATE, ZIP CODE 1182 WEST KYLER AVENUE HAYDEN, ID 83835	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey conducted from 4/28/14 to 5/1/14.  The survey was conducted by: Ashley Henschel, QIDP, Team Leader Trish O'Hara, RN  Common abbreviations used in this report are: BRF - Behavior Reporting Form CFA - Comprehensive Functional Assessment CS - Client Service DSS - Disabilities Specialist Senior ER - Extended Release HRC - Human Rights Committee LWOP - Leaving Without Permission PCP - Person Centered Plan PRN - As needed RN - Registered Nurse YMRS - Young Mania Rating Scale	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in implementation of blanket	W 125		

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: A. Bloetje TITLE: ADMINISTRATIVE DIRECTOR (X6) DATE: 5/28/14

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 125	Continued From page 1 restrictions to individuals' knives, not based on individual need, and without assuring due process protections. The findings include:  1. The facility was comprised of two sides: Side A, which housed Individual #1, Individual #4 and Individual #5 and Side B, which housed Individual #2 and Individual #3. An environmental review was conducted on Side A with the CS Manager and on Side B with the DSS on 4/29/14 from 10:40 - 11:45 a.m. At that time, knives were observed to be inside of a closed plastic container on the top shelf of a cabinet in each (Side A and Side B) laundry room. The cabinets where the knife containers were stored were both observed to be kept locked.  When asked, during the environmental review, the CS Manager stated she was not sure why the knives were locked.  Individual #1 - #3's records were reviewed on 4/30/14. No documentation related to the knife restriction could be found.  During an interview on 4/30/14 from 3:15 - 3:42 p.m., the CS Manager stated the facility restricted access to knives without determining individual need for the restriction, without attempting training, 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 was ensured.	W 125			
W 129	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS	W 129			

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W 129	<p>Continued From page 2</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure privacy was provided for 2 of 3 individuals (Individuals #2 and #3) who were observed receiving medications. This resulted in individuals' right to privacy being violated. Findings include:</p> <p>The facility was constructed as a duplex with 3 females residing on Side A and 2 males residing on Side B. Food items, utensils, and sensory items were shared by both sides of the building. Individuals and staff accessed both sides of the building through the co-joined garages between the two sides. The garages had doors, without locks, into the laundry areas of each side. These laundry areas were also used for medication administration.</p> <p>Medication administration was observed for Individual #2 on 4/28/14 at 3:00 p.m., and again on 4/29/14 from 6:00 - 6:30 a.m. for Individuals #2 and #3. During both observations, medication administration was interrupted by staff or other individuals entering the medication administration area through the garage door.</p> <p>In an interview on 4/29/14 from 10:40 - 11:45 a.m., the CS Manager said medication administration staff were to verbally alert persons attempting to enter, that the medication administration area was in use.</p>	W 129			

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W 129	Continued From page 3 However, observations showed this process to be ineffective in maintaining privacy during medication administration.	W 129			
W 154	The facility failed to ensure privacy during medication administration for individuals #2 and #3. 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure a thorough investigation was conducted for all allegations of abuse. This failure directly impacted 1 of 3 individuals (individual #1) for whom allegations had occurred, and had the potential to impact all of the individuals (individuals #1 - #5) residing in the facility. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include:  1. The facility's abuse policy, titled Abuse Prevention, dated 3/5/13, stated upon receiving an allegation meeting the criteria for investigation, the Lead Investigator would "Conduct a thorough investigation following the investigation protocol..." The policy defined general abuse as "ill-treatment, violation, revilement, malignment, exploitation, and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator. Abuse includes, but is not limited to, physical abuse, sexual abuse, psychological	W 154			

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W 154	Continued From page 4 (mental) abuse, and exploitation." Additionally, examples of psychological abuse included "Inappropriate screaming or yelling at a client."  Individual #1's PCP, dated 12/17/13, documented a 15 year old female whose diagnoses included mild intellectual disability and mood disorder.  Individual #1's BRFs from 12/2013 - 4/29/14 were reviewed. Her data included a BRF, dated 3/6/14. The "B: Behavior" section documented Individual #1 "stated 'Please take me to school. I don't want to get yelled at by [bus aide name].'" Further, the form documented Individual #1 stated "I hate [bus aide name] - I'm never riding the bus again - she's abusive'." However, there was no evidence the allegation was investigated per policy.  During the entrance conference on 4/28/14 at 11:00 a.m., the Acting Administrator stated the CS Manager conducted the investigations and he reviewed them.  During an interview on 4/30/14 at 4:55 p.m., the Acting Administrator stated he had been notified of Individual #1's allegation related to the bus aide. When asked, the CS Manager stated in an interview on 4/30/14 from 2:38 - 2:42 p.m., the allegation met the criteria for investigation, however, a formal investigation was not conducted.	W 154		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  The individual program plan states the specific	W 227		

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W 227	<p>Continued From page 5</p> <p>objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</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 an individual's PCP included objectives to meet their needs for 1 of 3 individuals (Individual #1) whose PCPs were reviewed. This resulted in a lack of program plans designed to address the needs of an individual. The findings include:</p> <p>1. Individual #1's PCP, dated 12/17/13, documented a 15 year old female whose diagnoses included mild intellectual disability and mood disorder.</p> <p>Individual #1's CFA for behavior, dated 12/2013, documented she engaged in maladaptive behaviors which included throwing objects, verbal assault, and obscene language. However, Individual #1's PCP did not contain objectives related to the behaviors.</p> <p>Individual #1's BRF's related to the identified behaviors, from 2/2014 - 4/29/14, were reviewed. The "PCP specific or Other" section of Individual #1's BRF included space for tracking maladaptive behaviors, including the following: throwing objects, verbal assault and obscene language. The data documented Individual #1 engaged in the maladaptive behaviors, no less than, as follows:</p> <p>February: Throwing objects: 4</p>	W 227			

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W 227	Continued From page 6 Verbal assault: 0 Obscene language: 10  March: Throwing objects: 8 Verbal assault: 10 Obscene language: 30  April: Throwing objects: 3 Verbal assault: 2 Obscene language: 22  When asked, the CS Manager stated during an interview on 5/1/14 from 8:10 - 10:00 a.m., objectives related to the specified maladaptive behaviors had not been created. She stated the PCP needed revised to include objectives for throwing objects, verbal assault and obscene language.  The facility failed to ensure objectives were developed to meet individual #1's behavioral needs.	W 227			
W 269	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 record review and staff interview, it was determined the facility failed to ensure behavior assessments contained updated information for 1 of 3 individuals (Individual #1) whose behavior assessments were reviewed.	W 259			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/01/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - KYLER			STREET ADDRESS, CITY, STATE, ZIP CODE 1182 WEST KYLER AVENUE HAYDEN, ID 83836		
(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 259	<p>Continued From page 7</p> <p>This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #1's PCP, dated 12/17/13, documented a 15 year old female whose diagnoses included mild intellectual disability and mood disorder.</p> <p>Individual #1's CFA for behavior, dated 12/2013, documented she engaged in maladaptive behaviors which included assault, destruction of property, injury to self, LWOP, throwing objects, food hoarding, verbal assault, obscene language and fecal manipulation. However, the assessment did not include updated information as follows:</p> <p>a. Individual #1's assessment documented she utilized a PRN psychotropic medication "when she becomes so anxious/agitated that she cannot be redirected with less intrusive methods." However, Individual #1's record contained a Physician's Order, signed 2/21/14, which documented the PRN medication had been discontinued.</p> <p>During an interview on 5/1/14 from 8:10 - 10:00 a.m., the CS Manager confirmed the PRN medication was no longer in use as the behavior assessment indicated.</p> <p>b. Individual #1's assessment documented maladaptive behaviors specific to Individual #1 included food hoarding and fecal manipulation. However, Individual #1's BRFs, from 12/2013 - 4/29/14, were reviewed and documented Individual #1 had zero instances of food hoarding or fecal manipulation.</p>	W 259			

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - KYLER			STREET ADDRESS, CITY, STATE, ZIP CODE 1162 WEST KYLER AVENUE HAYDEN, ID 83835		
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W 259	Continued From page 8	W 259			
W 264	<p>When asked, during an interview on 5/1/13 from 8:10 - 10:00 a.m., the CS Manager stated the behaviors were not being exhibited and the assessment needed updated.</p> <p>The facility failed to ensure Individual #1's CFA contained updated information on which to base program decisions.</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE</p> <p>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.</p> <p>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 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in access to knives being restricted without an identified cause. The findings include:</p> <p>1. The facility was comprised of two sides: Side A, which housed Individual #1, Individual #4 and Individual #5 and Side B, which housed Individual #2 and Individual #3. An environmental review was conducted on Side A with the CS Manager</p>	W 264			

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - KYLER			STREET ADDRESS, CITY, STATE, ZIP CODE 1102 WEST KYLER AVENUE HAYDEN, ID 83835		
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W 264	Continued From page 9 and on Side B with the DSS on 4/29/14 from 10:40 - 11:45 a.m. At that time, knives were observed to be inside of a closed plastic container on the top shelf of a cabinet in each (Side A and Side B) laundry room. The cabinets where the knife containers were stored were both observed to be kept locked.  When asked, during the environmental review, the CS Manager stated she was not sure why the knives were locked.  Individual #1 - #3's records were reviewed on 4/30/14. No evidence existed of the HRC's review of the facility practice to restrict access to knives.  During an interview on 4/30/14 from 3:15 - 3:42 p.m., the CS Manager stated the facility restricted all individuals' access to knives without review and approval from the HRC.  The facility failed to ensure all practices resulting in potential rights violations were reviewed and approved by the HRC.	W 264			
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  Standing or as needed programs to control inappropriate behavior are not permitted.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were removed as soon as they were determined to be unnecessary for 1 of 3 individuals (individual #1) whose restrictive	W 290			

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W 290	<p>Continued From page 10</p> <p>interventions were reviewed. This resulted in physical restraints being incorporated into an individual's behavior plan and not being used since her admission to the facility. The findings include:</p> <p>1. Individual #1's PCP, dated 12/17/13, documented a 15 year old female whose diagnoses included mild intellectual disability and mood disorder.</p> <p>Individual #1's Intervention Plan, dated 12/17/13, documented she engaged in assault (defined as an intentional physical action to another person which caused injury or would be perceived as painful), property destruction (defined as intentionally breaking or destroying property), injury caused by self (defined as an intentional self-inflicted injury or a hit to oneself which would be perceived as painful) and LWOP (defined as leaving an area without permission).</p> <p>The Intervention Plan documented if Individual #1 was escalating (defined as yelling, cursing, throwing items, slamming doors, posturing or reddening in the face) and "is in a group situation and her behaviors continue to escalate," staff were to engage Individual #1 in a transport restraint to a safe area. The plan also documented if Individual #1 engaged in assault or injury to self, staff were authorized to use a team control restraint. In an email, dated 5/1/14 and timed 7:14 p.m., the CS Manager stated the transport and team control restraints were incorporated into Individual #1's Intervention Plan on 2/28/13.</p> <p>On 4/30/14 at 12:30 p.m., information related to past restraint use was requested from the CS</p>	W 290			

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W 290	Continued From page 11 Manager. On 5/6/14, the CS Manager produced a BRF, dated 2/13/13, which she stated was documentation of the last restraints used with individual #1. The BRF documented individual #1 was restrained five times, all on 2/13/13, with emergency team control restraints in response to individual #1's assault and injury to self. Individual #1 had not been restrained since.  In an email dated 5/6/14 and timed 4:27 p.m., the CS Manager stated in general, restraints are removed from plan if they have not been used in 6 months. She stated the restraints were inadvertently left in individual #1's Intervention Plan due to clerical error.  The facility failed to ensure physical restraints were removed from individual #1's Intervention Plan as soon as they were determined to be unnecessary.	W 290			
W 312	483.450(a)(2) DRUG USAGE  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' PCPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3	W 312			

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - KYLER			STREET ADDRESS, CITY, STATE, ZIP CODE 1182 WEST KYLER AVENUE HAYDEN, ID 83835		
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W 312	<p>Continued From page 12</p> <p>individuals (individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified drug usage and how they may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's PCP, dated 12/17/13, documented a 15 year old female whose diagnoses included mild intellectual disability and mood disorder.</p> <p>Individual #1's Medication Management Plan, undated, documented she received 400 mg of Seroquel (an antipsychotic drug), 400 mg of Lamictal (an anticonvulsant drug) and 0.2 mg of Clonidine (an antihypertensive drug) daily for mood disorder as exhibited by maladaptive behaviors including injury to self.</p> <p>However, Individual #1's plan for Seroquel, Lamictal and Clonidine did not include increase or reduction criteria for the drugs as they related to their effects on injury to self behavior.</p> <p>When asked, the Pharmacist stated during an interview on 4/30/14 from 8:10 - 9:30 a.m., the drugs were not prescribed for injury to self behavior and the Medication Management Plan would be updated.</p> <p>Additionally, Individual #1's plan for Seroquel documented the drug would be considered for an increase "if physical assaults greater than twenty-five (25) per month...and YMRS score greater than thirty (30) per month" and the Medication Management Plan for Lamictal documented it would be considered for an increase "if physical assaults greater than thirty</p>	W 312			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/01/2014
NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - KYLER			STREET ADDRESS, CITY, STATE, ZIP CODE 1162 WEST KYLER AVENUE HAYDEN, ID 83835		
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W 312	Continued From page 13 (30) per month...or YMRS score greater than thirty-five (35) per month." The plan for Lamictal also documented the drug would be considered for a reduction when Individual #1 received a "YMRS score less than eight (8) per month for ten (10) consecutive months or evidence of adverse drug reaction."  However, Individual #1's record did not contain any YMRS scales.  When asked, the Pharmacist stated during an interview on 4/30/14 from 8:10 - 9:30 a.m., the YMRS scales were not being completed and as written, Individual #1 would not be able to meet her drug change criteria for Lamictal or Seroquel.  The facility failed to ensure comprehensive, accurate medication reduction plans were in place for each of Individual #1's behavior modifying drugs.	W 312			
W 361	483.460(i) PHARMACY SERVICES  The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the provision of routine drugs and biologicals was maintained for 3 of 3 Individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in individuals not consistently receiving	W 361			

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W 361	<p>Continued From page 14</p> <p>scheduled drugs and biologicals due to unavailability. The findings include:</p> <p>1. The facility utilized the back of the medication administration record to document medications not received and the reason they were not received. This was done by noting the date, time, medication, comment, and staff initials.</p> <p>Additionally, the front of the medication administration record was also used to document whether or not medications were received. Medication received was noted by staff initialing in the appropriate time slot for a medication. If the medication was not given, staff initialed the time slot and circled their initials.</p> <p>a. Individual #1 - #3's records documented medication changes which were not implemented as follows:</p> <p>- Individual #1's record included a Physician's Order, dated 4/25/14, which documented Individual #1's Trazodone (an antidepressant drug) was to be increased from 25 mg each evening to 50 mg each evening for fourteen days, when available. The order documented after the fourteen day period Individual #1's Trazodone was to increase to 100 mg daily.</p> <p>However, Individual #1's medication administration record, dated 4/20/14, was reviewed and documented as of 4/30/14, Individual #1 continued to receive Trazodone 25 mg daily.</p> <p>- Individual #2's record included a Physician's Order, dated 4/25/14, ordering Risperdal (an anti-psychotic drug) to be decreased from 3 mg</p>	W 361			

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W 361	<p>Continued From page 15</p> <p>twice a day to 2 mg in the morning and 3 mg in the evening, when available. As of 4/30/14, Individual #3's medication administration record documented he continued to receive Risperdal 3 mg twice a day.</p> <p>- Individual #3's record included Physician's Orders, dated 4/25/14, ordering Depakote ER (an anti-epileptic drug) to be decreased from 1500 mg daily to 750 mg daily, when available. As of 4/30/14, Individual #3's medication administration record documented he continued to receive Depakote ER 1500 mg daily.</p> <p>During an interview from 8:10 - 9:30 a.m. on 5/1/14, the RN stated while there was no written protocol related to filling prescriptions, the changes in orders should have been initiated in a more timely manner.</p> <p>b. Individual #3's record documented topical medication which was not administered due to a lack of availability as follows:</p> <p>- Individual #3's record included Physician's Orders, dated 3/5/14, for Benzoyl Peroxide 5% face wash (an acne drug). The face wash was to be used on affected areas twice a day.</p> <p>Individual #3's medication administration record, dated 3/5 - 3/31/14, was reviewed. The record for the face wash included circled initials from 3/5/14, night shift, through 3/11/14, morning shift. The back of the medication administration record documented the circled initials indicated that the face wash was not administered because the medication was "not available."</p> <p>- Individual #3's record included Physician's</p>	W 361		

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W 361	<p>Continued From page 16</p> <p>Orders, dated 3/4/14, for Benzoyl Peroxide 5% gel (an acne drug) face wash. The gel was to be applied to affected areas at bedtime after washing and patting dry.</p> <p>Individual #3's medication administration record, dated 3/5 - 3/31/14, was reviewed. The record for the gel included circled initials on 3/5/14, as well as from 3/7/14 through 3/10/14. The back of the medication administration record documented the circled initials indicated that the gel was not administered because the medication was "not available."</p> <p>The medication administration record for 3/6/14 was blank, however, the reverse side of the record documented "Benzoyl peroxide gel not available."</p> <p>During an interview from 8:10 - 9:30 a.m. on 5/1/14, the RN stated while there was no written protocol related to filling prescriptions, the changes in orders should have been initiated in a more timely manner.</p> <p>The facility failed to ensure all drugs and biologicals were provided as prescribed.</p>	W 361			

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensure survey conducted from 4/28/14 to 5/1/14.  The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Trish O'Hara, RN	M 000		
MM167	16.03.11.075.07 Exercise of Rights  Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal.  This Rule is not met as evidenced by: Refer to W125.	MM167		
MM170	16.03.11.075.07(b)(ii) Method for Investigating Grievances  The facility must have a written procedure for registering and resolving grievances and recommendations by residents or any individual or group designated by the resident as his representative. The procedure must ensure protection of the resident from any form of reprisal or intimidation. The written procedure must include: A method for investigating and assessing the validity of a grievance or recommendation; and  This Rule is not met as evidenced by:	MM170		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*ABlock*

ADMINISTRATIVE DIRECTOR

5/28/14

Bureau of Facility Standards

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MM170	Continued From page 1 Refer to W154.	MM170		
MM191	16.03.11.075.09(a) Last Resort  Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy.  This Rule is not met as evidenced by: Refer to W290.	MM191		
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 W264.	MM194		
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 W312.	MM197		
MM203	16.03.11.075.12(a) Treated with Consideration  Treated with consideration, respect, and full	MM203		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM209	Continued From page 2  recognition of his dignity and individually, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W129.	MM209		
MM380	16.03.11.120.03(a) Building and Equipment  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. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. The facility was designed as a duplex, with 3 females residing on Side A and 2 males residing on Side B.  During an environmental review, conducted with the CS Manager on 4/30/14 from 10:40 - 11:45 a.m., the following was noted:  On Side A:  - The linoleum in the dining area was bubbled up in numerous places.  On Side B:	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO TREATMENT CENTER - K	STREET ADDRESS, CITY, STATE, ZIP CODE 1182 WEST KYLER AVENUE HAYDEN, ID 83836
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 3  - The linoleum in the dining area was bubbled up in numerous areas. - The linoleum in front of the refrigerator was torn in two places. - The tile was broken in the doorway to Individual #2's bedroom. - There was no screen on Individual #2's bedroom window. - There was no screen on the window in the bathroom on the west side of the facility. - The top rail of the frame of the couch in the living area was broken.  The facility failed to ensure environmental repairs were maintained.	MM380		
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 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		