



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
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May 8, 2014

Bridger Fly, Administrator
Communicare, Inc #3 Pond
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #3 Pond, Provider #13G010

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #3 Pond, which was conducted on May 6, 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

Bridger Fly, Administrator
May 8, 2014
Page 2 of 2

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 21, 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.

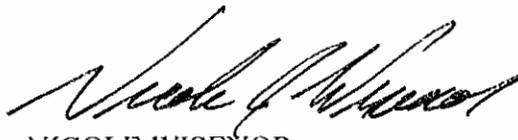
This request must be received by May 21, 2014. If a request for informal dispute resolution is received after May 21, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #3 POND			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 SOUTH POND BOISE, ID 83705	
(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 4/29/14 - 5/6/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Karen Marshall, MS, RD, LD Common abbreviations used in this report are: DCS - Direct Care Staff HPV - Human Papilloma Virus ILW - Instructional Lead Worker IPP - Individualized Program Plan LPN - Licensed Practical Nurse NPO - Nothing by mouth QIDP - Qualified Intellectual Disabilities Professional	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 and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in implementation of blanket restrictions to access to food and the kitchen, not based on individual need, and without assuring due process	W 125	The citation begins with following statements: "... the facility must allow and encourage individual clients to exercise their rights as clients of the facility, as citizens of the United States, including the right to file complaints, and the right to due process." "... This resulted in implementation of blanket restrictions to access to food and the kitchen, not based on individual need, and without assuring due process." Before specifying corrective actions there are a number of factors that collectively have resulted in the situation observed by surveyors that we would like to clarify.	07/06/14

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MAY 23 2014
FACILITY STANDARDS

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

[Signature] Administrator 5/23/2014

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 protections. The findings include: 1. Observations were conducted at the facility on 4/29/14 and 4/30/14. Individuals were denied access to the kitchen, as follows: a. An observation was conducted at the facility on 4/29/14 from 3:50 - 4:50 p.m. Upon entering the facility, two rolling utility carts were noted in the dining room by the kitchen. One had fabric covers on the sides, and the second had open shelves. The cart with open shelves was positioned at the end of the counter between the kitchen and dining room, blocking the entrance to the kitchen. A curtain was hung in the other entrance between the kitchen and the living room. All individuals had just arrived from their day programs and were placing their lunch bags on the counter between the kitchen and dining area. None of the individuals were observed to enter the kitchen. At 4:05 p.m., the ILW asked all individuals to sit down at the dining room tables to engage in a coloring activity. At 4:25 p.m., Individual #5 stood up from the table and walked to the counter between the dining area and the kitchen. Individual #5 picked up a plastic container that was sitting on the counter. While still standing in the dining area, Individual #5 tossed the plastic container into the kitchen sink. The cart remained blocking the entrance to the kitchen. A direct care staff asked Individual #5 to sit down and continue coloring. At 4:30 p.m., a direct care staff pushed the open sided cart into the kitchen and blocked the	W 125	1) Three individual's living at CCI #3 (Individuals #1, #3, and #5) have well documented issues related to taking either eating foods not included on their diets and/or ingesting food items that might be harmful to them. All of these individuals who have this issue addressed in their Behavior Management/ Support Plans (BMPs). 2) Individual #3 who most recently moved into this location is diagnosed with Prader-Willi disorder and his focus on procuring and eating foods is problematic. 3) Please note that prior to this individual's admission to this location, food management procedures designed for Individual #1 and #5 had not recently been identified by annual survey teams as "restrictive" in nature. 4) Individual #3 ingestion food items such as frozen food, uncooked food, and cans of food (he also takes can openers from the kitchen to open such food) and any other types of available food is ongoing and modification of this type of behavior has been only partially successful. He is very sophisticated about food procurement and is also very opportunistic. Possible methods of managing this behavior have been repeatedly discussed. One-to-one staffing is not needed for skills development; locking kitchen cupboards is an option but this is a restrictive measure we have not		

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W 125	<p>Continued From page 2</p> <p>entrance with the cloth sided cart. The direct care staff placed plastic cups and napkins onto the open sided cart, then placed plastic baggies with rice crackers and a container of juice on the shelf of the cloth covered cart. The direct care staff then moved the carts into the dining area while a second staff stood blocking the entrance to the kitchen.</p> <p>Individual #2 attempted to enter the kitchen and the staff blocking the entrance told him to sit at the table.</p> <p>Individuals #1 - #6 were then instructed, one by one, to get up and get a cup and napkin off the open sided cart. Once all the individuals were seated with cups and napkins, a direct care staff handed everyone but Individual #7 a baggie of rice crackers. Individual #7 was NPO and received all nutrition through a g-tube (gastrostomy tube - a tube inserted through the abdominal wall into the stomach).</p> <p>At 4:45 p.m., Individual #6 finished his snack and took his cup to the kitchen entrance. The ILW instructed a direct care staff to move the cart so Individual #6 could place his cup in the sink. Individuals #1 - #5 were instructed to leave their cups on the counter between the dining room and kitchen. A direct care staff stood at the end of the counter between the dining area and the kitchen, preventing individuals from entering the kitchen.</p> <p>b. An observation was conducted at the facility, on 4/29/14 from 5:25 - 6:55 p.m. Upon entering the facility, the cloth covered utility cart was noted to be blocking the entrance between the kitchen and the dining area. A direct care staff was in the kitchen preparing diner.</p>	W 125	<p>chosen to pursue. Locking up foods during sleeping hours is an option we did chose and this has had the most success.</p> <p>5) Due to the floor plan of this location it is not possible for staff to monitor then intervene related to food stealing unless they are actually located in the kitchen.</p> <p>6) Over the past year our attempts to manage Individual #3's access to food probably has resulted in procedures which can be viewed as restrictive. However, we would argue that these have developed in response to a very complex set of circumstances, have "morphed" into some procedures which do need to be reevaluated but that they developed in response to the needs primarily of Individual #3 and secondarily to the needs of Individuals #1 and #5.</p> <p>7) Our attempt at using "House Rules" to help us with the management of the issues identified has backfired as these have become rigid procedures rather and management guidelines.</p> <p>8) As to the issue of due process this citation is confusing as access to the kitchen and available food is not specified as a right either by ICF/ID listing of rights or by the listing of constitutional rights.</p>	

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W 125 Continued From page 3

At 5:30 p.m., Individual #5 went to the counter between the dining area and the kitchen, near the cart that was blocking the entrance. The direct care staff in the kitchen instructed Individual #5 to go sit down. Individual #1 then went to the counter between the dining area and kitchen and was also instructed to go and sit down.

At 5:50 p.m., Individual #5 went back to the counter between the dining room and kitchen. A direct care staff asked if he would like some water then instructed him to sit down. The cart remained blocking the entrance to the kitchen.

At 6:10 p.m., a direct care staff moved the open sided cart into the kitchen and placed plates, cups, silverware, and napkins on the cart, then moved it into the dining area against the wall. The staff positioned the cloth covered cart to block the entrance to the kitchen.

At 6:10 p.m., Individual #5 stood by the kitchen entrance. A direct care staff told him to sit down.

At 6:20 p.m., direct care staff began instructing individuals to wash their hands for diner. After washing their hands, individuals were instructed to get place settings from the open sided cart and sit at the table.

At 6:35 p.m., a direct care staff brought food from the kitchen on the cloth covered cart to the dining area.

Once the meal was completed, individuals were observed to clear their place settings to plastic containers sitting on the table.

W 125

Neither the kitchen nor the food available are "individual possessions" as defined in regulation but we understand both of these should be available to any member of this household as implied both by the normalization principle and by common sense.

In reviewing "Interpretive Guidelines" there are no examples related to this issue. None of the individuals at this location or their guardians have complained about the practices described and the guardians of Individuals #1, #3, and #5 are well aware of their food related issues as these have been discussed both at annual IPP staffings and through BMPs. None of these guardians or the Human Rights Committee Members who review BMPs have complained about limiting procedures.

We have been attempting to manage "food stealing" behaviors through positive behavior management strategies and with environmental changes rather than taking the very restrictive measure of locking kitchen cabinets and refrigerators which is a common intervention for individuals with a Prader-Willi Diagnosis.

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W 125 Continued From page 4

c. An observation was conducted at the facility on 4/30/14 from 6:50 - 8:10 a.m. Upon entering, the open sided cart was blocking the entrance to the kitchen. The cart had plates, bowls, napkins and utensils sitting on top.

At 6:55 a.m., Individual #5 stood by the kitchen entrance. The direct care staff in the kitchen instructed Individual #5 to get his place setting and sit at the table.

At 7:00 a.m., Individuals #1 - #4 and #6 entered the dining area and were instructed to get their place settings.

At 7:05 a.m., the direct care staff in the kitchen placed food on the cloth covered cart and rolled it to the dining area.

At 7:15 a.m., Individual #5 completed his breakfast and was cued to place his dishes in a plastic container staff placed on the table. When they finished, Individuals #1 - #4 and #6 were cued to take their place settings to the sink in the kitchen. This was the first time during the observations that any individuals other than Individual #6 were observed to be allowed in the kitchen.

During an interview on 5/6/14 from 9:30 - 11:30 a.m., the QIDP Supervisor and QIDP both stated there were 4 individuals in the facility that had to be monitored in the kitchen due to food issues, but staff were not supposed to be blocking individuals from entering the kitchen.

The facility failed to ensure individuals had free access to the kitchen.

W 125 9) We realize that our management of these situations may in reality be restrictive in nature but would appreciate further assistance and guidance in developing a reasonable response to this situation if the corrective actions we are planning are not sufficient. It is not reasonable, in our estimation, to provide unrestricted access to available foods. It is reasonable to look at our current mealtime activities and to change the mealtime culture so that it continues to be managed while providing to protections needed related to the unhealthy and/or excessive consumption of food, not only for Individual #3 but also for Individuals #1 and #5.

Corrective Actions:

- 1) After discussing the contributing factors to this citation we feel that there has been management "creep" related to food safety, food availability, and overall management of the kitchen at this location which has inadvertently resulted in practices that appear to be restrictive. Related to this issue we are planning the following:
 - a. Eliminate one of the carts and no longer place a cart in front of the kitchen entrance.
 - b. Explore adjusting the placement of the kitchen tables.
 - c. Explore the use of a kitchen alarm system so that staff can respond to entrance into the kitchen and provide both supervision and training.
- d. When an alarm system is identified, discuss the need for and use of this type of system with individuals and their guardians/representative and obtain informed consent for all individuals living at this location. Address any issues of concern

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W 125	Continued From page 5 2. An environmental review was conducted on 4/30/14 from 12:45 - 1:45 p.m. During that time, it was noted the only food stored in the kitchen was as follows: - A box of baking mix - One and a half gallons of milk - A half carton of eggs - A small carton of egg substitute - A small bag of carrots - An open container of applesauce All other food items were locked in a small room in the garage. During an interview on 5/1/14 at 8:36 a.m., a direct care staff stated food was kept locked due to issues with individuals taking food at night. During an interview on 5/6/14 from 9:30 - 11:30 a.m., the QIDP Supervisor stated there should be a representative sample of food items in the kitchen for individuals as needed, and that all food items should not be locked.	W 125	which might result from this process. e. Modify instructions to staff related to using the kitchen and food related issues as teaching/training opportunities. f. Redo the afternoon and weekend schedules to integrate kitchen activities into individual's schedules and accompany this process with additional staff training. g. Implement the training and observation changes noted in W249. h. Individual #3 has a BMP which focuses on food management. In addition he sees a counselor, a psychiatric provider and an occupational therapist on a regular basis. As various providers interact with Individual #3 food related issues will continue to be discussed.	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W-249	2) As related to the issue of due process, as stated in 8) under clarification, we do not agree that due process was violated as no one complained about our management of this situation and there is no specific reference to kitchen access in either constitutional or ICF/ID regulations. <i>W 125 Response: Continued on Page 6.1 of 13 Attachment</i>	

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CENTERS FOR MEDICARE &
MEDICAID SERVICES

OMB NO. 0938-0391

W125 CONTINUED

Page 6.1 of 13

We do however agree with the underlying issue related to rights training and feel we could do a better job at training efforts with both individuals served and employees. We have found an excellent pictorial document called "Bill of Right—People First—Responsibilities" on the internet and are attaching the first page as a sample of the training on rights (Attachment A) we plan to implement at this location.

Our intent is to make a copy of this material for each individual; develop a weekly group training session using this material as a base; supplement this material, over time, with some additional training materials (probably social stories); and to supplement existing staff training material (our "Rights" module) with this document.

Identifying Others Potentially Affected:
All individuals at this location are affected

System Changes: Please refer to corrective actions.

Monitoring:

- 1) For the next three months or until we feel assured that these issue is resolved, all mealtime observations will be increased with additional attention paid to the previously planned changes are implemented and effective. The QIDP will conduct two, the ILW will conduct three, the cook will conduct two and the AQIDP will conduct three. These mealtime observations will be reviewed by the Trending & Tracking Team which meets monthly and which includes the RN Supervisor and the QIDP Supervisor to insure the issue has

- been resolved. After resolution, the normal schedule of mealtime observations (one each by the AQIDP and two by the cook) will resume. The RN Supervisor will monitor the Observation book on a monthly basis to make sure these observation have occurred.
- 2) The QIDP will be responsible for implementing the changes described related to due process. Implementation plans and efforts will be discussed with and monitored by the QIDP supervisor to ensure the intent of change is accomplished. The QIDP supervisor will document these actions in a QIDP log.

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W 249	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed. This resulted in individuals' dining programs not being implemented. The findings include:</p> <p>1. An observation was conducted on 4/29/14 from 5:25 - 6:55 p.m. During that time, the evening meal was observed and the following was noted:</p> <p>a. Individual #2's 10/9/13 IPP stated he was a 57 year old male whose diagnoses included severe mental retardation.</p> <p>During the evening meal, direct care staff was observed to serve Individual #2 his food and cut the food for him with a rocker knife. The direct care staff was observed to pass the serving dishes to other staff at the table. Individual #2 was also observed to attempt to eat in a rapid manner, taking multiple bites before chewing and swallowing the food already in his mouth. The direct care staff was observed to place her hand over Individual #2's plate and tell Individual #2 he needed to rest his hands. The direct care staff was also observed to place her hand on Individual #2's wrist and direct his hand to his plate. After the meal, the direct care staff assisted Individual #2 to clear his place setting to a plastic container and leave the dining area.</p> <p>However, Individual #2's Dining program, dated 11/2013, included the following steps that were</p>	W 249	<p>In assessing the issues observed and documented by survey team members we have determined the following.</p> <ol style="list-style-type: none"> 1) We have a system of observation which includes regular observation by management staff of mealtime activities. The issues identified by surveyors had not been observed so we have concluded that this particular meal was not typical. 2) One of the staff observed who has Type I Diabetes was experiencing some blood sugar related issues during the observation. She had not experienced a state survey before and we believe this exacerbated her stress level and the resultant blood sugar issues which negatively impacted her interactions with individuals during the meal. 3) The Instructional Leadworker who was on duty was aware that the meal was atypical and although she did counseling after the fact she did not intervene immediately to correct all issues observed both by herself and by survey team members. She did do some intervention but this was not sufficient to appropriately manage the situation. 4) One of the staff working is assigned to another location, was filling in at this location, and had not been sufficiently trained in the mealtime routines at this location. 	07/06/14

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W 249	<p>Continued From page 7 not observed:</p> <ul style="list-style-type: none"> - Staff were to assist Individual #2 to pass food around the table. - Staff were to assist Individual #2 to measure and serve food to his plate. - If Individual #2 did not respond to cues to rest his hands, staff were to ask Individual #2 to set his utensil down. - Once his dishes were cleared to the plastic container, staff were to have him carry it to the sink, rinse his dishes and place them in the dishwasher. <p>Individual #2's Dining program was not implemented.</p> <p>b. Individual #4's 10/16/13 IPP stated he was a 67 year old male whose diagnoses included severe mental retardation.</p> <p>During the evening meal, direct care staff were observed to serve Individual #4's food to his plate and cut his food with a rocker knife.</p> <p>However, Individual #4's Dining program, dated 11/2013, included the following steps that were not observed:</p> <ul style="list-style-type: none"> - Staff were to fill measuring utensils and turn the handle towards Individual #4 for serving. - Staff were to cue Individual #4 to pick up the rocker knife. - Staff were to have Individual #4 hold his food with a fork in his left hand while cutting the food with the rocker knife. <p>Individual #4's Dining program was not implemented.</p>	W 249	<p>5) Performance anxiety always is present during surveys. Part of our staff training strategy is to desensitize staff to the observation process, but this strategy is not always effective although surveyors did not note similar issues during a breakfast observation.</p> <p>Corrective Actions: We will be taking the following actions to address each issue we have identified.</p> <p>1) Even though we feel that this surveyor observation of this meal was not typical based on our previous observations we are taking some actions in this area. We have reviewed our mealtime observation document and procedure and have updated our "Staff Observation" module (available upon request). The "Mealtime Observation" form has been updated and now includes a trigger for further training on the implementation of data based programs. (Attachment B). Management staff at this location will be retrained on observation using this updated material by the QIDP Supervisor and this system will be implemented at this location the first week of June 2014.</p> <p>2) Both the QIDP and AQIDP (house manager) at this location have discussed this employees health status and accommodation needs and have documented plans for communications by/with other staff on her status. In addition, this staff member decided that she will be responsible for discussing these issues with her co-workers. Her behavior during this surveyor observation was atypical of her general performance but any future such incidents will result in disciplinary action.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #3 POND		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 SOUTH POND BOISE, ID 83705	
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W 249	<p>Continued From page 8</p> <p>c. Individual #3's 10/4/13 IPP stated he was a 20 year old male whose diagnoses included mild intellectual disability.</p> <p>During the evening meal, direct care staff were observed to serve Individual #3 his food to his plate.</p> <p>However, Individual #3's Dining program, dated 2/2014, included the following step that was not observed:</p> <ul style="list-style-type: none"> - Staff were to ensure Individual #3 measured and served himself vegetables. <p>Individual #3's Dining program was not implemented.</p> <p>d. Individual #1's 10/16/13 IPP stated he was a 54 year old male whose diagnoses included moderate mental retardation.</p> <p>During the evening meal, direct care staff were noted to serve Individual #1's food to his plate and pass the serving dishes to the other direct care staff.</p> <p>However, Individual #1's Dining program, dated 11/2013, included the following steps that were not observed:</p> <ul style="list-style-type: none"> - Staff were to assist Individual #1 to pass food around the table. - Staff were to assist Individual #1 to measure and level food when serving himself. <p>Individual #1's Dining program was not implemented.</p>	W 249	<p>3) The ILW has been counseled both by the QIDP Supervisor and the QIDP related to expectations for interruption and correction. As noted in 1) the "Staff Observation" module has been updated and this includes clear instruction related to these expectations. The QIDP will do concentrate scheduled observations the next two months on mealtimes which will also include observation of the ILW and her staff training efforts during mealtimes.</p> <p>4) Due to the complexity of mealtime at this location, in the future when staff from other locations are requested to work, they will receive one-to-one training from the AQIDP, ILW, or other experienced staff on the complexities of mealtime prior to assisting with the meal. Guidelines for staff working at mealtimes will be added to the mealtime binder and will be placed as reference on the reverse side of the mealtime programs.</p> <p>5) We will continue to work with staff on performance anxiety issues through our observation process.</p> <p>6) At a staff meeting on 05/14/14 the QIDP, AQIDP and ILW did an in-depth inservice training session for staff on mealtime procedures. This training will be rewritten as general guidelines and will be paired with individual's mealtime TAs.</p> <p>Identifying Others Potentially Affected: All individuals at this location except Individual #7 who is NPO are affected.</p>

System Changes: Please refer to corrective actions.

Monitoring: For the next three months or until we feel assured that this issue

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W 249	Continued From page 9	W 249	is resolved, all mealtime observations will be increased. The QIDP will conduct two, the ILW will conduct three, the cook will conduct two and the AQIDP will conduct three. These mealtime observations will be reviewed by the Trending & Tracking Team which meets monthly and which includes the RN Supervisor and the QIDP Supervisor to insure the issue has been resolved. After resolution, the normal schedule of mealtime observations (one each by the AQIDP and two by the cook) will resume. The RN Supervisor will monitor the Observation book on a monthly basis to make sure these observation have occurred.		
W 324	<p>During an interview on 5/6/14 from 9:30 - 11:30 a.m., the QIDP stated dining programs were to be implemented during all meals. The ILW, who was present during the interview as well as during the meal observation, stated dining programs had not been implemented during the evening meal observation.</p> <p>The facility failed to ensure Individuals #1 - #4's dining programs were implemented.</p> <p>483.460(a)(3)(ii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.</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 immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 4 individuals (Individual #3) whose medical records were reviewed. This resulted in the potential for preventable illness to occur. The findings include:</p> <p>1. Individual #3's 10/4/13 IPP stated he was a 20 year old male whose diagnoses included mild intellectual disability.</p> <p>Individual #3's record was reviewed and did not contain documentation that an HPV vaccination</p>	W 324	<p>Corrective Actions: We are aware of this requirement but there was an issue of implementation of organizational expectations due to a change in nursing supervision that occurred in 2013. The attached memo dated 07/13 identified to nursing staff what immunizations were expected. In addition, in 12/13 the nursing summary form was modified to include expected immunizations. Most of the expectations outlined in this memo related to this issue were implemented but the HPV issue for this one individual was overlooked. Expectations will be reviewed again with both the RN Supervisor and the LPN assigned to this location so that this issue can be resolved.</p>	07/06/14	

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W 324	<p>Continued From page 10 had been received or discussed with the physician.</p> <p>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."</p> <p>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.</p> <p>During an interview on 5/6/14 from 9:30 - 11:30 a.m., the LPN stated Individual #3 had not received the vaccination and the issue had not been discussed with the physician. The QIDP Supervisor, who was present during the interview, stated vaccinations had been reviewed for all individuals but HPV had been overlooked.</p> <p>The facility failed to ensure Individual #3 received all recommended vaccinations.</p>	W 324	<p>Identifying Others Potentially Affected: Only one other person at this location is in this age range and action will also be taken to resolve this issue for him.</p> <p>System Changes: We are not making any systems change as we feel this is an implementation issue.</p> <p>Monitoring: The RN Supervisor will check immunization status during monthly record reviews.</p>
W 488	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p>	W 488	

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W 488	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual ate in a manner consistent with their developmental level which directly impacted 6 of 7 individuals (Individuals #1 - #6) who were observed during mealtime. This failure impacted individuals' ability to learn appropriate dining skills and master the social skills involved in dining. The findings include:</p> <p>1. An observation was conducted at the facility on 4/29/14 from 5:25 to 6:55 p.m. During that time, dinner was observed. The dinner menu included baked lasagna, green beans, bread and butter, mandarin orange slices, cookies, and milk.</p> <p>The dining room included 2 tables. Individuals #1 - #4 sat at the first table with DCS A and DCS B. Individuals #5 and #6 sat at the second table with DCS C. Individual #7 was NPO, receiving all nutrition through a g-tube (gastrostomy tube - a tube inserted through the abdominal wall into the stomach). Individual #7 sat at the end of the second table with the ILW.</p> <p>At 6:30 p.m., DCS B was observed in the kitchen placing servings of lasagna on individual plates. DCS B placed the plates containing the lasagna servings on the counter between the dining room and the kitchen. The plates were then placed on the table in front of each individual by the direct care staff.</p> <p>At 6:40 p.m., DCS A and DCS B were observed serving the green beans to Individuals #1 - #4, and DCS C served green beans to Individuals #5 and #6. This process was repeated with the</p>	W 488	<p>Please note that the issues involved focus on dining skills which we feel we have addressed in our response to W125. Issues with independent skill training in other area of daily living were not identified as problematic.</p> <p>Please refer to W125 for corrective actions, individuals affected, systems changes and monitoring.</p>	07/06/14

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W 488	<p>Continued From page 12 remaining menu items.</p> <p>No attempts were made to encourage individuals to engage in dining tasks, such as passing serving dishes or serving themselves.</p> <p>During an interview on 5/6/14 from 9:30 to 11:30 a.m., the ILW, who was present during the dinner observation, stated staff were running behind during the observation. The ILW and QIDP, who was also present during the interview, both stated individuals should have participated in serving themselves and passing food items around the tables.</p> <p>The facility failed to ensure individuals were provided an opportunity to participate in independent dining skills.</p>	W 488		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 4/29/14 - 5/6/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Karen Marshall, MS, RD, LD	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	Please refer to W125	
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W249.	MM212	Please refer to W249	
MM548	16.03.11.210.02(g) Immunization Record of immunizations; and This Rule is not met as evidenced by: Refer to W324.	MM548	Please refer to W324	

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TITLE

(X6) DATE

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