



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

August 1, 2014

Rex Redden, Administrator  
Idaho Falls Group Home #4 Summit  
P.O. Box 50457  
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #4 Summit, Provider #13G071

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #4 Summit, which was conducted on July 24, 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

Rex Redden, Administrator  
August 1, 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 **August 13, 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 August 13, 2014. If a request for informal dispute resolution is received after August 13, 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,



KAREN MARSHALL  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

KM/pmt  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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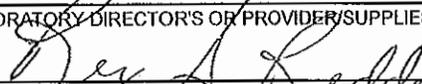
PRINTED: 07/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/24/2014
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NAME OF PROVIDER OR SUPPLIER  IDAHO FALLS GROUP HOME #4 SUMMIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3612 SUMMIT TRAIL IDAHO FALLS, ID 83402
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 7/21/14 to 7/24/14.</p> <p>The survey was conducted by:</p> <p>Karen Marshall, MS, RD, LD, Team Lead Michael Case, LSW, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADHD - Attention Deficit Hyperactivity Disorder AQIDP - Assistant Qualified Intellectual Disabilities Professional BMI - Body Mass Index HCA - Health Care Assistant HM - Home Manager ITTP - Interdisciplinary Treatment Team Plan Kcalorie - Kilocalorie/kcal OCD - Obsessive Compulsive Disorder QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian USDA - United States Department of Agriculture</p>	W 000		
W 314	<p>483.450(e)(4)(i) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be monitored closely in conjunction with the physician and the drug regimen review requirement at §483.460(j).</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 psychoactive medications were monitored by the</p>	W 314	<p>W 314</p> <p>1. The two medications that were being monitored by the individuals physician will now be monitored by the individuals psychiatrist.</p>	<p>RECEIVED</p> <p>AUG 13 2014</p> <p>FACILITY STANDARDS</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/11/14
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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 314	<p>Continued From page 1</p> <p>individual's physician for 1 of 3 individuals (Individual #3) whose psychoactive medications were reviewed. This resulted in the potential for medication concerns to go undetected. The findings include:</p> <p>1. Individual #3's <del>10/25/13</del> ITTP documented a 40 year old male whose diagnoses included profound mental retardation, autism, and seizure disorder.</p> <p>Individual #3's 7/1/14 through 7/31/14 Physician's Order sheet contained the following medication orders.</p> <p>For OCD: - Campral (a synthetic amino acid neurotransmitter drug) 333 mg tablet, 3 tablets twice daily - Celexa (an antidepressant drug) 30 mg at bedtime</p> <p>For aggression: - Thioridazine, also known as Mellaril (an antipsychotic drug) 10 mg every morning and 50 mg at bedtime</p> <p>Individual #3's Physician's Progress Notes, dated 8/15/13 and 2/13/14, documented the psychiatrist monitored Individual #3 for the use of Celexa for OCD. However, the psychiatrist did not monitor the use of Campral and Mellaril.</p> <p>Individual #3's medical record did not provide documentation of any other physician monitoring the use of Campral or Mellaril.</p> <p>The 2014 Nursing Drug Handbook contained the following information related to the Campral and</p>	W 314	<p>W 314 cont'd</p> <p>2. All individuals have the potential to be affected by this practice. All individuals psychoactive medications will be reviewed to ensure that the psychiatrist is monitoring them. If it is found that the medications are not being monitored by the psychiatrist, an appointment will be made for the individual with the psychiatrist and the medications and what they are tied to will be reviewed with the psychiatrist to ensure they are being prescribed and monitored by him.</p> <p>3. The Medical Coordinator will review all psychoactive medications taken by all individuals. If it is found that the medications are not being monitored by the psychiatrist, an appointment will be made for the individual with the psychiatrist and the medications and what they are tied to will be reviewed with the psychiatrist to ensure they are being prescribed and monitored by him.</p> <p>4. The QIDP will conduct quarterly chart reviews to ensure that all psychoactive medications are listed on the appointment summary after each psychiatric visit. The QIDP will initial all psychiatric appointment summary to ensure accuracy.</p> <p>5. Target date for completion will be September 30, 2014</p>		

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W 314	<p>Continued From page 2</p> <p>Mellaril medications:</p> <p>- Campral: "Safety alert!" Adverse reactions included, but were not limited to, "abnormal thinking...dizziness...suicidal thoughts...tremor, pain...abnormal vision...accidental injury, chills...flulike symptoms..."</p> <p>- Mellaril: Adverse reactions included, but were not limited to, "...neuroleptic malignant syndrome [refers to the combination of hyperthermia, rigidity, and autonomic dysregulation that can occur as a serious complication of the use of antipsychotic drugs], EEG [Electroencephalography, the measurement of electrical activity in different parts of the brain and the recording of such activity as a visual trace] changes, dizziness, orthostatic hypotension [also called postural hypotension, a form of low blood pressure that happens when a person stands up from sitting or lying down. Can make a person feel dizzy or lightheaded, and maybe even faint]...blurred vision...transient leukopenia [a decrease in the concentration of white blood cells in the blood lasting for a short time], and agranulocytosis [a syndrome of frequent chronic bacterial infections of the skin, lungs, throat, etc]."</p> <p>During an interview on 7/24/14 from 9:55 to 10:50 a.m., the HCA stated Individual #3's psychiatrist reviewed his psychoactive medications and signed the Physician's Progress Notes. Individual #3's general practitioner signed the Physician's Order sheets. The QIDP stated the facility would ensure the psychiatrist was aware Individual #3 was prescribed Celexa, Campral, and Thioridazine so the psychiatrist could monitor Individual #3.</p>	W 314			

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W 314	Continued From page 3	W 314			
W 336	<p>The facility failed to ensure a physician monitored the use of all medications prescribed for OCD and aggression.</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</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 nursing reviews were completed on a quarterly basis for 1 of 3 individuals (Individual #1) whose medical record was reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include:</p> <p>1. Individual #1's 6/19/14 ITTP documented a 20 year old male whose diagnoses included moderate mental retardation, adjustment disorder, and history of seizure disorder.</p> <p>Individual #1's record documented quarterly nursing reviews were completed on 8/27/13, 11/21/13, and 2/26/14. A completed nursing review for the second quarter (April, May, June) of 2014 was not in the record.</p> <p>During an interview on 7/24/14 from 9:55 to 10:50 a.m., the HCA stated the nursing review for the second quarter of 2014 was missed. The nurse was doing every other month and did not utilize</p>	W 336	<p>W 336</p> <p>1. The facility had a change in the RN consultant position during the months of February and March, 2014. This is the time frame that the quarterly nursing assessment was missing from. The Medical Coordinator is tracking the due date of all quarterly assessments. The Medical Coordinator is now sending correspondence via text message to the RN consultant reminding her of the quarterly assessments that are due that month.</p> <p>2. All individuals have the potential to be affected by this practice. The Medical Coordinator will review the quarterly nursing assessment schedule with the RN consultant to ensure she is aware of when the assessments are due.</p> <p>3. The RN consultant will submit completed quarterly nursing summaries to the Medical Coordinator once they are complete. The Medical Coordinator will check the nursing assessments against the schedule to ensure that all quarterly assessments that were due for the month were completed.</p> <p>4. The QIDP will conduct quarterly chart reviews to ensure that all quarterly nursing assessments have been completed in the appropriate time frame.</p> <p>5. Target date for completion will be September 30, 2014</p>		

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W 336	Continued From page 4 the monthly schedule.	W 336			
W 353	<p>The facility failed to ensure nursing reviews were completed on a quarterly basis.</p> <p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE</p> <p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed including radiographs when indicated and detection of manifestations of systemic disease.</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 a periodic comprehensive dental evaluation was completed for 1 of 3 individuals (Individual #2) whose dental records were reviewed. This resulted in the potential for an individual's dental needs to be unidentified and untreated. The findings include:</p> <p>1. Individual #2's 4/24/14 ITTP documented a 29 year old male whose diagnoses included severe mental retardation, autism, and seizure disorder.</p> <p>Individual #2's record documented he was seen on 2/23/14 by a dentist. The dentist's 2/23/14 Patient Note documented no x-rays. The record did not contain a dental note indicating when the most recent x-rays were obtained.</p> <p>During an interview on 7/24/14 from 9:55 to 10:50 a.m., the HCA stated she would check to determine when Individual #2's last comprehensive dental evaluation with x-rays was</p>	W 353	<p>W 353</p> <p>1. A semi-annual dental exam has been scheduled for the individual found to be affected by this deficient practice. Prior to the appointment, the treatment team will meet to discuss appropriate less restrictive interventions to try with the individual in order to attempt to obtain dental x-rays.</p> <p>2. This has the potential to affect all residents in all the facilities. The Medical Coordinator will review all dental examination notes for the past year and will notify the QIDP of any issues or concerns that arise from any dental exams. If any issues or concerns are noted, the Treatment Team will meet to discuss alternative less restrictive methods that may be used in order to obtain a comprehensive dental examination. A follow-up dental examination will then be scheduled and the less restrictive methods will be attempted. If this is not successful then the Treatment Team will meet again to discuss the possibility of implementing a more restrictive procedure to ensure that comprehensive dental exams are completed for each individual.</p> <p>3. The QIDP will review and initial all dental examination notes once they have been obtained by the Medical Coordinator to ensure that a comprehensive dental examination has occurred for each individual.</p> <p>4. The QIDP and AQIDP's will review the clients charts quarterly to ensure that all clients have received comprehensive dental examinations.</p> <p>5. Target date for completion will be September 30, 2014.</p>		

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W 353	Continued From page 5 completed. During a follow-up interview, on 7/24/14 at 3:00 p.m., the HCA stated there were no x-rays taken for the past 6 years.	W 353		
W 466	<p>The facility failed to ensure a comprehensive dental examination was obtained for Individual #2.</p> <p><b>483.480(a)(6) FOOD AND NUTRITION SERVICES</b></p> <p>Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the menus, as written, maintained caloric balance and nutrient density for fruits and vegetables for 5 of 6 individuals (Individuals #1 - #3, #5, and #6) who resided at the facility. This resulted in the potential for individuals' nutritional needs to not be met. The findings include:</p> <p>The individuals residing in the facility ranged in age from 12 to 41 years old.</p> <p>The 2010 Dietary Guidelines for Americans, a publication of the USDA and the U.S. Department of Health and Human Services, provides guidance to maintain caloric balance to achieve and sustain a healthy weight. Based on gender and age from 12 to 41 years old, the estimated</p>	W 466	<p>W 466</p> <ol style="list-style-type: none"> <li>The menus for the individuals found to have been affected by the deficient practice will be reviewed and revised to ensure that they maintain caloric balance and nutrient density for fruits and vegetables.</li> <li>All individuals have the potential to be affected by this practice. The menus in all facilities will be reviewed and revised to ensure that they maintain caloric balance and nutrient density for fruits and vegetables.</li> <li>The RD will review all revisions made to the menus and will ensure that the menus they maintain caloric balance and nutrient density for fruits and vegetables.</li> <li>Anytime there is a change in menus, the RD will review them before they are implemented to ensure they maintain caloric balance and nutrient density for fruits and vegetables. The RD will then sign off on the menus stating she has reviewed them and approved them for all facilities.</li> <li>Target date for completion will be September 30, 2014.</li> </ol>	

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W 466	<p>Continued From page 6</p> <p>daily caloric needs were 1,600 to 2,200. Based on 1,600 to 2,200 caloric needs per day, the recommended daily fruit intake ranged from 1 1/2 to 2 cups and the daily vegetable intake ranged from 2 to 3 cups.</p> <p>On 7/21/14 from 5:45 to 6:30 p.m., the dinner meal was observed. The foods served were 1 cup clam chowder, one dinner roll, and 1/2 cup green salad. Ranch dressing and milk were also served. At that time, the facility's menu was reviewed. The dinner menu was 1 cup soup of choice, one dinner roll, and 1/2 cup green salad. The ranch dressing and milk were not listed on the dinner menu.</p> <p>1. On 7/22/14 at 11:50 a.m., the facility's menus were reviewed. The Spring/Summer Week Four Menu was in place and used during the survey week. The menus were subsequently evaluated and the following was determined for total daily kcal provided, the daily kcal average, and the daily number of fruit and vegetable servings provided.</p> <p>Sunday: total kcal 1499, total fruit serving 1/2 cup, total vegetable serving 1/2 cup</p> <p>Monday: total kcal 1537, total fruit servings 2 cups, total vegetable servings 1/2 cup</p> <p>Tuesday: total kcal 1238, total fruit servings 1 cup, total vegetable servings 3/4 cup</p> <p>Wednesday: total kcal 1871, total fruit servings 2 cups, total vegetable servings 1 cup</p> <p>Thursday: total kcal 2075, total fruit servings 1/2 cup, total vegetable servings 1 1/2 cups</p>	W 466			

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W 466	Continued From page 7  Friday: total kcal 1573, total fruit servings 1/2 cup, total vegetable servings 1 1/2 cups  Saturday: total kcal 1526, total fruit servings 1 1/2 cups, total vegetable servings 2 cups  The Week Four daily total kcal ranged from 1238 to 2075. The Week Four daily kcal average for the week was 1609 kcal. The Week Four daily fruit servings ranged from 1/2 cup to 2 cups. The Week Four daily vegetable servings ranged from 1/2 cup to 2 cups.  During an interview on 7/24/14 from 11:00 to 11:25 a.m., an AQIDP for a sister facility within the company stated she developed the menus based on what Individuals #1 - #3, #5 and #6 would eat and she reviewed various regulations to ensure there was enough fish, protein, and fruit in the menus. The AQIDP said she then gave the menus to the RD for review.  During an interview on 7/24/14 from 12:50 to 1:10 p.m., the facility's RD stated the facility provided her with the menus. She said she had concerns with the menus and was in the process of reviewing the menus to ensure the individuals received a variety of foods from all food groups including fruits and vegetables served at each meal.  The facility failed to ensure the menus maintained caloric balance and nutrient density for fruits and vegetables.	W 466			
W 477	483.480(c)(1)(i) MENUS  Menus must be prepared in advance.	W 477			

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W 477	Continued From page 8  This STANDARD is not met as evidenced by: Based on record review, and staff interviews, it was determined the facility failed to ensure specialized menus were accessible for staff to utilize for 1 of 1 individual (Individual #4) whose gluten restricted diet was reviewed. This resulted in the potential for an individual's nutritional needs to not be met. The findings include:  1. Individual #4's ITTP, dated 6/9/14, documented a 12 year old male whose diagnoses included moderate mental retardation, Celiac disease, autism, and ADHD.  Individual #4's June 2014 Annual Assessment (Nutritional), documented Celiac disease, gluten free diet, and normal BMI.  Celiac disease is characterized by an abnormal immune response to a wheat gluten and to related proteins in barley and rye. The reaction to gluten can cause severe damage to the intestines and subsequent malabsorption of nutrients.  On 7/22/14 at 11:50 a.m., the facility's menu book was reviewed and did not include a menu for Celiac disease or a gluten free menu. At that time, the HM was interviewed and stated Individual #4's gluten free menu was in the menu book. The HM looked in the menu book and verified the menu book did not include a Celiac disease or a gluten free diet menu. The HM also stated the staff write down what Individual #4 ate because he typically refused foods. The HM then provided the surveyor with the documentation of foods Individual #4 refused and how much food he consumed.	W 477	W 477  1. The menu for the individual affected by this practice has been implemented into the facilities menu book.  2. All individuals have the potential to be affected by this practice. The menu books at all facilities will be reviewed to ensure that all individuals specific dietary needs are incorporated into the menu book for the specific facility.  3. The Home Inspection List that all of the management team uses upon entering the facility will be revised to incorporate checking for specific menus for the individuals with specific dietary needs.  4. Anytime a member of management enters a facility, they will utilize the Home Inspection List and will check all menu books to ensure that specific menus are in the menu book for the individuals with specific dietary needs. If a menu is found to be missing, the member of management will immediately inform the QIDP so corrective action can be taken. The Home Inspection Lists will be turned into the QIDP upon completion for review to ensure the appropriate menu was in the menu book for the specific individual.  5. Target date for completion will be September 30, 2014.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/24/2014
NAME OF PROVIDER OR SUPPLIER  IDAHO FALLS GROUP HOME #4 SUMMIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3612 SUMMIT TRAIL IDAHO FALLS, ID 83402		
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W 477	Continued From page 9	W 477			
W 480	<p>During an interview on 7/24/14 from 9:55 to 10:50 a.m., the QIDP stated Individual #4's individual diet menu should have been in the menu book.</p> <p>The facility failed to ensure the menu for Celiac disease or gluten free diet menu was available for staff in the facility's menu book.</p> <p>483.480(c)(1)(iv) MENUS</p> <p>Menus must include the average portion sizes for menu items.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the menus contained all portion sizes and foods, beverages, and condiments served at each meal for 6 of 6 individuals (Individuals #1 - #3, #5 and #6) who resided at the facility. This resulted in the potential for individual nutritional needs to not be met. The findings include:</p> <p>According to the USDA, sample menus should include food items and portion sizes including beverages such as water, coffee, tea, juice, and milk, margarine or butter, and condiments such as mustard, ketchup, and salad dressing(s).</p> <p>1. On 7/21/14 at 5:50 p.m., the dinner meal was observed. The foods served were 1 cup clam chowder, one dinner roll, and 1/2 cup green salad. Ranch dressing and milk were also served. The facility's dinner menu was 1 cup soup of choice, one dinner roll, and 1/2 cup green salad. The ranch dressing and milk were not listed on the dinner menu.</p>	W 480	<p>W 480</p> <p>1. The menus for the individuals found to have been affected by the deficient practice will be reviewed and revised to ensure that they include all food items and portion sizes including beverages, margarine or butter, and condiments.</p> <p>2. All individuals have the potential to be affected by this practice. The menus in all facilities will be reviewed and revised to ensure that they include all food items and portion sizes including beverages, margarine or butter, and condiments.</p> <p>3. The RD will review all revisions made to the menus and will ensure that they include all food items and portion sizes including beverages, margarine or butter, and condiments.</p> <p>4. Anytime there is a change in menus, the RD will review them before they are implemented to ensure they include all food items and portion sizes including beverages, margarine or butter, and condiments. The RD will then sign off on the menus stating she has reviewed them and approved them for all facilities.</p> <p>5. Target date for completion will be September 30, 2014.</p>		

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W 480	<p>Continued From page 10</p> <p>However, on 7/22/14 at 11:50 a.m., the facility's menus were reviewed. The Spring/Summer Week Four Menu was in place and used during the survey week. The menus were subsequently evaluated. The menus did not include all food items and portions sizes served at each meal. Examples include, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Sunday through Saturday for Breakfast, Lunch, and Dinner: Beverages, butter or margarine, and condiments were not included on the menus.</li> <li>- Tuesday: 10:30 a.m. snack was 5 crackers with cheese. The type crackers and the type and amount of cheese were not identified.</li> <li>- Thursday: 3:30 p.m. snack was 1/2 cup carrots with ranch. The amount of ranch (dressing) was not identified.</li> <li>- Dinner rolls were included at various meals, however, as written, butter or margarine was not part of the menu.</li> </ul> <p>During an interview on 7/24/14 from 11:00 to 11:25 a.m., an AQIDP for a sister facility within the company stated the menus were developed based on what Individuals #1 - #3, #5 and #6 would eat and she reviewed various regulations to ensure there was enough fish, protein, and fruit in the menus.</p> <p>During an interview on 7/24/14 from 12:50 to 1:10 p.m., the facility's RD stated the facility provided her with the menus and she had concerns with the menus. She was reviewing the menus and the menus should include food items and portion</p>	W 480		

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W 480	Continued From page 11 sizes for butter or margarine, salad dressing(s), and beverages served at each meal or with a snack.  The facility failed to ensure the facility menus included all food items and portions sizes including beverages, margarine or butter, and condiments.	W 480			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: IDAHO FALLS GROUP HOME #4 SUMMIT  
STREET ADDRESS, CITY, STATE, ZIP CODE: 3612 SUMMIT TRAIL IDAHO FALLS, ID 83402

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensing survey conducted from 7/21/14 to 7/24/14.  The survey was conducted by:  Karen Marshall, MS, RD, LD, Team Lead Michael Case, LSW, QIDP	M 000		
MM660	16.03.11.250.05 General Diets  The general menu must provide for the food and nutritional needs of the resident in accordance with the Recommended Daily Allowances of the Food and Nutritional Board of the National Academy of Service. A daily guide must be based on the following allowances: This Rule is not met as evidenced by: Refer to W466.	MM660	MM660 Refer to W 466	
MM669	16.03.11.250.06(d) Written Diet Plan  A written diet plan must be made for each type of diet unless each resident's individual diet is written daily. This Rule is not met as evidenced by: Refer to W477.	MM669	MM669 Refer to W 477	
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation  The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336.	MM766	MM766 Refer to W 336	
MM781	16.03.11.270.04(a) Comprehensive Diagnostic Services	MM781	MM781 Refer W 353	

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FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

*Dex A. Redden*

*Administrator*

8/11/14

Bureau of Facility Standards

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MM781	Continued From page 1  There must be comprehensive diagnostic services for all residents which include: This Rule is not met as evidenced by: Refer to W353.	MM781		