



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

CERTIFIED MAIL: 7000 1670 0011 3315 1835

August 13, 2014

Peter Talefemar, Administrator  
Belmont Care Center  
4806 Hawthorne Road  
Chubbuck, ID 83202

RE: Belmont Care Center, Provider #13G046

Dear Mr. Talefemar:

Based on the Medicaid/Licensure survey completed at Belmont Care Center on July 28, 2014, we have determined that Belmont Care Center is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) Conditions of Participation of **Client Protections (42 CFR 483.420) and Physical Environment (42 CFR 483.470)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Belmont Care Center to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

**It is important** that your Credible Allegation/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;

Peter Talefemar  
August 13, 2014  
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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
6. Include dates when corrective action(s) will be completed.

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

**Such corrections must be achieved and compliance verified by this office, before September 11, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 3, 2014.**

Please complete your Allegation of Compliance/Plan of Correction and submit to this office by **August 28, 2014.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Belmont Care Center ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective July 28, 2014, through November 25, 2014. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **September 10, 2014**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Peter Talefemar  
August 13, 2014  
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Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT  
Licensing and Certification Administration, DHW  
PO Box 83720  
Boise, ID 83720-0009  
Phone: (208)334-6626  
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 26, 2014. If a request for informal dispute resolution is received after August 26, 2014 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me 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



Belmont Management  
4806 Hawthorne Road  
Chubbuck, Idaho 83202

**RECEIVED**

**SEP 03 2014**

**FACILITY STANDARDS**

August 28, 2014

RE: Statement of Corrections

Dear Ms. Wisenor,

Please accept this as our letter of Credible Allegation that corrections of deficiencies found during the recent survey at Belmont Care Center have been or will be made by September 3, 2014.

We feel we have made corrections and will be ready for your survey to assure compliance. If you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Halladay', written in a cursive style.

Merinda Halladay

City Director

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

PRINTED: 08/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2014
NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 7/21/14 to 7/28/14.</p> <p>The survey was conducted by: Ashley Henscheld, QIDP, Team Leader Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADL - Activity of Daily Living AQIDP - Assistant Qualified Intellectual Disabilities Professional IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record NSAID - Non-Steroidal Anti-Inflammatory Drug PRN - As needed QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse SIB - Self-Injurious Behavior TV - Television</p>	W 000	<p><b>RECEIVED</b></p> <p><b>SEP 03 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for for 4 of 4 individuals (Individuals #1 - #4) whose records were reviewed, with the potential to affect</p>	W 104		

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

*M. Halladay*

TITLE

*City Director*

(X6) DATE

*8/28/14*

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 104	<p>Continued From page 1</p> <p>all individuals (Individuals #1 - #16) residing in the facility. This failure resulted in the governing body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include:</p> <p>1. During observations conducted on 7/21/14 and 7/22/14 for a cumulative 4 hours and 41 minutes, video cameras were noted to be mounted near the ceiling in the common areas of the facility. Two cameras, located in the common area next to the bathrooms, were noted to be directed toward the wall/floor, facing away from the common area.</p> <p>Upon review, it was noted Individual #1 - #4's records contained a Written Informed Consent for Video Camera Surveillance which documented "The cameras will be placed in general common use areas...Viewing will be done for all shifts at varying times, a minimum of 1 time per week, per shift, for at least 15 minutes."</p> <p>However, during an interview on 7/25/14 from 12:10 - 2:12 p.m., the City Director stated the cameras were operable, but difficult to access. She estimated the facility struggled with gaining access to video camera monitoring for approximately two and a half years. The City Director stated the viewings were not being completed as indicated in the Written Informed Consents.</p> <p>The governing body failed to ensure video camera monitoring was implemented as written.</p> <p>2. Refer to W111 as it relates to the governing body's failure to ensure the facility maintained a record keeping system that accurately</p>	W 104	<p><b>POC W104 483.410(a)(1) GOVERNING BODY</b></p> <p>Belmont will ensure the governing body exercises general policy, budget, and operating direction over the facility.</p> <ol style="list-style-type: none"> <li>1. Refer to W111</li> <li>2. Refer to W121</li> <li>3. Refer to W122</li> <li>4. Refer to W159</li> <li>5. Refer to 406</li> </ol> <p>Person Responsible: QIDP, Administrator, and City Director.</p> <p>Monitor: Policies will be reviewed quarterly to ensure policies are being implemented as written.</p>	9/3/14	

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W 104	Continued From page 2 documented individuals' medical care.  3. Refer to W121 as it relates to the governing body's failure to ensure the facility provided each individual with an adequate bedroom.  4. Refer to W122 - Condition of Participation: Client Protections and related standard level deficiencies as they relate to the governing body's failure to ensure individuals' rights were upheld.  5. Refer to W159 as it relates to the governing body's failure to ensure the QIDP provided sufficient monitoring and coordination for individuals.  6. Refer to W406 - Condition of Participation: Physical Environment and related standard level deficiencies as they relate to the governing body's failure to ensure the facility provided each individual with an environment which promoted independence.  The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to uphold individuals' rights and meet individuals' programmatic and environmental needs.	W 104			
W 111	483.410(c)(1) CLIENT RECORDS  The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a	W 111			

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W 111	<p>Continued From page 3</p> <p>record keeping system that contained complete information for 4 of 5 individuals (Individuals #1 - #3 and #10) whose medical records were reviewed. This resulted in a lack of documentation to ensure appropriate medical care was provided. The findings include:</p> <p>1. Facility MARs, dated 1/1/14 - 6/30/14, were reviewed and did not include comprehensive information related to PRN medication administration, as follows:</p> <p>a. Individual #1's IPP, dated 7/31/13, documented he was a 32 year old male with diagnoses including mild intellectual disability. The MARs documented he received the following PRN medications:</p> <ul style="list-style-type: none"> <li>- "Allergy relief" for "eye" on 1/3/14</li> <li>- Benadryl (an antihistamine drug) for cough and congestion on 2/11/14</li> <li>- Benadryl and Tylenol (an analgesic drug) for "Head/Dizzy" on 3/6/14</li> <li>- "Allergy relief" for "coughing, sneezing" on 4/17/14</li> </ul> <p>Individual #1 did not receive any PRN medications after 4/17/14.</p> <p>b. Individual #2's IPP, dated 3/4/14, documented a 31 year old male whose diagnoses included mild intellectual disability. The MARs documented he received PRN medications including, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Tylenol for sore throat on 4/10/14</li> <li>- Tylenol for headache on 3/16/14, 6/3/14, 6/9/14, 6/15/14, 6/16/14 (twice), 6/17/14, 6/24/14, 6/25/14, 6/26/14, 6/27/14 (three times) and</li> </ul>	W 111	<p><b>POC W111-483-410(c)(1)</b></p> <p><b>CLIENT RECORDS</b></p> <p>Belmont will develop and maintain a recordkeeping system that documents the individual's health care, active treatment, social information, and protection of the individual's rights.</p> <p>Training will be completed with all staff regarding Medication Administration and Medication Administration Records. The training will also address charting the effectiveness of PRN medications and documenting all medication passes.</p> <p>In addition, training will be completed with all staff regarding neurological checks and reporting. Training will also be completed with Administrative staff rotate being on call regarding documentation and follow up with incidents that are reported.</p> <p>Person Responsible: RN, LPN, Program Supervisors, and City Director.</p> <p>Monitor: The Nursing Department will do training with all the staff regarding Medication Administration, documentation and Neurological checks. Annually, staff will recertify in Medication Administration. The RN and LPN will do random observations on medication passes monthly. The RN and LPN will also complete random checks on the Medication Administration Records. Program Supervisors will complete weekly checks on the Medication Administration Records and Medication Administration. Any concerns or issues will be reported to the Nursing Department.</p> <p>Training will be completed with</p>	

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W 111	<p>Continued From page 4 6/28/14</p> <ul style="list-style-type: none"> <li>- Cough drop for cough on 6/15/14 and 6/17/14 (three times)</li> <li>- Allergy relief for throat/allergies on 6/20/14, 6/21/14, 6/24/14, 6/25/14, 6/26/14 (two times), 6/27/14, 6/28/14 (two times) and 6/29/14</li> </ul> <p>c. Individual #3's IPP, dated 1/8/14, documented he was a 39 year old male with diagnoses including mild intellectual disability. The MARs documented he received PRN medications including, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Tylenol for headache on 1/5/14, 1/6/14, 1/7/14, 1/15/14, 3/4/14, 5/6/14, 6/14/14 and 6/28/14</li> <li>- Ibuprofen (an NSAID) for mouth pain on 4/18/14 and 4/23/14</li> <li>- "Allergy relief" for allergies on 5/6/14 (twice)</li> <li>- Cough syrup for cough on 5/8/14, 5/12/14 (twice) and 5/16/14</li> <li>- Tussin chest congestion (an antitussive drug) for cough on 5/21/14</li> </ul> <p>However, Individual #1 - #3's records did not include information related to the results of the PRN drugs to evaluate the efficacy and need for further PRN administration.</p> <p>During an interview on 7/25/14 from 12:10 - 2:12 p.m., the RN stated medication administration documentation had been an on-going issue with facility staff. She stated each time a staff called for a PRN, she reminded them to record the PRN efficacy, however, staff continued to incorrectly complete the MARs. The RN stated staff should have followed-up on each PRN's efficacy and documented the information.</p> <p>The facility failed to keep a complete record of</p>	W 111	Administrative Staff regarding Incident /Accidents and follow up. This training will be completed quarterly by the City Director.	9/3/14

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W 111	<p>Continued From page 5</p> <p>Individual #1 - #3's PRN medication efficacies.</p> <p>2. Individual #10's IPP, dated 4/9/14, stated he was a 26 year old male whose diagnoses included mild intellectual disability.</p> <p>A review of the facility's Incident/Accident Reports from 4/1/14 to 7/21/14 documented Individual #10 received blows to the head without sufficient documentation of monitoring for potential head injury, as follows:</p> <p>a. An Incident/Accident Report, dated 4/8/14 and timed 3:57 p.m., documented Individual #10 was "playing basket ball, got hit several times by accident by both residents and staff. Fell down, scrapped nuckles [sic]." In the "Injuries" section, staff documented "scrapped nuckles [sic], hit head, eyes, knees, shoulder, head arm but no bruises." Under "What did you do..." staff documented "made sure he was ok and let him recover before letting him continue."</p> <p>Under the Nursing Instructions/Follow-up section, the LPN made a note, dated 4/9/14 and timed 10:00 a.m., which stated there were no signs or symptoms "of infection noted."</p> <p>No additional documentation related to monitoring for potential injury was present.</p> <p>b. An Incident/Accident Report, dated 4/8/14 and timed 7:31 p.m., documented Individual #10 was "Playing volley ball, hit the ball into a tree, ball came back and smacked him in the head." In the "Injuries" section, staff documented "hit head when hit and fell." Under "What did you do..." staff documented "let him recover, made sure he wasn't dizzy [sic], unconscious [sic], got him to</p>	W 111			

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W 111	<p>Continued From page 6 speak and laugh."</p> <p>Under the Nursing Instructions/Follow-up section, the LPN made a note, dated 4/9/14 and timed 10:00 a.m., which stated there were no signs or symptoms "of injury noted."</p> <p>No additional documentation related to monitoring for potential injury was present.</p> <p>c. An Incident/Accident Report, dated 4/19/14 and timed 7:08 p.m., documented Individual #10 was "playing basketball [and] got hit in head with elbow by [former resident]. He seemed fine after a couple of minutes. He was hurling at first but then he was fine." In the "Injuries" section, staff documented "hit to head with elbow by another resident." Under "What did you do..." staff documented "After he seemed ok we kept playing basketball."</p> <p>Under the Nursing Instructions/Follow-up section, the RN made a note, dated 4/20/14 and timed 10:00 a.m., which stated there were no signs or symptoms of "injury @ this time."</p> <p>No additional documentation related to monitoring for potential injury was present.</p> <p>d. An Incident/Accident Report, dated 4/28/14 and timed 5:40 p.m., stated Individual #10 "was playing basketball....staff shut [sic] basketball, [Individual #10] was by basket, tried to catch ball, [and] it hit him on the head as ball went through his hands. He looked dizzy [sic] [and] his eyes did not look right but then after a couple of minutes he was fine." The "Injuries" section was blank. Under "What did you do..." staff documented "I notified supervisor [and] nurse on call."</p>	W 111			

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W 111	Continued From page 7  Under the Nursing Instructions/Follow-up section, the RN made a note, dated 4/29/14 and timed 8:00 a.m., which stated "Neuro [check] [within normal limits]."  However, no additional documentation related to monitoring for potential injury, including the neuro check, was present.  When asked, during an interview on 7/24/14 from 8:52 - 9:00 a.m., the LPN stated she did not have any neuro checks for the head hits.  During an interview on 8/1/14 from 12:20 - 12:33 p.m., the RN stated anytime staff called nursing related to head hits the nurse would review each sign and symptom of a concussion. She stated if staff indicated any symptoms of concern were present, the nurse would go to the facility and visually examine the individual or would instruct staff to take the individual to the emergency room.	W 111			
W 121	The facility failed to ensure neurological monitoring for Individual #10 was documented. 483.410(d)(4) SERVICES PROVIDED WITH OUTSIDE SOURCES  If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in §483.470(a) through (g), (j) and (k).  This STANDARD is not met as evidenced by:	W 121			

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 VAUGHN AVENUE POCATELLO, ID 83204	
(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 121	<p>Continued From page 8</p> <p>Based on observation and individual and staff interview, it was determined the facility failed to ensure the physical environment promoted the health, independence and learning for 1 of 16 individuals (Individual #5) residing in the facility. This failure resulted an individual not being provided with a bedroom including an appropriate bed, functional furniture and appropriate closet and storage space. The findings include:</p> <p>1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>When asked, during an interview on 7/25/14 at 8:10 a.m., the City Director stated the facility was in a leased building, but Individual #5 should have been provided with an adequate bedroom.</p> <p>The facility failed to ensure Individual #5 was provided with an adequate bedroom.</p> <p>2. Refer to W406 - Condition of Participation:</p>	W 121	<p><b>POC W121 483.410(d)(4) SERVICES PROVIDED WITH OUTSIDE SOURCES</b></p> <p>Belmont will ensure direct responsibility for the standards relating to physical environment.</p> <p>The physical environment was modified to promote the health, independence and learning for the individual. The individual was provided with a bedroom that included an appropriate bed, functional furniture and appropriate closet and storage space.</p> <p>Belmont will ensure prior to admission there is an appropriate room with functional furniture and appropriate closet and storage space for individuals being admitted.</p> <p>1. Refer to W406</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment promotes the health, independence and learning for the individual that is being admitted.</p>	9/3/14

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 VAUGHN AVENUE POCATELLO, ID 83204	
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W 121	Continued From page 9 Physical Environment and related standard level deficiencies as they relate to the facility's failure to ensure each individual was provided with an environment which promoted independence.	W 121		
W 122	483.420 CLIENT PROTECTIONS  The facility must ensure that specific client protections requirements are met.  This CONDITION is not met as evidenced by: Based on policy review, observation, record review and staff and individual interview, it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals' rights. These failures resulted in a lack of effective systems to uphold individuals' rights. The findings include:  1. Refer to W125 as it relates to the facility's failure to ensure each individual was taught and encouraged to exercise their rights.  2. Refer to W129 as it relates to the facility's failure to ensure each individual was provided opportunities for privacy.  3. Refer to W137 as it relates to the facility's failure to ensure each individual had unrestricted access to personal possessions.  The cumulative effect of these deficient practices resulted in individuals' rights being violated.	W 122	POC W122 483.420 CLIENT PROTECTIONS  Belmont will ensure that specific client protections requirements are met.  1. Refer to W127 2. Refer to W129 3. Refer to W137  Person Responsible: DSPs, Program Supervisors, Assistant QIDP/QIDP, Assistant Behavior Specialists, LPCs, City Director.  Monitor: Monthly the Administrative Team will review client protection concerns in the on-going Behavior Meetings.	9/3/14
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients.	W 125		

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W 125	<p>Continued From page 10</p> <p>Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, observation and individual and staff interview, It was determined the facility failed to ensure Individuals' rights were promoted for 5 of 5 individuals (Individuals #1, #3, #5, #6 and #9) interviewed regarding grievances, with the potential to affect all individuals (Individuals #1 - #16) residing in the facility. This failure resulted in a lack of understanding and implementation of the grievance process. The findings include:</p> <p>1. The facility's Consumer Grievances policy, dated 1/9/13, documented "Grievances can be given either verbally or in writing. All grievances will be taken seriously and be investigated by the Administrator or Designee." However, the facility failed to encourage and assist individuals with their right to file grievances, as follows:</p> <p>a. An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City</p>	W 125	<p><b>POC W125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</b></p> <p>Belmont will ensure the rights of all individuals. Belmont will allow and encourage individuals to exercise their rights as individuals of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process</p> <p>Training will be done with all staff regarding the Grievance policy and the procedures that are to be followed. In addition, a separate meeting will be held with the individuals to explain the process. A new grievance form has been created for individuals to voice their concerns. For those that are unable to write, staff will assist them in completing and turning in the form.</p> <p>Person Responsible: DSP, Lead DSP, Program Supervisors, Assistant QIDP/QIDP, Assistant Behavior Specialist/Behavior Specialist, LPC, and City Director.</p> <p>Monitor: The Grievance policy will be incorporated into the initial admission paperwork that is reviewed. A signed copy of this policy will be kept in their individual record. Grievance forms will be turned daily or as received. Tracking will be implemented to track the grievance and the outcome. Monthly during individual home meetings any concerns the individuals have may be addressed.</p>	9/3/14	

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W 125	<p>Continued From page 11</p> <p>Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>The TV room was noted to contain general facility supplies, including a TV, entertainment center, fish tank, a cabinet of staff Inboxes as well as approximately twelve house-supply board games.</p> <p>When asked, Individual #5 stated, during an interview on 7/22/14 from 7:22 - 7:25 a.m., he had his own bedroom prior to his incarceration. Individual #5 stated he was frustrated that he did not have his own space.</p> <p>During observations conducted on 7/21/14 and 7/22/14 for a cumulative 4 hours and 41 minutes, the double doors to the TV room were noted to be kept open. Additionally, no less than six individuals were noted to partake in various activities in the TV room with and without Individual #5.</p> <p>During a second interview on 7/24/14 from 9:03 - 9:06 a.m., Individual #5 stated he reported his complaints about the bedroom setup (e.g. lack of bed, storage space, etc.) to the floor leader but nothing had been done. Individual #3, also present during the interview, stated Individual #5 had been complaining about the situation since Individual #5 returned from his incarceration.</p> <p>Additionally, Individual #5 stated one day in particular he had requested a different direct care staff from the floor leader and his request was not addressed.</p> <p>b. During an interview on 7/22/14 at approximately 12:20 p.m., Individual #1 stated he had multiple concerns about facility procedures,</p>	W 125			

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W 125	<p>Continued From page 12 including which movies and video games were permitted. When asked, Individual #1 stated he did not know the grievance process and wanted to be able to discuss the concerns with someone he could trust to relay the information. Documentation related to Individual #1's grievances could not be found.</p> <p>c. During an interview on 7/24/14 at approximately 8:40 a.m., Individual #3 stated he could not remember the grievance process as he had not had any issues at the facility.</p> <p>d. During an interview on 7/24/14 at approximately 8:45 a.m., Individual #9 stated he had multiple concerns with the facility, including a delay in getting out of the facility and direct care staff using their cell phones during work. He stated the facility had "hassle logs" which he had not ever completed. Individual #9 stated he typically took his complaints directly to the Administrator, QIDP or Assistant Behavior Specialist. Individual #9 stated he thought facility staff tried to resolve his complaints, however, he never received follow-up after a complaint, so he could not say for sure. Documentation related to Individual #9's grievances could not be found.</p> <p>e. During an interview on 7/24/14 at approximately 10:00 a.m., Individual #6 stated he had concerns with the facility, including how group counseling was implemented. He stated he voiced his concerns to the floor leader and Administrator and felt like his complaints went unheard. Documentation related to Individual #6's grievances could not be found.</p> <p>On 7/24/14 at approximately 10:25 a.m., grievances from the past six months were</p>	W 125		

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W 125	Continued From page 13 requested. The City Director was unable to produce evidence of any complaints being reported and/or addressed.	W 125			
W 129	<p>During an interview on 7/25/14 from 12:10 - 2:12 p.m., the QIDP stated the facility had not documented grievances and follow-up in the past and would re-evaluate the grievance process. Facility staff present (including the City Director, QIDP, AQIDP and the Assistant Behavior Specialist) took note of the concerns and stated they would be addressed.</p> <p>The facility failed to ensure individuals were aware of, and encouraged to utilize, the grievance process and that it was implemented per policy.</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</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, record review and staff and individual interview, it was determined the facility failed to ensure 1 of 16 individuals (Individual #5) residing in the facility was provided with the opportunity to personal privacy. This resulted in an individual's right to privacy being violated. The findings include:</p> <p>1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.</p>	W 129			

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W 129	<p>Continued From page 14</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be pulling away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>The TV room was noted to contain general facility supplies, including a TV, entertainment center, fish tank, a cabinet of staff inboxes as well as approximately twelve house-supply board games.</p> <p>When asked, Individual #5 stated, during an interview on 7/22/14 from 7:22 - 7:25 a.m., he had his own bedroom prior to his incarceration. Individual #5 stated he was frustrated that he did not have his own space.</p> <p>During observations conducted on 7/21/14 and 7/22/14 for a cumulative 4 hours and 41 minutes, the double doors to the TV room were noted to be kept open. Additionally, no less than six individuals were noted to partake in various activities in the TV room with and without Individual #5.</p> <p>In an interview on 7/22/14 from 10:24 - 10:33 a.m., the QIDP stated if Individual #5 wanted privacy, he would have to let the staff know and that staff would ask individuals to leave the TV</p>	W 129	<p>POC W129 483.420(a)(7) <b>PROTECTION OF CLIENTS RIGHTS</b></p> <p>Belmont will ensure the rights of all individuals. Belmont will provide each individuals with the opportunity for personal privacy.</p> <p>The individual was removed for the living space into a room that provided him with the opportunity to personal privacy.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure it provides the opportunity for personal privacy.</p>	9/3/14	

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204		
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W 129	Continued From page 15 room. The QIDP stated that all staff used the inboxes and that they would need to be removed from the TV room to provide Individual #5 with privacy.	W 129			
W 137	The facility failed to ensure Individual #5's right to privacy was not violated. 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.  This STANDARD is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the facility failed to ensure individuals had access to personal possessions for 1 of 16 individuals (Individual #5) whose personal items were observed. This resulted in an individual's right to his personal possessions not being upheld. The findings include:  1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.  An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual	W 137			

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W 137	<p>Continued From page 16</p> <p>#5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>On 7/22/14 at 10:00 a.m., Individual #5 gave a tour of his living space. In the TV room, he pointed out six plastic drawers which contained some of his personal possessions, including clothing. Individual #5 also pointed to a pile of shoes between the couch and phone stand which he stated belonged to him.</p> <p>The TV room did not contain a closet. The TV room contained various cabinets, including an entertainment center and a stand underneath the facility fish tank. However, none of the storage space in the TV room had been designated to Individual #5.</p> <p>During the tour on 7/22/14 at 10:00 a.m., Individual #5 also requested access to the dietary office. After a staff unlocked the dietary office, Individual #5 showed a laundry basket for his dirty clothes that was kept in the office. Individual #5 indicated the remainder of his personal possessions were stored in the facility "archive." The archive room was a locked room at the base of the stairwell, on the lower level of the facility. The room contained a large cabinet which included notebooks, video game guitars, a stereo, clothes and shoes Individual #5 stated belonged to him.</p> <p>When asked, during an interview on 7/22/14 from 10:24 - 10:33 a.m., the City Director stated she</p>	W 137	<p><b>POC W137 483.420(a)(12) PROTECTION OF CLIENT RIGHTS</b></p> <p>Belmont will ensure the rights of all individuals. Belmont will ensure that individuals have the right to retain and use appropriate personal possessions and clothing.</p> <p>The individual was moved to a living space that allowed him to retain and use his personal possessions.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment allows the individual to retain and use personal possessions.</p>	9/3/14	

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W 137	Continued From page 17 was aware that Individual #5's possessions were stored in the TV room, dietary office and archive room. She stated the storage set-up was temporary until a permanent bed and bedroom space opened up for Individual #5. The City Director stated in the meantime Individual #5 was able to ask for access to his possessions.	W 137			
W 159	The facility failed to ensure Individual #5's right to retain and use personal possessions was upheld. 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observation, record review and individual and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight of individuals' active treatment programs for 4 of 4 individuals (Individuals #1 - #4) whose active treatment schedules were reviewed, with the potential to affect all individuals (Individuals #1 - #16) residing in the facility. This failure resulted in a lack of sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of assessments, objectives, program development and protection of rights. The findings include:  1. Individual #1's IPP, dated 7/31/13, documented a 32 year old male whose diagnoses included mild intellectual disability.  a. Individual #1's Comprehensive Functional	W 159			

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W 159	<p>Continued From page 18</p> <p>Assessment, dated 7/26/13, documented Individual #1's non-compliance, including, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Tooth Brushing: "Will often refuse to brush teeth at appropriate times, or even will go days without brushing."</li> <li>- Miscellaneous Grooming: "Often will refuse to use deodorant and presents with body odor."</li> <li>- Dressing: "Often will refuse to wear clean clothing after shower, or before attending Day [Treatment]."</li> <li>- Undressing: "Often will struggle with non-compliance, not because he is not capable of."</li> <li>- Vocational Skills: "Will often refuse to participate or complete Vocational Treatment."</li> <li>- Community Leisure: "Often will refuse group activities."</li> <li>- Nursing: Medications: "Often will refuse to complete medication routine" and "Does not often take interest in Medical or Medication Treatment. Is capable of learning and progressing in this area, but he will often struggle with non-compliance."</li> </ul> <p>Additionally, his behavior assessment, dated 7/15/14, indicated Individual #1's non-compliance was defined as "refusing rules, refusing chores, refusing to participate in his...restrictions, refusing group, refusing to participate in vocational training, refusing ADLs, refusing medications and refusing programs."</p> <p>Individual #1's IPP documented the following related to Individual #1's refusals:</p> <ul style="list-style-type: none"> <li>- Toileting: "It is the opinion of the treatment team that [Individual #1] will use the bathroom for an</li> </ul>	W 159	<p><b>POC W159 483.430(a)</b> <b>QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Belmont will ensure each individual's active treatment program will be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Belmont will review to ensure plans are sufficiently developed and implemented to address on-going behavioral and programmatic needs for all individuals.</p> <ol style="list-style-type: none"> <li>1. Refer to W122</li> <li>2. Refer to W252</li> <li>3. Refer to W257</li> <li>4. Refer to W290</li> <li>5. Refer to W312</li> <li>6. Refer to W481</li> </ol> <p>Person Responsible: Assistant QIDP/QIDP, Assistant Behavior Specialist/Behavior Specialist, Administrator, and City Director.</p> <p>Monitor: Monthly plans will be reviewed monthly. Quarterly or as needed progress or regression will be reviewed by the Treatment Team. The City Director and QIDP will work with each department to ensure individuals records are reviewed and audited quarterly.</p>	9/3/14	

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204		
(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)	(X6) COMPLETION DATE	
W 159	<p>Continued From page 19</p> <p>excessive amount of time to avoid treatment." - Showering/Bathing: "Currently, [Individual #1] will take showers for a very extensive amount of time (2-3 hours)...The treatment team feels that [Individual #1] uses the time in the shower to avoid treatment..." - Personal Hygiene: "The treatment team feels that if [sic] he is able to complete all tasks, but struggles to [sic] due to refusals..." - Academic history: "[Individual #1] has refused and is unwilling to complete new tasks that will promote growth in many of his academic skills."</p> <p>Individual #1's IPP included an objective "to decrease non-compliant behaviors to 200 incidents per month for three consecutive months." His Non-Compliance Program, revised 5/1/14, included instructions to staff to positively reinforce compliance, use the prompt hierarchy for cueing and to discuss his non-compliance objective.</p> <p>Individual #1's monthly behavior summaries from 9/2013 - 6/2014 were reviewed. Individual #1 engaged in non-compliance, as follows:</p> <ul style="list-style-type: none"> <li>- 9/2013: 111 times</li> <li>- 10/2013: Data collection sheets destroyed</li> <li>- 11/2013: 154 times</li> <li>- 12/2013: 104 times</li> <li>- 1/2014: 137 times</li> <li>- 2/2014: 112 times</li> <li>- 3/2014: 163 times</li> <li>- 4/2014: 153 times</li> </ul> <p>Individual #1's 4/2014 Behavior Summary for Individual #1's non-compliance objective documented "met his program goal for the month A [sic] revision was implemented in May. The</p>	W 159			

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W 159	<p>Continued From page 20</p> <p>revision was to decrease the frequency of reinforcement. The majority of incidents of non-compliance included [Individual #1] refusing to participate in day treatment and refusing to follow rules."</p> <p>However, Individual #1's monthly behavior summaries documented he continued to engage in non-compliance, as follows:</p> <ul style="list-style-type: none"> <li>- 5/2014: 148 times</li> <li>- 6/2014: 208 times</li> </ul> <p>When asked what actions had been taken to address Individual #1's non-compliance, during an interview on 7/25/14 from 10:35 - 11:40 a.m., the AQIDP stated the team was looking at moving Individual #1 to a sister facility in the company and/or implementing a money reinforcement program. She stated the team hoped the change in environment and use of money reinforcement would motivate Individual #1. The AQIDP stated past interventions including discussing the situation with Individual #1's advocate, who tried to meet with Individual #1, but Individual #1 refused.</p> <p>During an interview on 7/25/14 from 11:05 - 11:09 a.m., the Assistant Behavior Specialist stated in an attempt to reduce refusals, the facility met with Individual #1's guardian and made minor revisions to Individual #1's Non-Compliance Program. The Assistant Behavior Specialist stated the facility's attempts would motivate Individual #1 for approximately one week at a time.</p> <p>The facility failed to ensure plans were sufficiently developed and implemented to address Individual</p>	W 159			

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3825 VAUGHN AVENUE POCATELLO, ID 83204		
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W 159	<p>Continued From page 21 #1's on-going non-compliance.</p> <p>b. Individual #1's program summaries from 9/2013 - 5/2014 were reviewed. The summaries from 9/2013 - 4/2014 included tracking for Individual #1's anger coping skills, conflict resolution skills and anxiety coping skills objectives. However, Individual #1's 5/2014 program summaries did not include information related to those objectives.</p> <p>When asked, in an interview on 7/25/14 from 12:10 - 2:12 p.m., the Assistant Behavior Specialist stated tracking for the identified objectives for May 2014 was missed due to miscommunication.</p> <p>The facility failed to ensure the QIDP provided sufficient monitoring to ensure all objectives were reviewed monthly.</p> <p>2. Individual #3's IPP, dated 1/8/14, indicated he was a 39 year old male with diagnoses including mild intellectual disability.</p> <p>a. Individual #3's program summaries from 2/2014 - 5/2014 were reviewed. The summaries from 2/2014 - 4/2014 included tracking for Individual #3's depression coping skills, healthy body skills and insomnia coping skills objectives. However, Individual #3's 5/2014 program summaries did not include information related to those objectives.</p> <p>When asked, in an interview on 7/25/14 from 12:10 - 2:12 p.m., the Assistant Behavior Specialist stated tracking for the identified objectives for May 2014 was missed due to miscommunication.</p>	W 159			

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W 159	Continued From page 22  The facility failed to ensure the QIDP provided sufficient monitoring to ensure all objectives were reviewed monthly.  3. Refer to W122 - Condition of Participation: Client Protections and related standard level deficiencies as they relate to the QIDP's failure to ensure individuals' rights were upheld.  4. Refer to W252 as it relates to the facility's failure to ensure the QIDP ensured data was collected as specified in individuals' program plans.  5. Refer to W257 as it relates to the facility's failure to ensure the QIDP ensured objectives were revised when an individual failed to make progress towards them.  6. Refer to W290 as it relates to the facility's failure to ensure the QIDP ensured restrictive interventions were implemented only when the use of those interventions was justified.  7. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed.  8. Refer to W481 as it relates to the facility's failure to ensure the QIDP ensured the menus included accurate information related to food actually served.	W 159			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION	W 252			

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W 252	<p>Continued From page 23</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</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 sufficient data was collected to determine the efficacy of intervention strategies for 3 of 4 individuals (Individuals #1 - #3) whose program data was reviewed. That failure had the potential to impede the ability of the treatment team in evaluating the effectiveness of programmatic techniques. The findings include:</p> <p>1. Individual #1's IPP, dated 7/31/13, documented a 32 year old male whose diagnoses included mild intellectual disability.</p> <p>His program data for May and June 2014 was reviewed. Data was not consistently collected as specified in his programs. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's follow health choices program, revised 8/2013, documented data was to be taken 6 times a day (during breakfast, lunch, dinner and his morning, afternoon and evening snacks). Data was not taken at the frequency specified on the plan, as follows:</p> <p>5/2014: - Only 2 data probes were taken on 5/5/14, 5/14/14 and 5/19/14.</p>	W 252	<p><b>POC W252 483.440(e)(1) PROGRAM DOCUMENTATION</b></p> <p>Belmont will ensure data relative to accomplishment of the criteria specified in individual program plan objectives is documented in measureable terms.</p> <p>A training will be completed with all staff regarding data collection. The training will also address the frequency of collecting data based on the instructions in the body of the programming.</p> <p>Person Responsible: Assistant QIDP/QIDP, Assistant Behavior Specialist/Behavior Specialist, Supervisors, Lead DSPs, and City Director.</p> <p>Monitor: Lead DSPs will complete random data collection checks throughout the shifts to ensure programs are being run and documentation collected. Program Supervisors will complete weekly checks. Assistant QIDPs/QIDP and Assistant Behavior Specialists will be responsible for reviewing program books bi-monthly to ensure programs are being run and documentation is being collected. In addition, on the floor training will be completed with staff that are identified as struggling with program implementation and data collection.</p>	9/3/14

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W 252	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>- Only 1 data probe was taken on 5/1/14 - 5/4/14, 5/7/14 - 5/11/14, 5/13/14, 5/17/14, 5/18/14, 5/20/14 - 5/25/14, 5/27/14 and 5/31/14.</li> <li>- No data was collected on 5/8/14, 5/12/14, 5/15/14, 5/16/14, 5/26/14 and 5/28/14 - 5/30/14.</li> </ul> <p>6/2014:</p> <ul style="list-style-type: none"> <li>- Only 2 data probes were taken on 6/1/14 and 6/21/14.</li> <li>- Only 1 data probe was taken on 6/3/14, 6/4/14, 6/7/14 - 6/12/14, 6/15/14, 6/17/14 - 6/19/14, 6/22/14, 6/23/14, 6/25/14 and 6/27/14.</li> <li>- No data was collected on 6/2/14, 6/5/14, 6/6/14, 6/13/14, 6/14/14, 6/16/14, 6/20/14, 6/24/14, 6/26/14 and 6/28/14 - 6/30/14.</li> </ul> <p>b. Individual #1's academic task program, dated 8/17/13, documented data was to be taken once a day, Monday - Friday. Data was not taken at the frequency specified on the plan, as follows:</p> <ul style="list-style-type: none"> <li>- 5/2014: Data had been collected only 7 times during the month. No data had been collected on 5/1/14, 5/2/14, 5/5/14 - 5/7/14, 5/12/14, 5/13/14, 5/15/14, 5/21/14, 5/23/14 or 5/26/14 - 5/30/14.</li> <li>- 6/2014: Data had been collected only 2 times during the month. No data had been collected on 6/2/14 - 6/6/14, 6/9/14 - 6/12/14, 6/16/14 - 6/18/14, 6/20/14, 6/23/14 - 6/27/14 and 6/30/14.</li> </ul> <p>c. Individual #1's vocational tasks program, dated 8/30/13, documented data was to be taken once a day, Monday - Friday. Data was not taken at the frequency specified on the plan, as follows:</p>	W 252			

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3026 VAUGHN AVENUE POCATELLO, ID 83204		
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W 252	<p>Continued From page 25</p> <p>5/2014: Data had been collected only 4 times during the month. - No data had been collected on 5/1/14 - 5/2/14, 5/5/14 - 5/9/14, 5/12/14, 5/13/14, 5/15/14, 5/16/14, 5/21/14, 5/23/14 or 5/26/14 - 5/30/14.</p> <p>6/2014: Data had been collected only 2 times during the month. - No data had been collected on 6/2/14 - 6/6/14, 6/9/14 - 6/12/14, 6/16/14 - 6/18/14, 6/20/14, 6/23/14 - 6/27/14 and 6/30/14.</p> <p>d. Individual #1 had a program in place to address his maladaptive behavior of non-compliance. However, data collection for Individual #1's non-compliance program was not consistent with data collected for his other programs.</p> <p>For example, Individual #1's shower program, revised 5/2014, stated if he exceeded 45 minutes in the bathroom shower, staff were to document he was non-compliant for that hour and every hour he was in the bathroom. The shower program further stated staff were to document he was non-compliant every hour after the third day that he refused to complete his shower routine.</p> <p>Individual #1's non-compliance plan, revised 5/1/14, stated staff were to record each time Individual #1 was non-compliant. Staff were to use a "Non-compliance Data Sheet" marking a "1" for appropriate behavior, a "0" for inappropriate behavior or an "S" to indicate he was sleeping. Data was to be record every hour throughout the day.</p> <p>Staff were also to complete a "Non-Compliance Checklist." The checklist included a column</p>	W 252		

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W 252	<p>Continued From page 26</p> <p>listing tasks Individual #1 refused, such as chores, day treatment, medications, etc. Each time Individual #1 demonstrated non-compliance, staff were to place a tally mark next to the task he was refusing.</p> <p>Additionally, the "Non-Compliance Checklist" stated staff were to complete a "Stepping Stones" form providing details of the incident.</p> <p>Staff were required to complete no less than 4 forms each time Individual #1 refused a task.</p> <p>Individual #1's showering data, non-compliance data sheet, non-compliance checklist and stepping stones data for 6/2014 was reviewed. Data was not consistently collected among the various forms. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Individual #1's shower data documented he refused to shower on 6/12/14. His non-compliance data sheet included "0" (indicating non-compliance) in the time blocks for 7:00 - 11:00 a.m., 2:00 p.m. and 10:00 p.m. His non-compliance checklist included only 1 tally mark in the row titled "Refuse programs." No other tally marks were recorded in any other row, including the row titled "Refused ADLs." Additionally, a Stepping Stones form for 6/12/14 could not be found.</li> <li>- Individual #1's shower data documented he refused to shower on 6/20/14. His non-compliance data sheet included "0" (indicating non-compliance) in the time blocks for 7:00 a.m. - 3:00 p.m. and 9:00 - 10:00 p.m. His non-compliance checklist included multiple tally marks indicating refusals to follow the rules,</li> </ul>	W 252			

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W 252	<p>Continued From page 27</p> <p>refusal of treatment, refusal of programs, refusal of ADLs, and refusal of medications. However, Stepping Stones forms for 6/20/14 could not be found.</p> <p>- Individual #1's shower data documented he refused to shower on 6/28/14. His non-compliance data sheet included "0" (indicating non-compliance) in the time blocks for 3:00 - 10:00 p.m. His non-compliance checklist included only 1 tally mark in the row titled "Refuse programs." No other tally marks were recorded in any other row, including the row titled "Refused ADLs." Additionally, a Stepping Stones form for 6/28/14 could not be found.</p> <p>When asked about the data, during an interview on 7/25/14 from 12:10 - 2:12 p.m., the AQIDP stated data should have been collected in the manner specified on the training programs.</p> <p>The facility failed to ensure Individual #1's program data was collected at the frequency specified on his training programs.</p> <p>2. Individual #2's IPP, dated 3/4/14, documented a 31 year old male whose diagnoses included mild intellectual disability.</p> <p>His program data for May and June 2014 was reviewed. Data was not consistently collected as specified in his programs, as follows:</p> <p>a. Individual #2's Identify medications program, dated 4/2013, documented data was to be taken twice daily. Data was not taken at the frequency specified on the plan, as follows:</p> <p>5/2014:</p>	W 252		

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 VAUGHN AVENUE POCATELLO, ID 83204	
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W 252	<p>Continued From page 28</p> <p>- Only 1 data probe was taken on 5/1/14, 5/3/14, 5/5/14, 5/8/14 - 5/10/14, 5/12/14, 5/19/14, 5/22/14 and 5/27/14 - 5/29/14.</p> <p>- No data was collected on 5/2/14, 5/4/14, 5/6/14, 5/11/14, 5/15/14 - 5/18/14, 5/24/14, 5/25/14, 5/30/14 and 5/31/14.</p> <p>6/2014: - Only 1 data probe was taken on 6/1/14, 6/5/14 - 6/9/14, 6/13/14, 6/15/14, 6/23/14 and 6/26/14.</p> <p>- No data was collected on 6/2/14, 6/12/14, 6/24/14, 6/25/14 and 6/27/14 - 6/30/14.</p> <p>b. Individual #2's define informed consent program, dated 4/2013, documented data was to be taken twice a day. Data was not taken at the frequency specified on the plan, as follows:</p> <p>5/2014: - Only 1 data probe was taken on 5/3/14, 5/5/14, 5/8/14 - 5/10/14, 5/12/14, 5/19/14, 5/22/14, 5/28/14 and 5/29/14.</p> <p>- No data was collected on 5/2/14, 5/4/14, 5/6/14, 5/11/14, 5/15/14 - 5/18/14, 5/24/14, 5/25/14, 5/30/14 and 5/31/14.</p> <p>6/2014: - Only 1 data probe was taken on 6/1/14, 6/5/14 - 6/8/14, 6/13/14, 6/15/14, 6/23/14 and 6/26/14.</p> <p>- No data was collected on 6/2/14, 6/12/14, 6/24/14, 6/25/14 and 6/27/14 - 6/30/14.</p> <p>When asked about the data on 7/25/14 from 12:10 - 2:12 p.m., the AQIDP stated data should have been collected in the manner specified on</p>	W 252		

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 VAUGHN AVENUE POCATELLO, ID 83204	
(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 252	<p>Continued From page 29 the training programs.</p> <p>The facility failed to ensure Individual #2's program data was collected at the frequency specified on his training programs.</p> <p>3. Individual #3's IPP, dated 1/8/14, documented he was a 39 year old male with diagnoses including mild intellectual disability.</p> <p>Individual #3's program data for May and June 2014 was reviewed. Data was not consistently collected as specified in his programs. Examples included, but were not limited to, the following:</p> <p>a. Individual #3's chew on appropriate item program, dated 2/7/14, documented data was to be taken twice a day. Data was not taken at the frequency specified on the plan as follows:</p> <p>5/2014: - Only 1 data probe was taken on 5/1/14, 5/9/14, 5/11/14, 5/14/14, 5/16/14 and 5/19/14. - No data was taken on 5/20/14 - 5/31/14.</p> <p>6/2014: - Only 1 data probe was taken on 6/1/14, 6/5/14, 6/6/14, 6/12/14 - 6/15/14, 6/17/14, 6/19/14, 6/21/14 and 6/23/14. - No data was taken on 6/24/14 - 6/30/14.</p> <p>b. Individual #3's track money log program, revised 2/2014, documented data was to be taken twice a day. Data was not taken at the frequency specified on the plan as follows:</p> <p>5/2014:</p>	W 252		

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W 252	<p>Continued From page 30</p> <p>- Only 1 data probe was taken on 5/1/14, 5/2/14, 5/5/14, 5/6/14, 5/13/14, 5/14/14, 5/16/14, 5/18/14, 5/20/14, 5/22/14, 5/23/14, 5/25/14, 5/26/14, 5/28/14, 5/30/14 and 5/31/14.</p> <p>- No data was taken on 5/3/14, 5/7/14, 5/9/14, 5/11/14, 5/21/14, 5/24/14, 5/27/14 and 5/29/14.</p> <p>6/2014:</p> <p>- Only 1 data probe was taken on 6/7/14 - 6/10/14, 6/14/14, 6/15/14, 6/17/14, 6/20/14, 6/23/14, 6/24/14 and 6/28/14.</p> <p>- No data was taken on 6/1/14 - 6/5/14, 6/12/14, 6/13/14, 6/18/14, 6/19/14, 6/21/14, 6/22/14, 6/26/14, 6/27/14, 6/29/14 and 6/30/14.</p> <p>c. Individual #3's career research program, dated 2/7/14, documented data was to be taken 7 days a week (Monday - Friday). Data was not taken at the frequency specified on the plan as follows:</p> <p>5/2014: Data had been collected only 7 times during the month.</p> <p>- No data had been collected on 5/1/14 - 5/7/14, 5/9/14 - 5/11/14, 5/13/14, 5/14/14, 5/17/14, 5/18/14, 5/20/14, 5/21/14, 5/23/14 - 5/28/14 and 5/30/14.</p> <p>6/2014:</p> <p>- No data had been collected for the month of June.</p> <p>d. Individual #3's pain level tracking program, dated 2/7/14, documented data was to be taken twice a day. Data was not taken at the frequency specified on the plan as follows:</p> <p>5/2014:</p>	W 252		

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W 252	Continued From page 31 - Only 1 data probe was taken on 5/4/14, 5/11/14, 5/13/14, 5/16/14 and 5/18/14.  - No data was taken on 5/19/14 - 5/31/14.  6/2014: - Only 1 data probe was taken on 6/6/14, 6/9/14, 6/11/14, 6/15/14, 6/19/14 and 6/20/14.  - No data was taken on 6/14/14, 6/21/14 and 6/23/14 - 6/30/14.  e. Individual #3's IPP contained an objective to "complete his insomnia coping skills routine." Additionally, Individual #3's IPP included an objective which stated "Staff will monitor and record patterns of sleep..."  However, information related to Individual #3's sleep, including his average nightly sleep goal or sleep tracking, could not be found in Individual #3's record.  During an interview on 7/25/14 from 12:10 - 2:12 p.m., the Assistant Behavior Specialist stated she would submit any information related to sleep tracking. However, as of 8/1/14, no sleep tracking for Individual #3 had been sent.  When asked about the data on 7/25/14 from 12:10 - 2:12 p.m., the AQIDP stated data should have been collected in the manner specified on the training programs.  The facility failed to ensure Individual #3's program data was collected at the frequency specified on his training programs.	W 252		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING &	W 257		

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NAME OF PROVIDER OR SUPPLIER  <b>BELMONT CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3026 VAUGHN AVENUE POCATELLO, ID 83204</b>		
(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 257	<p>Continued From page 32 CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</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 IPPs were revised when individuals failed to progress towards identified objectives for 1 of 4 individuals (Individual #1) whose program summaries were reviewed. Without revisions to program plans when progress had not been demonstrated, an individual would continue experiencing a lack of success. The findings include:</p> <p>1. Individual #1's IPP, dated 7/31/13, documented he was a 32 year old male with diagnoses including mild intellectual disability.</p> <p>Individual #1's Monthly Program Summaries, dated 9/2013 - 5/2014, documented a lack of progress. Examples included, but were not limited to, the following:</p> <p>a. The objective for completing bedroom corrections was set at 55% success for 3 consecutive months. His Monthly Program Summaries showed the following status of the objective:</p> <p>- 9/2013: 0% - 10/2013: 0% - 11/2013: 0%</p>	W 257	<p><b>POC W257 483.440(f)(1)(iii) PROGRAM MONITORING &amp; CHANGE</b></p> <p>Belmont will ensure the individual program plan is reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the individual is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>All programs will be reviewed monthly by the Assistant Behavior Specialist and Assistant QMRP/QMRP. The Assistant QIDP/QIPD and Assistant Behavior Specialist will re-assess programming to fit current needs when individuals are failing to progress towards the program goal. Based on the re-assessment, program revisions will be implemented.</p> <p>Person Responsible: Assistant QMRP/QMRP's and Behavioral Specialist.</p> <p>Monitor: Monthly monitoring of programs and status will be completed by the Assistant QMRP, QMRP, and Behavioral Specialist. Quarterly review of individuals programming will be completed by the Treatment Team.</p>	9/3/14

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W 257	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>- 12/2013: 0%</li> <li>- 1/2014: 0%</li> <li>- 2/2014: 0%</li> <li>- 3/2014: 0%</li> <li>- 4/2014: 0%</li> <li>- 5/2014: 0%</li> </ul> <p>The documentation indicated the program was revised to include a second verbal cue in 1/2014 and additional light physical assistance was added in 5/2014. However, significant revisions to address Individual #1's failure to show consistent or sustained progress for 3 consecutive months were not made.</p> <p>b. The objective for wearing eyeglasses was set at 65% success for 3 consecutive months. His Monthly Program Summaries showed the following status of the objective:</p> <ul style="list-style-type: none"> <li>- 9/2013: 0%</li> <li>- 10/2013: 0%</li> <li>- 11/2013: 0%</li> <li>- 12/2013: 0%</li> <li>- 1/2014: 0%</li> <li>- 2/2014: 0%</li> <li>- 3/2014: 0%</li> <li>- 4/2014: 0%</li> <li>- 5/2014: 0%</li> </ul> <p>The documentation indicated the program was revised to include a second verbal cue in 1/2014 and in 5/2014 the program was revised to focus on wearing eyeglasses during day treatment. However, significant revisions to address Individual #1's failure to show consistent or sustained progress for 3 consecutive months were not made.</p>	W 257		

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W 257	<p>Continued From page 34</p> <p>c. The objective for exercising four times per week was set at 60% success for 3 consecutive months. His Monthly Program Summaries showed the following status of the objective:</p> <ul style="list-style-type: none"> <li>- 9/2013: 15%</li> <li>- 10/2013: 10%</li> <li>- 11/2013: 0%</li> <li>- 12/2013: 16%</li> <li>- 1/2014: 26%</li> <li>- 2/2014: 29%</li> <li>- 3/2014: 38%</li> <li>- 4/2014: 28%</li> <li>- 5/2014: 16%</li> </ul> <p>The documentation indicated the program was revised to include a second verbal cue in 1/2014 and in 5/2014 the objective was dropped to exercising three times per week. However, significant revisions to address Individual #1's failure to show consistent or sustained progress for 3 consecutive months were not made.</p> <p>d. The objective for personal hygiene was set at 50% success for 3 consecutive months. His Monthly Program Summaries showed the following status of the objective:</p> <ul style="list-style-type: none"> <li>- 9/2013: 18%</li> <li>- 10/2013: 28%</li> <li>- 11/2013: 31%</li> <li>- 12/2013: 17%</li> <li>- 1/2014: 23%</li> <li>- 2/2014: 19%</li> <li>- 3/2014: 16%</li> <li>- 4/2014: 11%</li> <li>- 5/2014: 34%</li> </ul> <p>The documentation indicated the program was</p>	W 257			

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W 257	Continued From page 35 revised to include a second verbal cue in 1/2014 and a reminder was added in 5/2014. However, significant revisions to address Individual #1's failure to show consistent or sustained progress for 3 consecutive months were not made.  During an interview on 7/25/14 from 10:35 - 11:40 a.m., the AQIDP stated it had been a struggle to motivate Individual #1 to continuously participate in his programming due to refusals. The AQIDP stated the team was looking at moving Individual #1 to a sister facility in the company and/or implementing a money reinforcement program. She stated the team hoped the change in environment and use of money reinforcement would motivate Individual #1. The AQIDP stated the Monthly Program Summaries were an accurate related to Individual #1's program progress.  During an interview on 7/25/14 from 11:05 - 11:09 a.m., the Assistant Behavior Specialist stated in an attempt to reduce refusals, the facility met with Individual #1's guardian and made minor revisions to Individual #1's Non-Compliance Program but no significant program revisions had been made.  The facility failed to ensure objectives were revised when Individual #1 failed to make progress towards them.	W 257			
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  Standing or as needed programs to control inappropriate behavior are not permitted.	W 290			

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W 290	<p>Continued From page 36</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 standing programs to control inappropriate behavior, in the absence of evidence to justify such usage, were not in place for 4 of 4 individuals (Individuals #1 - #4) whose behavioral interventions were reviewed. This resulted in restrictive suicide interventions being incorporated into behavior plans without justification for their use. The findings include:</p> <p>1. Individual #1 - #4's records were reviewed and each included an Individualized Suicide Intervention Plan. The plan for Individual #1 was implemented on 2/1/12, for Individual #2 on 9/28/12, for Individual #3 on 11/11/11 and for Individual #4 on 6/11/14.</p> <p>The plans all documented if the individual exhibited suicidal behavior (defined as more than two consecutive hours of depressive symptoms or hopelessness) staff were to place the individual under arm's length line of sight supervision. Additionally, the plans instructed staff to remove any dangerous items from the individual's possession, utilizing the facility's restraint system if needed.</p> <p>However, Individual #1, #2 and #4's records documented the individuals had never engaged in any suicidal ideation. Individual #3's record indicated he thought about suicide during an incarceration between 2004 and 2005, with no suicidal ideation since.</p> <p>When asked during an interview on 7/25/14 from 12:10 - 2:12 p.m., the Assistant Behavior</p>	W 290	<p>POC W290 483.450(b)(5) <b>MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</b></p> <p>Belmont will ensure standing or as needed programs to control inappropriate behavior are not permitted.</p> <p>Programming for all individuals will be reviewed by the Treatment Team to determine program needs. Programs will be revised to reflect individual's current needs.</p> <p>The Behavior Hierarchy will be revised to include behavior fading criteria.</p> <p>Person Responsible: Assistant QIDP/QIDP, Assistant Behavior Specialist, and City Director.</p> <p>Monitor: Monthly the Assistant Behavior Specialist/ QIDP will review programming to ensure it accurately reflects the individual's maladaptive behavior and the interventions needed. Quarterly the Treatment Team will review programming that addresses maladaptive behaviors.</p>	9/3/14

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W 290	Continued From page 37 Specialist stated due to past instruction related to maladaptive behaviors, the suicide intervention guidelines were implemented for all individuals, regardless of need. She stated suicidal ideation for each individual would be re-assessed.	W 290	<b>POC W312 483.450(e)(2) DRUG USAGE</b>  Belmont will ensure drugs used for control of inappropriate behavior will be used only as an integral part of the individual's program plan that is directed specifically towards the reduction of an eventual elimination of the behaviors for which the drugs are employed.  Belmont will ensure that medications used for the reduction of and possible elimination of the behaviors for which the drugs are employed. Belmont will ensure that each required section on the reduction plan will be completed and clearly defined with specific guidelines for reduction.  Behavior modification plans will be reviewed for all individuals taking medications used for control of inappropriate behaviors. The reduction criteria will be revised and clarified as needed.  Person Responsible: Assistant Behavior Specialist, Assistant QIDP/QIDP, and City Director.  Monitor: Medication Reduction Plans will be monitored through monthly behavioral summaries, during monthly behavioral meetings, and quarterly with the psychiatrist.		
W 312	The facility failed to ensure restrictive suicide interventions were implemented only with justification for their use. <b>483.450(e)(2) DRUG USAGE</b>  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 an individual's IPP that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 2 individuals (Individual #2) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified the drug's usage and how it may change in relation to progress or regression. The findings include:  1. Individual #2's IPP, dated 3/4/14, documented a 31 year old male whose diagnoses included mild intellectual disability.	W 312		9/3/14	

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W 312	Continued From page 38 Individual #2's record contained Physician's Orders, dated 6/25/14, documenting he received Trazodone (an antidepressant drug) 50 mg for sleep.  His Medication Reduction Plan, undated, documented "[Individual #2] needs to sleep for 8 consistent hours without disruption (with the exception of getting up to use the restroom during sleeping hours which he is not awake for more than 15 minutes) for 80% of the time for 3 consecutive months."  However, Individual #2's behavior summaries, from 1/2014 - 5/2014, documented he had met criteria for his sleep objective for each of those months.  When asked during an interview on 7/25/14 from 12:10 - 2:12 p.m., the Assistant Behavior Specialist stated they were encouraging Individual #2 to sleep 8 hours during an earlier timeframe (e.g. 10:00 p.m. - 6:00 a.m.) as he typically went to sleep at 12:30 a.m. She further stated the intent was to adjust his circadian rhythm and that it should have been stated clearer.  The facility failed to ensure Individual #2's medication reduction plan was implemented as written.	W 312			
W 406	483.470 PHYSICAL ENVIRONMENT  The facility must ensure that specific physical environment requirements are met.	W 406			

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 VAUGHN AVENUE POCATELLO, ID 83204		
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W 406	Continued From page 39 This CONDITION is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the facility failed to ensure each individual was provided with a bedroom which included an appropriate bed, functional furniture, and appropriate closet and storage space. This resulted in a violation of an individual's right to access personal possessions and a hindrance to an individual's ability to function independently. The findings include:  1. Refer to W418 as it relates to the facility's failure to ensure a separate bed with a clean, comfortable mattress was provided to each individual.  2. Refer to W420 as it relates to the facility's failure to ensure each individual was provided with appropriate, functional furniture, based on individual needs and preferences.  3. Refer to W421 as it relates to the facility's failure to ensure a bedroom with closet space was provided to each individual.  4. Refer to W423 as it relates to the facility's failure to ensure a bedroom with sufficient storage space was provided to each individual.	W 406	<b>POC W406 483.470 PHYSICAL ENVIRONMENT</b>  Belmont will ensure that specific physical environment requirements are met.  The physical environment was modified to promote the health, independence and learning for the individual. The individual was provided with a bedroom that included an appropriate bed, functional furniture and appropriate closet and storage space.  Belmont will ensure prior to admission there is an appropriate room with functional furniture and appropriate closet and storage space for individuals being admitted.  1. Refer to W418 2. Refer to W420 3. Refer to W421 4. Refer to W423  Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.  Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment promotes the health, independence and learning for the individual that is being admitted.		
W 418	<b>483.470(b)(4)(ii) CLIENT BEDROOMS</b>  The facility must provide each client with a clean, comfortable mattress.  This STANDARD is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the	W 418		9/3/14	

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W 418	<p>Continued From page 40</p> <p>facility failed to ensure a separate, clean and comfortable bed was provided to 2 of 16 individuals (Individuals #5 and #15) residing in the facility. This resulted in individuals not having clean and/or comfortable mattresses. The findings include:</p> <p>1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>On 7/22/14 at 10:00 a.m., Individual #5 gave a tour of his living space in the TV room. During that time, Individual #5 stated the mattress of the fold-out bed was hard. Individual #5 stated he woke up sore each morning.</p> <p>During a second interview on 7/24/14 from 9:03 - 9:06 a.m., Individual #5 stated he reported his complaints about the mattress to the floor leader but nothing was done.</p> <p>During an interview on 7/22/14, from 10:24 -</p>	W 418	<p><b>POC W418 483.470(b)(4)(ii) CLIENT BEDROOMS</b></p> <p>Belmont will provide each individual with a clean, comfortable mattress.</p> <p>The physical environment was modified to promote the health, independence and learning for the individual. A separate, clean and comfortable bed was provided.</p> <p>All mattresses will be evaluated to ensure they are clean and comfortable.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, and City Director.</p> <p>Monitor: Monthly the Program Supervisor and Housekeeping Supervisor will complete mattress checks to ensure they are clean and comfortable. Quarterly the City Director will complete mattress checks during environment checks.</p>	9/3/14	

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W 418	Continued From page 41 10:33 a.m. with the QIDP and the City Director, the City Director stated the fold-out bed and mattress was all Individual #5 had been provided. The City Director stated she did not know that a fold-out bed was not sufficient and that Individual #5 would be provided with a new bed and mattress by the end of the day.  2. An environmental review was conducted at the facility on 7/22/14 from 12:00 - 1:30 p.m. During that time, Individual #15's mattress was noted to have a layer of gray across the top.  The facility failed to ensure each individual was provided with a separate bed with a clean, comfortable mattress.	W 418			
W 420	483.470(b)(4)(iv) CLIENT BEDROOMS  The facility must provide each client with functional furniture, appropriate to the clients needs.  This STANDARD is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the facility failed to ensure functional furniture, appropriate to individual needs was selected for 1 of 16 individuals (Individual #5) residing in the facility. This resulted in an individual not having appropriate, functional furniture. The findings include:  1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and Insomnia.	W 420			

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W 420	<p>Continued From page 42</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>On 7/22/14 at 10:00 a.m., Individual #5 gave a tour of his living space. In the TV room, he pointed out six plastic drawers which contained some of his personal possessions, including clothing. Each drawer was less than five inches deep. Individual #5 also pointed to a pile of shoes between the couch and phone stand which he stated belonged to him.</p> <p>The TV room contained various cabinets, including an entertainment center and a stand underneath the facility fish tank. However, none of the storage space in the TV room had been designated to Individual #5. Additionally, the room did not contain any other furniture (e.g. dresser, nightstand, etc.) for Individual #5's personal use.</p> <p>During a second interview on 7/24/14 from 9:03 - 9:06 a.m., Individual #5 stated he reported his complaints about the storage of items to the floor leader, but nothing had been done.</p> <p>When asked, during an interview on 7/22/14 from</p>	W 420	<p><b>POC W420 483.470(b)(4)(iv) CLIENT BEDROOMS</b></p> <p>Belmont will provide each individual with functional furniture, appropriate to the individual's needs.</p> <p>The physical environment was modified to promote the health, independence and learning for the individual. The individual was provided with a bedroom that included an appropriate bed, functional furniture and appropriate closet and storage space.</p> <p>Belmont will ensure prior to admission there is an appropriate room with functional furniture and appropriate closet and storage space for individuals being admitted.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment promotes the health, independence and learning for the individual that is being admitted.</p>	9/3/14	

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W 420	Continued From page 43 10:24 - 10:33 a.m., the City Director stated she was aware that Individual #5's possessions were stored in multiple locations of the facility, including the TV room, dietary office and archive room. She stated the storage set-up was temporary until a permanent bed and bedroom space opened up for individual #5. The City Director stated in the meantime Individual #5 was able to ask for access to his possessions.	W 420			
W 421	The facility failed to ensure Individual #5 was provided with functional furniture to meet his needs. 483.470(b)(4)(iv) CLIENT BEDROOMS The facility must provide each client with individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.  This STANDARD is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the facility failed to ensure a bedroom with closet space was provided for 1 of 16 individuals (Individual #5) residing in the facility. This resulted in an individual not having access to clothes racks and shelves for his personal possessions. The findings include:  1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.  Individual #5's 7/2/14 personal possessions Inventory stated he owned the following:	W 421			

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3026 VAUGHN AVENUE POCATELLO, ID 83204	
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W 421	<p>Continued From page 44</p> <ul style="list-style-type: none"> <li>- 1 Radio</li> <li>- 5 boxer shorts</li> <li>- 3 pairs of shoes</li> <li>- 3 pairs of sweat pants</li> <li>- 3 pairs of jeans</li> <li>- 5 t-shirts</li> <li>- 10 socks</li> <li>- 1 flat sheet</li> <li>- 1 fitted sheet</li> <li>- 1 pillowcase</li> <li>- 1 comforter</li> <li>- 1 pillow</li> <li>- 1 winter coat</li> <li>- Various paperwork</li> </ul> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>On 7/22/14 at 10:00 a.m., Individual #5 gave a tour of his living space in the TV room. The TV room did not contain a closet.</p> <p>When asked, during an interview on 7/22/14 from 10:24 - 10:33 a.m., the City Director stated she was aware that Individual #5's possessions were stored in multiple locations of the facility, including</p>	W 421	<p><b>POC W421 483.470(b)(4)(iv) CLIENT BEDROOMS</b></p> <p>Belmont will provide each individual with closet space in the individual's bedroom with clothes racks and shelves accessible to the individual.</p> <p>The physical environment was modified to promote the health, independence and learning for the individual. The individual was provided with a bedroom that included an appropriate bed, functional furniture and appropriate closet and storage space.</p> <p>Belmont will ensure prior to admission there is an appropriate room with functional furniture and appropriate closet and storage space for individuals being admitted.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment promotes the health, independence and learning for the individual that is being admitted.</p>	9/3/14

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204	
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W 421	Continued From page 45 the TV room, dietary office and archive room. She stated the storage set-up was temporary until a permanent bed and bedroom space opened up for Individual #5. The City Director stated in the meantime Individual #5 was able to ask for access to his possessions.	W 421		
W 423	The facility failed to ensure a bedroom with closet space was provided to Individual #5. 483.470(c)(2) STORAGE SPACE IN BEDROOMS  The facility must provide suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.  This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure a bedroom with storage space was provided for 1 of 16 individuals (Individual #5) residing in the facility. This resulted in an individual's access to personal possessions being restricted without due process. The findings include:  1. Individual #5's IPP, dated 6/11/14, indicated he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.  An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct	W 423		

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W 423	<p>Continued From page 46</p> <p>care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>On 7/22/14 at 10:00 a.m., Individual #5 gave a tour of his living space. In the TV room, he pointed out six plastic drawers which contained his personal possessions. Individual #5 also pointed to a pile of shoes between the couch and phone stand which he stated belonged to him.</p> <p>The TV room did not contain a closet. The TV room contained various cabinets, including an entertainment center and a stand underneath the facility fish tank, however, none of the storage space in the TV room had been designated to Individual #5.</p> <p>During the tour on 7/22/14 at 10:00 a.m., Individual #5 also requested access to the dietary office. After a staff unlocked the dietary office, Individual #5 showed a laundry basket for his dirty clothes that was kept in the office. Individual #5 indicated the remainder of his personal possessions were stored in the facility "archive." The archive room was a locked room at the base of the stairwell, on the lower level of the facility. The room contained a large cabinet which included notebooks, video game guitars, a stereo, clothes and shoes Individual #5 stated belonged to him. During the tour, Individual #5 stated he wished he did not have to go up and down the stairs to access his belongings.</p>	W 423	<p><b>POC W423 483.470(c)(2) STORAGE SPACE IN BEDROOMS</b></p> <p>Belmont will provide suitable storage space, accessible to the individuals, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.</p> <p>The physical environment was modified to promote the health, independence and learning for the individual. The individual was provided with a bedroom that included an appropriate bed, functional furniture and appropriate closet and storage space.</p> <p>Belmont will ensure prior to admission there is an appropriate room with functional furniture and appropriate closet and storage space for individuals being admitted.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment promotes the health, independence and learning for the individual that is being admitted.</p>	9/3/14	

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W 423	Continued From page 47  During a second interview on 7/24/14 from 9:03 - 9:06 a.m., Individual #5 stated he reported his complaints about the storage of items to the floor leader, but nothing had been done.  When asked, during an interview on 7/22/14 from 10:24 - 10:33 a.m., the City Director stated she was aware that Individual #5's possessions were stored in the TV room, dietary office and archive room. She stated the storage set-up was temporary until a permanent bed and bedroom space opened up for Individual #5. The City Director stated in the meantime Individual #5 was able to ask for access to his possessions.	W 423			
W 481	483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days.  This STANDARD is not met as evidenced by: Based on observation, review of menus and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days which directly impacted 16 of 16 individuals (Individuals #1 - #16) residing in the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:  1. A meal observation was conducted at the facility on 7/21/14 from 4:00 - 5:25 p.m. The facility's menu, dated 7/20/14 - 7/26/14, was reviewed and documented the evening meal for	W 481			

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 VAUGHN AVENUE POCATELLO, ID 83204		
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W 481	<p>Continued From page 48 7/21/14 was to consist of the following:</p> <ul style="list-style-type: none"> <li>- Salsa Chicken</li> <li>- Hamburger bun</li> <li>- Fideo (a type of pasta)</li> <li>- Tossed green salad</li> <li>- Cantaloupe</li> </ul> <p>However, no tossed green salad was served.</p> <p>When asked, on 7/23/14 at approximately 8:10 a.m., the Dietary Manager stated when anything different from the planned menu was served, staff were to complete a menu change form and submit it to her. The Dietary Manager stated she had not seen a menu change form yet, but would follow-up.</p> <p>During a follow-up interview on 7/23/14 at 2:08 p.m., the Dietary Manager stated the 7/21/14 change from the evening menu was missed and should have been noted.</p> <p>The facility failed to ensure accurate documentation of food actually served was kept.</p>	W 481	<p>POC W481 483.480(c)(2) MENUS</p> <p>Belmont will ensure menus for food actually served will be kept on file for 30 days.</p> <p>Training will be completed with all staff regarding the record keeping of the actual food served.</p> <p>Person Responsible: Lead DSPs, Program Supervisors, Dietary Manager, and Registered Dietician.</p> <p>Monitor: The Lead DSP and/or Program Supervisor will ensure the Actual Food Served is logged daily. The daily logs will be turned into the Dietary Manager. Weekly the Dietician will review and file the logs.</p>	9/3/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2014
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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204
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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensure survey conducted from 7/21/14 to 7/28/14.  The survey was conducted by: Ashley Henschel, QIDP, Team Leader Jim Troutfetter, QIDP  Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disabilities Professional IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional TV - Television	M 000	RECEIVED SEP 03 2014 FACILITY STANDARDS	
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	POC MM167 16.03.11.075.07 Exercise of Rights  Refer to W125	9/3/14
MM177	16.03.11.075.09 Protection from Abuse and Restraint  Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical	MM177	POC MM177 16.03.11.075.09 Protection from Abuse and Restraint  Refer to W122	9/3/14

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*M. Halladay*

TITLE

*City Director*

(X6) DATE

*8/28/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2014
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MM177	Continued From page 1  restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10).  This Rule is not met as evidenced by: Refer to W122.	MM177		
MM191	16.03.11.075.09(c) 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	POC MM191 16.03.11.075.09 (c) Last Resort  Refer to W290	9/3/14
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	POC MM197 16.03.11.075.10 (d) Written Plans  Refer to W312	9/3/14
MM203	16.03.11.075.12(a) Treated with Consideration  Treated with consideration, respect, and full recognition of his dignity and individuality,	MM203		

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MM203	Continued From page 2  including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W129.	MM203			
MM209	16.03.11.075.15 Right to Personal Items  Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	<b>POC MM380 16.03.11.120.03 (a) Building and Equipment</b> <ol style="list-style-type: none"> <li>1. The piece of laminate behind the toaster will be replaced.</li> <li>2. The laminate behind the washing sink will be repaired or replaced.</li> <li>3. The missing drawer to the right of the stove will be replaced.</li> <li>4. The microwave in the dining area was cleaned. The rotating plate will be replaced.</li> <li>5. The carpet in the common area will be cleaned.</li> <li>6. The remote sensor for the air conditioner will be re-attached to the wall.</li> <li>7. The covers to the exhaust fans in the shower rooms will be replaced. The fans above the toilets will be cleaned.</li> <li>8. The toilet bolt covers upstairs will be replaced.</li> <li>9. The area outside next to the air conditioner was cleaned.</li> <li>10. The corner of the roof to the left of the street facing the door will be repaired.</li> </ol>		
MM379	16.03.11.120.03 General Building Requirements  General Building Requirements. All buildings to be used for ICF/ID facilities must be of such character to be suitable for such usage. These buildings will be subject to approval by the Department. Other requirements are as follows:  This Rule is not met as evidenced by: Refer to W406.	MM379			
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	MM380			

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MM380	<p>Continued From page 3</p> <p>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 16 of 16 individuals (Individuals #1 - #16) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 7/22/14 from 12:00 - 1:30 p.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- Behind the roaster ovens in the kitchen there was a piece of missing laminate approximately 18 inches long.</li> <li>- Behind the warewashing sink there was a strip of loose laminate approximately 3 feet long.</li> <li>- There was a missing drawer to the right of the stove.</li> <li>- The microwave in the dining area had food debris on the interior and the rotating plate was missing.</li> <li>- There were various stains on the carpet in the common areas.</li> <li>- In the TV room next to the entertainment center the remote sensor for the air conditioner was coming off the wall.</li> <li>- The exhaust fans in the showers of both upstairs bathrooms had broken covers and the fans above the toilets were plugged with dust.</li> <li>- The toilet bolt covers were missing in all three upstairs bathrooms.</li> </ul>	MM380	<ol style="list-style-type: none"> <li>11. The door knob on the exit door at the end of the hallway will be repaired.</li> <li>12. Individual 15's room was cleaned.</li> <li>13. The lower cabinet of Individual 15's room was cleaned.</li> <li>14. The clothing in Individual 7's room was washed and put away.</li> <li>15. The carpet in Individual 6's bedroom will be cleaned.</li> <li>16. The carpet in Individual 4's bedroom will be cleaned.</li> <li>17. The hole in Individual 8 and 13's room will be repaired.</li> </ol> <p>Person Responsible: Dietary Manager, Housekeeping, Residential Program Supervisor, and City Director</p> <p>Monitor: Monthly facility inspections be completed by the Program Supervisor and Housekeeping. Quarterly the City Director will complete facility inspections.</p>	9/3/14

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MM380	Continued From page 4  - There were no less than 5 soda bottles/cans in the area next to the air conditioner outside the facility.  - The corner of the roof to the left of the street facing door had water leaking from it and decaying wood.  - The door knob on the exit door at the end of the hallway was broken.  - There was garbage on Individual #15's bedroom floor, including an empty can, an empty bag and crumpled paper.  - The lower cabinets of Individual #15's entertainment center contained clutter, including a used Tupperware lined with a dried substance, piles of paper stores with old fishing bait containers with residual dirt inside and a burrito wrapped in foil.  - There was clothing piled up in the corner of Individual #7's room.  - There were two stains on the floor of Individual #6's bedroom.  - There were 3 stains approximately 4 inches in diameter in Individual #4's bedroom.  - There was a hole in the wall of Individual #8 and Individual #13's bedroom, which appeared to be a former electrical outlet.  The facility failed to ensure the environment was kept clean and repairs were completed and maintained.	MM380		

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MM390	Continued From page 5	MM390	POC MM390 16.03.11.120.04 (d)(ii)	
MM390	<p>16.03.11.120.04(d)(ii) Attic Story, Trailer House</p> <p>In any attic story, trailer house or in any other room other than an approved room. This Rule is not met as evidenced by: Based on observation, record review and staff and individual interview, it was determined the facility failed to ensure a bedroom was provided to 1 of 16 individuals (Individual #5) residing in the facility. This resulted in an individual sleeping in the facility TV room instead of a bedroom. The findings include:</p> <p>1. Individual #5's IPP, dated 6/11/14, indicated he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be pulling away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>During an interview on 7/22/14 from 10:24 - 10:33 a.m., the QIDP and City Director stated they were aware of Individual #5's living situation and planned to provide him with a permanent bed as soon as a vacancy opened up.</p>	MM390	<p>Attic Story, Trailer House</p> <p>Belmont will provide each individual with closet space in the individual's bedroom with clothes racks and shelves accessible to the individual.</p> <p>The physical environment was modified to promote the health, independence and learning for the individual. The individual was provided with a bedroom that included an appropriate bed, functional furniture and appropriate closet and storage space.</p> <p>Belmont will ensure prior to admission there is an appropriate room with functional furniture and appropriate closet and storage space for individuals being admitted.</p> <p>Person Responsible: Program Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Prior to an admission, the Supervisor, Housekeeping Supervisor, Assistant QIDP/QIDP, and City Director will evaluate the living space to ensure the physical environment promotes the health, independence and learning for the individual that is being admitted.</p>	<p>9/3/14</p>

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MM390	Continued From page 6 The facility failed to ensure individual #5 resided in an approved bedroom.	MM390		
MM406	16.03.11.120.04(i) Recreation Room  Every facility must provide a minimum of twenty-five (25) square feet per licensed bed for living and/or recreational activities. It must be for the sole use of the resident, and under no circumstances can these rooms be used as bedrooms by residents or personnel. A hall or entry is not acceptable as a living room or recreation room. This Rule is not met as evidenced by: Refer to W121.	MM406	POC MM406 16.03.11.120.04 (i) Recreation Room  Refer to W121	9/3/14
MM409	16.03.11.120.04(j)(ii) Springs and Mattress  Have satisfactory springs in good repair and a clean, comfortable mattress that is standard in size for the bed. Each mattress must be rendered and maintained water repellent. This Rule is not met as evidenced by: Refer to W418.	MM409	POC MM409 16.03.11.120.04 (j)(ii) Springs and Mattress  Refer to W418	9/3/14
MM410	16.03.11.120.04(k) Closet Space  Closet space must be provided in each resident bedroom (minimum of two (2) lineal feet per bed). If a common closet is used for two (2) persons, there must be a physical separation of clothing for each person. This Rule is not met as evidenced by: Refer to W421.	MM410	POC MM410 16.03.11.120.04 (k) Closet Space  Refer to W421	9/3/14
MM412	16.03.11.120.04(m) Furniture and Equipment  All furniture and equipment must be maintained in	MM412		

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MM412	<p>Continued From page 7</p> <p>a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all furniture was kept in good repair for 16 of 16 individuals (Individuals #1 - #16) residing in the facility. This resulted in individuals' furniture being inaccessible and/or kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 7/22/14 from 12:00 - 1:30 p.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- The couch by the window in the TV room had approximately 1 foot of missing material on the lower front.</li> <li>- The couch by the window in the TV room had a cushion that had a hole approximately 12 inches by 20 inches with the stuffing coming out.</li> <li>- The couch in the TV room by the phone had broken springs, an area of torn upholstery approximately 8 inches long and a broken leg on the left side.</li> <li>- Three of the four of the drawers of Individual #1's bed frame were missing stops on the back to prevent them from falling out when opened.</li> <li>- All of the drawers of Individual #4's bed frame were missing stops on the back to prevent them from falling out when opened.</li> <li>- All of the drawers of Individual #6's bed frame were missing stops on the back to prevent them from falling out when opened.</li> </ul>	MM412	<p>POC MM412 16.03.11.120.04 (m) Furniture and Equipment</p> <p>Belmont will ensure all furniture and equipment is maintained in a sanitary manner, kept in good repair, and is located to permit convenient use by individuals.</p> <ol style="list-style-type: none"> <li>1. The couch in the TV room will be repaired or replaced.</li> <li>2. The couch cushion in the TV room will be repaired or replaced.</li> <li>3. The couch in the TV room by the phone will be replaced.</li> <li>4. The drawers in individuals #1 bed frame will be repaired.</li> <li>5. The drawers in individual #4's bed frame will be repaired.</li> <li>6. The drawers in individual #6's bed frame will be repaired.</li> <li>7. The drawers in individual #6's dresser will be repaired.</li> <li>8. The handles on individual #8's bed frame drawers will be replaced.</li> <li>9. The drawers on individual #9's bed frame drawers will be replaced.</li> <li>10. The knob on individual #9's drawer will be replaced.</li> <li>11. The drawers of individual #11's bed frame will be repaired.</li> </ol>	

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MM412	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>- All of the drawers of Individual #6's dresser were missing stops on the back to prevent them from falling out when opened.</li> <li>- The two left drawers of Individual #8's bed frame were missing the right handles.</li> <li>- The top right drawer of Individual #8's bed frame was missing the left handle.</li> <li>- All of the drawers of Individual #9's bed frame were missing stops on the back to prevent them from falling out when opened.</li> <li>- Individual #9's top right drawer of his bed frame was missing the left knob.</li> <li>- Individual #9's dresser was badly scratched and chipped. Additionally, the bottom drawer was missing the left handle.</li> <li>- All of the drawers of Individual #11's bed frame were missing stops on the back to prevent them from falling out when opened.</li> <li>- Individual #12's wardrobe was blocked with a pile of clutter, limiting access.</li> <li>- Three of the four drawers of Individual #13's bed frame were missing stops on the back to prevent them from falling out when opened.</li> <li>- Individual #15's bed frame was reversed, with the drawers of the bed frame pushed up against the wardrobe, rendering the bed frame drawers and wardrobe inaccessible.</li> </ul> <p>The facility failed to ensure furniture repairs were maintained and furniture was accessible.</p>	MM412	<ul style="list-style-type: none"> <li>12. The pile of clutter in front of individual #12's closet will be removed.</li> <li>13. The drawers in individual #15's bed frame will be repaired.</li> </ul> <p>Person Responsible: Dietary Manager, Housekeeping, Residential Program Supervisor, and City Director</p> <p>Monitor: Monthly facility inspections be completed by the Program Supervisor and Housekeeping. Quarterly the City Director will complete facility inspections.</p>	9/3/14

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MM418	Continued From page 9	MM418		
MM418	16.03.11.120.06(a) General Storage Areas  General storage areas (minimum of ten (10) square feet per licensed bed) must be provided, in addition to suitable storage provided in the resident's bedrooms for personal clothing, possessions and individual prosthetic equipment. This Rule is not met as evidenced by: Refer to W420 and W423.	MM418	POC MM 16.03.11.120.06 (a) General Storage Areas  Refer to W420 Refer to W423	9/3/14
MM520	16.03.11.200.03(a) Establishing and Implementing polices  The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W104.	MM520	POC MM520 16.03.11.200.06 (a) Establishing and Implementing Policies  Refer to W104	9/3/14
MM567	16.03.11.210.04(k) Record of resident's personal effects  Record of resident's personal effects. An inventory of all valuables entrusted to the facility for safekeeping must be kept. A proper accounting of resident's funds deposited with the facility for safekeeping and/or expenditure must be kept and made available to authorized individuals for review, which must include the resident so affected. This Rule is not met as evidenced by: Based on observallon, record review and staff and individual interview, it was determined the facility failed to ensure accurate, complete	MM567		

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3825 VAUGHN AVENUE POCATELLO, ID 83204
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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
MM567	<p>Continued From page 10</p> <p>personal possession inventories were maintained for 1 for 16 individuals (individual #5) residing in the facility. This resulted in the potential loss of an individual's personal property. The findings include:</p> <p>1. Individual #5's IPP, dated 6/11/14, documented he was a 23 year old male whose diagnoses included borderline intellectual functioning and insomnia.</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., individual #5 was noted to be pulling away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:16 a.m., a direct care staff stated individual #5 slept on the fold-out bed in the TV room. The staff stated individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that individual #5 was re-admitted to the facility on 7/16/14.</p> <p>On 7/22/14 at 10:00 a.m., individual #5 gave a tour of his living space. In the TV room, he pointed out six plastic drawers which contained some of his personal possessions, including clothing. Each drawer was less than five inches deep. Individual #5 also pointed to a pile of shoes between the couch and end table which he stated belonged to him.</p> <p>During the tour on 7/22/14 at 10:00 a.m., individual #5 also requested access to the dietary office. After a staff unlocked the dietary office, individual #5 showed a laundry basket for his dirty clothes that was kept in the office. Individual #5</p>	MM567	<p>POC MM567 16.03.11.120.04 (k) Record of resident's personal effects</p> <p>Belmont will ensure record of individuals' personal effects. An inventory of all valuables entrusted to Belmont for safekeeping will be kept. A proper accounting of individuals funds deposited with Belmont for safekeeping and/or expenditure will be kept and made available to authorized individuals for review, which will include the individuals affected.</p> <p>Upon admission an inventory of all personal items will be completed. The inventory will be kept in each individuals' record.</p> <p>Person Responsible: Program Supervisor, Assistant QIDP/QIDP, and City Director.</p> <p>Monitor: Upon admission, the Assistant QIDP/QIDP or Program Supervisor will complete an inventory of all the individual's items. At least annually the inventory lists will be updated with any additional items that have been acquired.</p>	9/3/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/28/2014
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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3826 VAUGHN AVENUE POCATELLO, ID 83204
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MM567	<p>Continued From page 11</p> <p>Indicated the remainder of his personal possessions were stored in the facility "archive." The archive room was a locked room at the base of the stairwell, on the lower level of the facility. The room contained a large cabinet which included notebooks, video game guitars, a stereo, clothes and shoes Individual #5 stated belonged to him.</p> <p>However, Individual #5's 7/2/14 personal possessions inventory stated he owned the following:</p> <ul style="list-style-type: none"> <li>- Radio</li> <li>- 5 boxer shorts</li> <li>- 3 pairs of shoes</li> <li>- 3 pairs of sweat pants</li> <li>- 3 pairs of jeans</li> <li>- 5 t-shirts</li> <li>- 10 socks</li> <li>- 1 flat sheet</li> <li>- 1 fitted sheet</li> <li>- 1 pillowcase</li> <li>- 1 comforter</li> <li>- 1 pillow</li> <li>- 1 winter coat</li> <li>- Various paperwork</li> </ul> <p>Individual #5's personal possessions inventory did not include documentation of all of his possessions, such as his video game guitars and shoes.</p> <p>When asked, during an interview on 7/25/14 from 12:10 - 2:12 p.m., for the most recent personal possession inventory for Individual #5, the AQIDP was only able to locate the 7/2/14 inventory.</p> <p>The facility failed to ensure Individual #5's personal possession inventory was maintained</p>	MM567		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  07/28/2014
NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204		
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MM567	Continued From page 12 with accurate, current information.	MM567	POC MM570 16.03.11.210.05 (b) Medication and Treatments		
MM570	16.03.11.210.05(b) Medications and Treatments  A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W111.	MM570	Refer to W111	9/3/14	
MM672	16.03.11.07(a) Menu Preparation  Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to W481.	MM672	POC MM672 16.03.11.07 (a) Menu Preparation  Refer to W481	9/3/14	
MM725	16.03.11.270.01(b) QMRP  The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement.  This Rule is not met as evidenced by: Refer to W159.	MM725	POC MM725 16.03.11.270 (b) QMRP  Refer to W159	9/3/14	
MM730	16.03.11.270.01(d)(I) Diagnostic and Prognostic Data	MM730	POC MM730 16.03.11.270.01 (d)(i) Diagnostic and Prognostic Data  Refer to W481 - W 252 CHANGED TO W 252 PER CITY DIRECTOR BY JIM TRAVIFFER ON 9-8-14 <i>Jim Traviff</i>	9/3/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/28/2014
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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 VAUGHN AVENUE POCATELLO, ID 83204
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MM730	Continued From page 13 Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W262.	MM730	POC MM861 16.03.11.270.08 (f)(iii) Periodic Review  Refer to W257	9/3/14
MM861	16.03.11.270.08(f)(iii) Periodic Review  Initiating periodic review of each individual plan of care for necessary modifications or adjustments.  This Rule is not met as evidenced by: Refer to W257.	MM861	POC MM951 16.03.11.320.02 Maximum Allowable Beds  Belmont will ensure time-limited emergency placements approved by the Department are for the correct individual. A new request was submitted for the correct individual.	
MM951	16.03.11.320.02 Maximum Allowable Beds  License Must Specify Maximum Allowable Beds. Each license must specify the maximum allowable number of beds in each facility, which number cannot be exceeded, except on a time-limited emergency basis, with the authorization of the Department. This Rule is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure the facility's licensed bed capacity was not exceeded without Department authorization. This resulted in an individual being admitted to the facility without the necessary approvals. The findings include:  1. The facility's State license, effective 1/1/14, was issued for 15 beds. On 6/20/14, the facility submitted a letter, requesting approval to temporarily exceed the 15 bed capacity to allow for the emergency placement of Individual #11.  Department authorization to temporarily exceed the 15 bed capacity was granted on 6/20/14. The authorization letter stated the request was being	MM951	Person Responsible: City Director.  Monitor: The City Director will work with the Department regarding emergency placements prior to admission. In addition, the City Director will ensure the individual listed in the documentation is the individual in the temporary room placement.	9/3/14

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NAME OF PROVIDER OR SUPPLIER  BELMONT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204
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MM951	<p>Continued From page 14</p> <p>granted "to temporarily increase the licensed bed capacity...from 15 to 16 beds, to allow for the admission of [Individual #11]" and was effective from 6/23/14 - 7/23/14. The authorization letter further stated it was only for the persons, facility, and time periods specified and it was not considered as a precedent or to be given any force or effect in any other proceeding.</p> <p>An observation was conducted at the facility on 7/22/14 from 6:40 - 7:56 a.m. At 7:00 a.m., Individual #5 was noted to be putting away bedding and the fold-out bed in the TV room. When asked, on 7/22/14 at 7:15 a.m., a direct care staff stated Individual #5 slept on the fold-out bed in the TV room. The staff stated Individual #5 was incarcerated for approximately one month, and returned to the facility around 7/18/14. The direct care staff stated Individual #5 had been staying in the TV room since his return to the facility. On 7/28/14 at 9:36 a.m., the City Director clarified that Individual #5 was re-admitted to the facility on 7/16/14.</p> <p>Additionally, during an environmental review conducted on 7/22/14 from 12:00 - 1:30 p.m., it was noted Individual #11 and Individual #4 shared a bedroom. On 7/29/14 at 9:36 a.m., the City Director indicated Individual #11 was admitted to the facility on 6/26/14.</p> <p>During an interview on 7/22/14 from 10:24 - 10:33 a.m., the City Director stated the facility hoped to discharge an individual to one of their sister facilities in the near future. The City Director stated at that time, Individual #5 would be moved into a permanent bedroom.</p> <p>The facility failed to obtain authorization to temporarily exceed the 15 bed capacity to allow</p>	MM951		

Bureau of Facility Standards

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MM951	Continued From page 15 for the emergency placement of Individual #5.	MM951		