



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

September 8, 2014

Steve Young, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #1 Springfield, which was conducted on August 26, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Steve Young, Administrator
September 8, 2014
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **September 21, 2014**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

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

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

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #1 SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 8/18/14 - 8/26/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Trish O'Hara, RN Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactive Disorder AQIDP - Assistant Qualified Intellectual Disability Professional IPP - Individual Program Plan MR - Mental Retardation OCD - Obsessive Compulsive Disorder OT - Occupational Therapy PT - Physical Therapy	W 000		
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained complete information for 1 of 3 individuals (Individual #1) whose medical record was reviewed. This resulted in a lack of documentation to ensure appropriate medical care was provided. The findings include: 1. Individual #1's IPP, dated 1/16/14, documented a 38 year old male whose diagnoses included severe MR, autism, and stereotypic/repetitive disorder.	W 218		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stelle Young TITLE: Program Supervisor (X6) DATE: 9/18/14

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 218	Continued From page 1 Individual #1's record documented a PT assessment, dated 1/13/14. The assessment stated "For his given age of 54, [Individual #1's] has indeed had what appears to be a great year relative to his overall physical functioning." The assessment went on to address Individual #1's weight stating "This is excellent for his given age of 54." Individual #1's IPP, dated 1/16/14, documented Individual #1's birth date as 12/5/75, giving a chronological age of 38 years old. A difference of 16 years in age created the potential for inaccurate assessment due to comparison of Individual #1 with incorrect age benchmarks for expected physical function, weight, activity, needs, etc. In an interview on 8/22/14 from 12:10 - 1:10 p.m., the AQIDP stated the person doing the assessment for Individual #1 had done several assessments the same day and must have confused Individual #1 with someone else when writing her notes. The facility failed to ensure the PT assessment accurately reflected Individual #1.	W 218		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.	W 312		

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W 312	<p>Continued From page 2</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 behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs were employed for 3 of 3 individuals (Individuals #1 - #3) whose behavior modifying drugs were reviewed. This resulted in individuals receiving behavior modifying drugs without a plan that identified the drugs usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1 was a 38 year old male whose diagnoses included severe MR, autism, and stereotypic/repetitive disorder. He was taking two medications, Buspar (an anxiolytic drug) and Risperdal (an antipsychotic drug) to reduce episodes of aggression.</p> <p>His Psychotropic Medication Plan, dated 3/31/14, addressed criteria for the increase and decrease of the two drugs as follows:</p> <p>Buspar dosage would be reduced first. This would occur when incidents of aggression decreased to 100/month for three months. Risperdal would be reduced second. This would occur when incidents of aggression decreased to 140/month for three months.</p> <p>In an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the AQIDP said the criteria for reduction of the medications was incorrect. He said the plan should have stated Buspar would be reduced when incidents of aggression decreased to</p>	W 312		
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W 312	<p>Continued From page 3</p> <p>140/month for three months, and Risperdal would be reduced when incidents of aggression decreased to 100/month for three months.</p> <p>The plan further stated the Risperdal dosage would be increased first. This would occur "if aggression increases." Buspar would be increased second. This would occur "if aggression increases."</p> <p>In an interview on 8/22/14 from 12:10 - 1:10 p.m., the AQIDP said the plan should have specifically addressed the number of aggressive incidents, as well as specifying a time frame during which data for aggressive incidents would be collected prior to drug dosages being increased.</p> <p>The facility failed to ensure comprehensive, accurate psychotropic medication plans were in place for each of Individual #1's behavior modifying drugs.</p> <p>2. Individual #2 was a 27 year old male with diagnoses including mild MR, ADHD, OCD, bipolar, and schizoaffective disorder. He was taking Abilify (an antipsychotic drug) and Lithium (an antimanic drug) to decrease bipolar symptoms described as pacing, mood changes, and disruptive behaviors. He was also taking Paxil (an antidepressant drug) and Seroquel (an antipsychotic drug) to decrease OCD symptoms described as perseverating over objects or events.</p> <p>A Psychotropic Medication Plan, dated 8/18/14, addressed criteria for the increase of the four drugs as follows:</p> <p>Lithium would be increased first and Abilify would</p>	W 312		
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W 312	<p>Continued From page 4</p> <p>be increased second "If bipolar symptoms increase."</p> <p>Additionally, Paxil would be increased first and Seroquel would be increased second "if OCD symptoms increase."</p> <p>In an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the AQIDP said the plan should have specifically addressed the number of bipolar and OCD symptoms, as well as specifying a time frame during which data for bipolar and OCD symptoms would be collected prior to drug dosages being increased.</p> <p>The facility failed to ensure comprehensive, accurate psychotropic medication plans were in place for each of Individual #2's behavior modifying drugs.</p> <p>3. Individual #3's IPP, dated 2/20/14, documented he was a 34 year old male whose diagnoses included moderate MR. He was taking Zyprexa (an antipsychotic drug) for aggression and Prozac (an antidepressant drug) for depression.</p> <p>A Psychotropic Medication Plan, dated 5/2/14, addressed criteria for the increase of the two drugs as follows:</p> <p>Zyprexa would be increased "when aggression incidents increased."</p> <p>Prozac would be increased "when depression symptoms increase."</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the AQIDP stated specific information related to increase criteria was not included in</p>	W 312		
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W 312	Continued From page 5 Individual #3's medication reduction plan.	W 312		
W 336	The facility failed to ensure a comprehensive psychotropic medication plan was in place for each of Individual #3's behavior modifying drugs. 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews were completed on a quarterly basis for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: Individual #1 - #3's medical records were reviewed. Individual #1 - #3's records did not include nursing reviews for the fourth quarter (October, November, December) of 2013. During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the LPN stated fourth quarter 2013 nursing reviews could not be located and possibly were not done.	W 336		
W 362	The facility failed to ensure quarterly nursing reviews were completed for Individuals #1 - #3. 483.460(j)(1) DRUG REGIMEN REVIEW	W 362		

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W 362	<p>Continued From page 6</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</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 the pharmacist conducted routine comprehensive drug regimen reviews. This directly impacted 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed, and had the potential to impact all individuals residing at the facility. This resulted in a lack of quarterly pharmacy reviews being completed. The findings include:</p> <p>1. Individual #1 - #3's medical records were reviewed. Individual #1 - #3's records included pharmacy reviews dated 3/10/14, 8/15/14 and 12/5/13. However, none of the records contained quarterly pharmacy reviews for the second quarter (April, May, June) of 2014.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the nurse stated the pharmacy did not complete second quarter reviews.</p>	W 362		
W 434	<p>483.470(f)(3) FLOORS</p> <p>The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff</p>	W 434		

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W 434	<p>Continued From page 7</p> <p>interview, it was determined the facility failed to ensure the facility floor was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in a potential increase in fall risks and the creation of unsanitary conditions. The findings include:</p> <p>1. During an environmental review on 8/20/14 from 9:30 - 10:30 a.m., the condition of the kitchen vinyl flooring was noted. The vinyl was cracked and separated from the baseboards around the entire room and dirt and debris had accumulated in the separated areas. The vinyl also had deep scratches in front of the pantry where the door dragged on the vinyl surface.</p> <p>The facility maintenance person was present during the review. He said a bid for vinyl replacement had been obtained and had been sent to the corporate office for approval. No response had been forthcoming from the corporate office. When asked how long ago this had occurred, the maintenance person stated "a very long time ago."</p> <p>An estimate for replacing the flooring at the facility was requested and reviewed. The estimate was dated 1/3/2014. In a telephone interview on 9/2/14 at 11:00 a.m., the City Director said the estimate had been forwarded to the corporate office and no response had been received as of this date.</p> <p>However, the Idaho State Director stated, via email received on 9/8/14 at 8:59 a.m., the bid was obtained but was not forwarded to the facility's corporate office.</p> <p>The facility failed to ensure the kitchen vinyl</p>	W 434		
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W 434	Continued From page 8 flooring was maintained in a safe and sanitary condition.	W 434		
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on record review, staff interview, and observations, it was determined the facility failed to ensure individuals received services consistent with their program plans for 1 of 3 individuals (Individual #1) whose record was reviewed. This resulted in an individual's training program not being consistently implemented. The findings include: Individual #1's IPP, dated 1/16/14, documented a 38 year old male whose diagnoses included severe MR, autism, and stereotypic/repetitive disorder. His OT assessment, dated January/2014, recommended Individual #1 use a lip plate, a wedge behind his back during meals, and a chair with arms. His IPP, dated 1/16/14, documented a service objective plan that included the use of the wedge, lip plate and armed chair. Observations were done at the facility on 8/18/14 from 4:00 - 5:35 p.m. This included the observation of the evening meal. During the meal, Individual #1 was not observed to be seated in a chair with arms. He did not have a wedge behind his back during the meal, and he	W 484		

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W 484	<p>Continued From page 9 had a flat dinner plate rather than a lip plate.</p> <p>In an interview on 8/22/14 from 12:10 - 1:10 p.m., the AQIDP confirmed the OT recommendation and the service objective program. He further stated the items were present in the home and staff should be using the items during all meals.</p> <p>The facility failed to ensure Individual #1 was provided with assistive equipment in accordance with his plan.</p>	W 484		
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Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 8/18/14 - 8/26/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Trish O'Hara, RN Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional	M 000		
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		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in the environment being kept in	MM380		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve Young</i>	TITLE Program Supervisor	(X6) DATE 9/18/14
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STATE FORM 6896 H8RJ11 II continuation sheet 1 of 5

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #1 SPRINGFIE	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	<p>Continued From page 1</p> <p>ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 8/20/14 from 9:30 - 10:30 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> - The kitchen vinyl flooring was cracked and separated from the baseboard around the entire room. - The light in the exhaust fan over the stovetop did not work. - There was no screen on the window in Individual #3's bedroom. - There was no screen on the window in the bedroom shared by Individuals #2 and #4. - Individual #2's dresser had four broken drawers that fell forward and down when opened. - There was a 2 inch by 5 inch hole in the drywall at the foot of Individual #4's bed. - There was a large, yellow stain, approximately 2 feet by 3 inches, on the floor outside of Individual #1 and Individual #5's bathroom. - There was an unpainted spot on the wall, approximately 6 inches in diameter, next to Individual #5's bed. - There was an unpainted square on the wall, approximately 3 inches by 4 inches, between Individual #1 and Individual #5's beds. - There were rusted scrapes in the flooring underneath the corners of Individual #5's bed frame. 	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #1 SPRINGFIE	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	<p>Continued From page 2</p> <ul style="list-style-type: none"> - There was an approximately 1/4 inch gap between the shower stall and flooring in Individual #1 and Individual #5's bathroom. The gap had accumulated dirt and debris. - There were no less than ten chips and/or scratches in the paint in Individual #1 and Individual #5's bathroom. - There was a chip, approximately 3 inches wide, in the paint in Individual #1 and Individual #5's bathroom that exposed the drywall. - There was a 12 inch by 12 inch area of mold on the ceiling behind the door in Individuals #2 and #4's bedroom. - The main bathroom had 3 broken floor tiles. - There were no less than ten chips and/or scratches in the paint in the main bathroom. - There was an unpainted square on the wall, approximately 6 inches by 6 inches, to the right of the mirror in the main bathroom. - There was an approximately 1/2 inch gap between the bathtub and flooring in the corner of the main bathroom. The gap had accumulated dirt and debris. - There was a banana chair in the living room with ripped upholstery fabric. - There was no screen on the window in the dining area. - The door leading to the garage was broken across the bottom edge. 	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIE	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 3 The facility maintenance person was present when the environmental review was conducted and acknowledged the needed repairs. The facility failed to ensure the environment was kept clean and repairs were completed and maintained.	MM380		
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 record review and staff interview, it was determined the facility failed to ensure accurate, complete personal possession inventories were maintained for 5 of 5 individuals currently residing at the facility and 1 former individual (Individual #6) who had been discharged. This resulted in the potential loss of individuals' personal property. The findings include: On 8/20/14 at 10:00 a.m., records were requested for all individuals who were residing in the facility in July, 2014. The AQIDP stated that personal inventory logs were not kept for individuals who currently or formerly resided at the facility. The facility failed to ensure personal possession inventory was maintained with accurate, current	MM567		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #1 SPRINGFIE	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SPRINGFIELD IDAHO FALLS, ID 83404
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MM567	Continued From page 4 information for Individuals #1 - #6.	MM567		
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 W484.	MM725		
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362.	MM758		

SPRINGFIELD'S SURVEY DATED 8/26/14 PLAN OF CORRECTION

RECEIVED

October 29, 2014

OCT 31 2014

W218-

FACILITY STANDARDS

- Assessment will be reviewed more thoroughly by QIDP/AQIDP and assessments will be brought to IDT meetings and shared with the team for team review as well as quarterly at our internal peer review performed by homes QIDP/AQIDP's.
- A quarterly peer review will be scheduled on facility calendar and a checklist will be utilized to assure all items are complete and correct.
- All future assessments will be reviewed by PBS Coordinator prior to annual IDT meetings.
- All assessments will be reviewed and revised as needed by December 1, 2014 by AQIDP/QIDP/PBS Coordinator.

W312-

- The QIDP/AQIDP will review all psychotropic medication plans/ medication reduction plans monthly with the team including the psychiatrist and psychologist at psychotropic medication review meetings.
- The psychiatrist and psychologist will also be educated on the importance of on-going review of medications and diagnosis's.
- All psychotropic medication plans will be reviewed by the team and revised as needed.
- This will be completed by October 31, 2014 by the QIDP/AQIDP/team.

W336-

- All monthly nursing assessments will be reviewed for accuracy and timelines by the CLPN (charge licensed practical nurse) and double checked through filing system.

- Double checked through filing system means, the nursing assistant will make sure all MD, pharmacy review, and nursing reviews are accounted for. If not, CLPN will be notified immediately.
- This will be completed by October 31, 2014 by the CLPN.

W362-

- A new pharmacist has been obtained, has committed to be at all quarterly medication meetings and provide accurate quarterly reviews.
- These reviews will be reviewed by CLPN and faxed to the MD if indicated.
- These will also be checked by the nursing assistant through filing.
- This will be completed by November 3, 2014 by CLPN.

W434-

- Per governing body, bids are being obtained for all floors in need of repair. In addition, to ensure such repairs are completed, the governing body has implemented a universal checklist which will be reviewed by the governing body and the governing body will define the roles and responsibilities of corporate as well as facility roles and responsibilities.
- All universal home checklists will be completed by lead DSP's and turned in to program supervisors and reviewed by the 15th of each month.
- Weekly phone calls to State Director to discuss any needed repairs. These repairs will then be evaluated and authorized through state director.
- This will be completed by city director by October 31, 2014.
- The floors are being replaced one home per month until all five homes completed.

W484-

- QIDP/AQIDP will assure special devices/adaptive equipment will be listed in the service objectives for individuals per consultant recommendations and

discussed monthly at the home behavior meetings to assure these devices and equipment are being furnished and implemented.

- All service objectives have been reviewed and inventoried per consultant recommendations.
- This was completed October 16, 2014 by QIDP/AQIDP.

MM197-

Refer to W312.

MM380-

- A monthly universal checklist will be implemented by the governing body to include any environmental needs that are turned in to the Program Supervisors and City Director.
- All repairs needed are given to maintenance supervisor, program supervisor as well as a copy to the city director to assure these repairs are being performed. If repairs are not followed through with by following week, the city director will be notified and followed through with by possible disciplinary action.
- This will be completed by November 25, 2014 by the city director.

MM567-

- An individual property inventory will be completed upon admission and maintained quarterly by home supervisor and QIDP/AQIDP.
- Inventory was taken for all individuals and will be updated as purchases are made (personal items, electronics, entertainments, etc excluding edibles). This will be reviewed monthly by program supervisor and initialed.
- This will be completed by October 1, 2014 by QIDP/AQIDP.

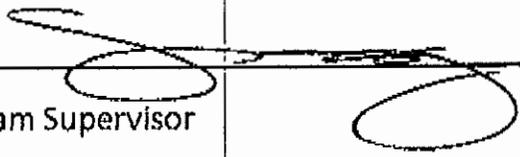
MM725-

Refer to W484.

MM758-

Refer to W362

Program Supervisor

A handwritten signature in black ink, consisting of several loops and a horizontal stroke, is written across the signature line.

Date

10-31-14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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September 5, 2014

Steve Young, Administrator
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83402

Provider #13G063

Dear Mr. Young:

On **August 26, 2014**, a complaint survey was conducted at Yellowstone Group Home #1 Springfield. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006562

Allegation #1: Individuals are inappropriately restrained.

Findings #1: An unannounced visit was made to the facility from 8/18/14 - 8/22/14. During the visit observations were conducted and records and facility policies were reviewed with the following results:

A policy titled "Behavior Support Method Hierarchy & Definitions," dated 1/3/14, described behavioral interventions, according to Levels 1 - 6, from less to most restrictive. The policy stated "supportive restraints are to be employed only when absolutely necessary and as a last resort to protect individuals from injury to themselves and others." The policy stated "All Therapeutic Options (the facility's restraint system) guidelines must be utilized while utilizing restraints."

A second policy titled "Abuse, Neglect, Mistreatment and Injuries of An Unknown Source," dated 1/9/13, included the misuse of restraints, defining it as "physical control not in accordance with accepted professional practice." The policy went stated "all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source are thoroughly investigated."

Steve Young, Administrator
September 5, 2014
Page 2 of 4

Four individuals' records were reviewed, including their Positive Behavior Support Plans. All 4 Positive Behavior Support Plans included the use of Therapeutic Options restraints. All 4 Positive Behavior Support Plans contained appropriate consent by each individual or legal guardian for use of the Therapeutic Option restraint system, as well as Human Rights Committee approval.

One individual's Positive Behavioral Support Plan allowed Therapeutic Options restraints up to and including 2 person body control restraint to control physical aggression, property destruction, and self injurious behavior. The individual's record documented 5 incidents where emergency restraints, beyond Therapeutic Options guidelines, were used when he continued to be a danger to himself and others and less restrictive measures had failed. Baskethold restraints were used two times and a prone restraint was used three times.

The five incidents were recognized by staff to be potential misuse of restraints, according to facility policy, and were reported and investigated immediately by facility administration. The investigations into the potential misuse of restraints were reviewed. The facility investigations concluded the emergency restraints were necessary to prevent further harm to the individual and others, and no abuse had occurred. The investigations were thorough and included appropriate corrective actions.

Additionally, Incident/Accident Reports were reviewed from 4/2014 - 7/2014, for all individuals residing at the facility and no concerns were identified. Further, during a cumulative observation time of 6 hours, no inappropriate restraints were observed.

The facility identified, investigated, and addressed all allegations of inappropriate restraint use. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility does not adequately coordinate services resulting in medications errors occurring.

Findings #2: An unannounced visit was made to the facility from 8/18/14 - 8/22/14. During the visit observations and interviews were conducted and records were reviewed with the following results:

In an interview on 8/22/14 from 9:00 a.m. - 1:10 p.m., the facility nurse stated if an individual was expected to be away from the facility, prescription medications would be sent with him/her.

Steve Young, Administrator
September 5, 2014
Page 3 of 4

Observations of individuals at off-site locations were conducted on 8/19/14 from 10:00 - 10:45 a.m. and again on 8/19/14 from 12:00 - 12:35 p.m. During the observations it was noted that individuals received medications as prescribed at their day programs.

Four individuals' records were reviewed for medication administration. None of the medication administration records, dated 7/1/14 - 7/31/14, included documentation of medication errors due to individuals being away from the facility.

Additionally, one individual's record showed he had been taken from the facility unexpectedly by local police. Due to the arrest, his medication had not been sent with the individual at the time. However, when the facility was later contacted by a local hospital, the facility immediately forwarded medication information pertaining to the individual to the hospital via fax.

It could not be established that the facility failed to adequately coordinate services resulting in medications errors occurring. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Personal possession inventories are not maintained resulting in individuals not receiving all of their possessions when they are discharged from the facility.

Findings #3: An unannounced visit was made to the facility from 8/18/14 - 8/22/14. During the visit interviews were conducted and records were reviewed with the following results:

Personal possession inventory logs were requested for 6 individuals who had resided at the facility within the past year. However, the Assistant Qualified Intellectual Disabilities Professional stated on 8/21/14 at 4:00 p.m., that personal inventory logs were not kept for individuals who currently or formerly resided at the facility.

The facility failed to ensure personal inventory logs were kept. Therefore, the allegation was substantiated and deficient practice was cited at M567.

Conclusion #3: Substantiated. State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

Steve Young, Administrator
September 5, 2014
Page 4 of 4

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt