



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 9, 2014

Dennis Butler, Administrator
Yellowstone Group Home #2 Sunnybrook
560 West Sunnyside Lane
Idaho Falls, ID 83402

RE: Yellowstone Group Home #2 Sunnybrook, Provider #13G064

Dear Mr. Butler:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #2 Sunnybrook, 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

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

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

After you have completed your Plan of Correction, return the original to this office by **September 22, 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 22, 2014. If a request for informal dispute resolution is received after September 22, 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

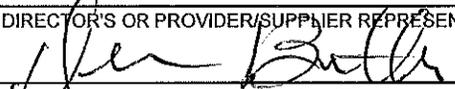
PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(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 #2 SUNNYBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	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: 1:1 - One-to-one ABC - Antecedent, Behavior, Consequence CBC - Complete Blood Count CFA - Comprehensive Functional Assessment IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QIDP - Qualified Intellectual Disabilities Professional SIB - Self Injurious Behavior TO - Therapeutic Options (a restraint system)	W 000	<p><i>RECEIVED</i></p> <p><i>SEP 26 2014</i></p> <p><i>FACILITY STANDARDS</i></p>	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review, staff interview and a review of the facility's compliance history, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This failure resulted in the governing body providing insufficient direction and control over the facility necessary to ensure individuals'	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE QIDP	(X6) DATE 9-22-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	<p>Continued From page 1 needs were met. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W159 as it relates to the governing body's failure to ensure the QIDP provided sufficient monitoring and coordination to meet individuals' identified needs. The facility was previously cited at W159 during the annual recertification survey, dated 10/18/12, the annual recertification survey, dated 10/25/13, and the annual recertification follow-up survey, dated 1/13/14. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance. 2. Refer to W214 as it relates to the governing body's failure to ensure behavior assessments were accurate and comprehensive. The facility was previously cited at W214 during the annual recertification survey, dated 10/18/12, the annual recertification survey, dated 10/25/13, and the annual recertification follow-up survey, dated 1/13/14. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance. 3. Refer to W249 as it relates to the governing body's failure to ensure individuals received training and services consistent with their program plans. The facility was previously cited at W249 during the annual recertification survey, dated 10/25/13, and the annual recertification follow-up survey, dated 1/13/14. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance. 4. Refer to W252 as it relates to the governing 	W 104		
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W 104	<p>Continued From page 2</p> <p>body's failure to ensure data was collected as indicated by individuals' plans. The facility was previously cited at W252 during the annual recertification survey, dated 10/25/13. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance.</p> <p>5. Refer to W289 as it relates to the governing body's failure to ensure methods for behavioral intervention were adequately developed and documented. The facility was previously cited at W289 during the annual recertification survey, dated 10/18/12, and the annual recertification survey, dated 10/25/13. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance.</p> <p>6. Refer to W312 as it relates to the governing body's failure to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that defined how the drugs might change in relation to the behaviors for which the drugs were employed. The facility was previously cited at W312 during the annual recertification survey, dated 10/18/12, the annual recertification survey, dated 10/25/13, and the annual recertification follow-up survey, dated 1/13/14. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies and sustained compliance.</p> <p>The governing body failed to take actions that identified and resolved systematic problems, which impeded the facility's ability to meet the individuals' behavioral and programmatic needs.</p>	W 104			

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W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</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 outside services were sufficiently coordinated and monitored for 1 of 3 individuals (Individual #2) whose outside services were reviewed. This resulted in outside services not being sufficiently coordinated and monitored and a lack of comprehensive information being available to all team members on which to base program decisions. The findings include:</p> <p>1. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder.</p> <p>a. Individual #2's monthly behavior summaries, dated 1/2014 - 6/2014, were reviewed. The 1/2014 Behavior Summary Sheet documented Individual #2 "requested a counselor and saw him for a few times but is requesting a female counselor. Program Supervisor is working on this..."</p> <p>The 4/2014 Behavior Summary Sheet documented Individual #2 "requested a female counselor. She will not see the counselor here...QIDP talked to her father about this during the month and is working on this..."</p> <p>No other information related to counseling could be found in Individual #2's record.</p>	W 120		

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W 120	Continued From page 4 During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated he had not obtained counseling notes or a treatment plan from Individual #2's counselor. The QIDP also stated a female counselor had not yet been found for Individual #2. On 8/26/14, the facility submitted "counseling notes 2014" for Individual #2. The notes, written by the facility psychologist, documented "Each Monday after team meeting I would attempt to talk with [Individual #2] as requested by the QIDP...Attempts were very difficult as [Individual #2] did not want to participate in any sessions..." However, the notes did not include any additional information (when the sessions took place, what goals were discussed, etc.). The facility failed to ensure Individual #2's outside services were sufficiently coordinated and monitored.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure	W 124		

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W 124	<p>Continued From page 5</p> <p>sufficient information was provided to guardians on which to base consent decisions for 2 of 3 individuals (Individuals #1 and #2) whose consents were reviewed. This resulted in inaccurate, insufficient information being provided to individuals' guardians regarding restrictive interventions. The findings include:</p> <p>1. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation, schizoaffective disorder and anxiety disorder. Individual #1's Written Informed Consents were reviewed and did not include comprehensive, accurate information. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's Psychotropic Medication Plan, undated, documented Individual #1 received Klonopin (an anticonvulsant drug) for aggressive behavior associated with schizoaffective disorder. However, Individual #1's Klonopin Written Informed Consent, dated 8/1/13, documented Individual #1 "has a diagnosis of bipolar with psychosis and a major depressive disorder, Klonopin is needed to stabilize mood [and] decrease anxiety/aggression."</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1's Klonopin was used for both anxiety and aggression, however the diagnoses on the Written Informed Consent were incorrect.</p> <p>b. Individual #1's Psychotropic Medication Plan, undated, documented Individual #1 received Lithium (an antimanic drug) for disruptive behavior and "anxiety type incidents" associated with anxiety disorder. However, Individual #1's</p>	W 124			

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W 124	<p>Continued From page 6</p> <p>Lithium Written Informed Consent, dated 5/8/14, documented Individual #1 received Lithium to "Stabilize mood [and] decrease episodes of aggression, agitation and anxiety."</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1's medication plan was accurate related to Lithium and the identified use in the Written Informed Consent was incorrect.</p> <p>c. Individual #1's Positive Behavior Support Intervention Plan for disruptive behavior, dated 5/1/14, documented when Individual #1 engaged in disruptive behavior "Staff should maintain 1:1 arms [sic] length until she is calm and has become interested in the activity or leisure time." However, no information related to 1:1 staffing could be found in Individual #1's behavior plan Written Informed Consent, dated 5/1/14.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated the 1:1 staffing intervention for Individual #1's disruptive behavior would be added into the Written Informed Consent.</p> <p>The facility failed to ensure Individual #1's Written Informed Consents included comprehensive and accurate information to allow Individual #1's guardian to make informed decisions.</p> <p>2. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder. Individual #2's Written Informed Consents were reviewed and did not include comprehensive, accurate information, as follows:</p>	W 124			

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W 124	Continued From page 7 a. Individual #2's MARs from 11/2013 - 8/2014 were reviewed. The MARs documented Individual #1 received Tenex (an antihypertensive drug) for tardive dyskinesia (involuntary, repetitive body movements). However, Individual #2's Tenex Written Informed Consent, dated 3/6/14, documented she received Tenex "for mood stability with episodes of aggression." During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated the Tenex consent was inaccurate and the medication was used for tardive dyskinesia. The facility failed to ensure Individual #2's Written Informed Consents included comprehensive and accurate information to allow Individual #2's guardian to make informed decisions.	W 124		
W 159	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 record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight of individuals' active treatment programs for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed, with the potential to affect all individuals (Individuals #1 - #6) 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 and program development. The	W 159		

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W 159	<p>Continued From page 8 findings include:</p> <ol style="list-style-type: none"> 1. Refer to W120 as it relates to the facility's failure to ensure the QIDP ensured an individual's outside services were coordinated and monitored. 2. Refer to W124 as it relates to the facility's failure to ensure the QIDP ensured Written Informed Consents contained accurate, comprehensive information. 3. Refer to W212 as it relates to the facility's failure to ensure the QIDP ensured individual's diagnoses were accurately identified. 4. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' behavior assessments were accurate and included comprehensive information. 5. Refer to W223 as it relates to the facility's failure to ensure the QIDP comprehensively assessed each individuals' leisure skills. 6. Refer to W249 as it relates to the facility's failure to ensure the QIDP ensured individuals received training and services consistent with their program plans. 7. 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. 8. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured techniques used to manage inappropriate behavior were sufficiently incorporated into individuals' behavior programs. 	W 159		
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W 159	Continued From page 9	W 159		
W 212	<p>9. 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 defined how the drugs might change in relation to the behaviors for which the drugs were employed.</p> <p>483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.</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 that evaluation data was available to support the diagnoses for 1 of 3 individuals (Individual #1) whose records were reviewed. This resulted in the potential for an individual to receive unnecessary interventions based on inaccurate diagnoses. The findings include:</p> <p>1. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder.</p> <p>Individual #2's Behavioral Assessment, dated 4/1/14, documented Individual #2's diagnoses included moderate intellectual disability, bipolar disorder, oppositional defiant disorder and seizure disorder.</p> <p>Individual #2's record included a Psychiatric Evaluation, dated 4/2/13, which documented Individual #2's diagnoses as disruptive behavior</p>	W 212		

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W 212	Continued From page 10 disorder, mood disorder and mental retardation by history. Individual #2's record did not include relevant, objective and accurate documentation related to how the diagnoses of moderate intellectual disability, bipolar disorder, oppositional defiant disorder and seizure disorder were determined (i.e., evidence of seizures, major depressive or manic episodes, etc.). During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the LPN stated she typically documented admission diagnoses and revised them as needed. The QIDP, also present during the interview, stated he thought the incorrect diagnoses may have been from a past IPP. The QIDP stated they would follow-up with Individual #2's physician. In a follow-up interview, on 8/26/14 from 1:09 - 1:55 p.m., the QIDP stated Individual #2 had an appointment scheduled to clarify her diagnoses as the team was unable to determine which were accurate. The facility failed to ensure that evaluation data was available to support Individual #2's diagnoses.	W 212			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 214			

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W 214	<p>Continued From page 11</p> <p>was determined the facility failed to ensure behavioral assessments contained accurate and comprehensive information for 2 of 3 individuals (Individuals #1 and #2) whose behavioral interventions were reviewed. This resulted in a lack of accurate information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation.</p> <p>Individual #1's Behavioral Assessment, dated 4/3/14, stated she engaged in maladaptive behaviors which included aggression, property destruction and disruptive behavior. However, the Behavioral Assessment did not include accurate, comprehensive information. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's Behavioral Assessment for each behavior listed schizoaffective disorder as the "Associated Diagnosis." The assessment did not contain additional information regarding how Individual #1's diagnosis impacted her demonstrated maladaptive behaviors.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated additional information related to Individual #1's diagnosis in relation to her behavior was not included in the assessment.</p> <p>b. Individual #1's Behavioral Assessment for each behavior listed Klonopin (an anticonvulsant drug), Celexa (an antidepressant drug) and Clozaril (an antipsychotic drug) as "Associated Psychoactive Medications." The assessment did not contain any additional information related to how her</p>	W 214			

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W 214	<p>Continued From page 12</p> <p>psychotropic medications impacted her behavior.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated additional information related to Individual #1's medications in relation to her behavior was not included in the assessment.</p> <p>c. For all behaviors, under both "Events that typically precede the Maladaptive Behavior" and "Events that typically follow the Maladaptive Behavior," the assessment included power struggles with staff, communication challenges with staff, loss of control, being over cued and waiting for preferred activities.</p> <p>Additionally, Individual #1's Behavioral Assessment did not include any information related to what "over cued" was for Individual #1.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated specific information related to over cuing would be added to the assessment. The QIDP stated the matching preceding and following events lists were incorrect and would be revised.</p> <p>d. Individual #1's Behavioral Assessment for aggression documented "she will often begin with attention seeking behavior..." However, the assessment did not contain any additional information related to attention seeking behavior for Individual #1.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1's attention seeking behavior needed to be better assessed and would be clarified.</p> <p>e. Individual #1's Behavioral Assessment for</p>	W 214		

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W 214	<p>Continued From page 13</p> <p>disruptive behavior stated her "anxiety also plays a role in her attention seeking behavior; at times she will stare/glare at others as a symptom of her anxiety." However, no other information related to anxiety symptoms was included in the assessment.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated additional information related to Individual #1's anxiety could be found on her anxiety tracking sheet, but was not identified in the assessment. The Positive Behavior Support Specialist, also present during the interview, stated the facility received recent education related to behavioral documentation and all assessments and plans would be revised.</p> <p>The facility failed to ensure Individual #1's Behavioral Assessment contained accurate, comprehensive information on which to base program decisions.</p> <p>2. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder.</p> <p>Individual #2's Behavioral Assessment, dated 4/1/14, stated she engaged in maladaptive behaviors which included elopement, hurting others, property destruction and disruptive behavior. However, the Behavioral Assessment did not include accurate, comprehensive information. Examples included, but were not limited to, the following:</p> <p>a. Individual #2's Behavioral Assessment for each behavior listed bipolar disorder and oppositional defiant disorder as the "Associated Diagnosis."</p>	W 214			

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W 214	<p>Continued From page 14</p> <p>The assessment did not contain additional information regarding how Individual #2's diagnoses impacted her demonstrated maladaptive behaviors.</p> <p>Additionally, documentation related to the diagnoses of bipolar disorder and oppositional defiant disorder could not be found.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated he thought the diagnoses may have been from a past IPP. The QIDP stated they would follow-up with Individual #2's physician.</p> <p>b. Individual #2's Behavioral Assessment for each behavior listed Lamictal (an anticonvulsant drug) and Abilify (an antipsychotic drug) as "Associated Psychoactive Medications." The assessment did not contain any additional information related to how her psychotropic medications impacted her behavior.</p> <p>Additionally, Individual #2's MARs, dated 11/2013 - 8/2014, documented Individual #2 was prescribed Lamictal for seizures.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Lamictal was for seizures and needed to be removed from the Behavioral Assessment. He stated assessment information related to Individual #2's medications would be revised.</p> <p>c. Individual #2's Psychotropic Medication Plan, undated, documented she received Vistaril (an anxiolytic drug) for lack of sleep. However, her Behavioral Assessment did not include information related to how her maladaptive</p>	W 214		
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W 214	<p>Continued From page 15</p> <p>behaviors were impacted by her sleep, how much sleep was needed, etc.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated he obtained information related to Vistaril from an old plan and her assessment needed to be updated.</p> <p>d. Individual #2's Behavioral Assessment for elopement documented "When she gets to the point of displaying uncooperative behavior..." However, Individual #2's assessment did not include any additional information related to uncooperative behavior.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated information related to uncooperative behavior was from an old assessment and should have been removed.</p> <p>e. Individual #2's Behavioral Assessment for all behaviors, under "Events that typically follow the Maladaptive Behavior," included "access to item, person or task," "time" and "request is avoided."</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated the events following Individual #2's maladaptive behaviors were confusing in the assessment and needed to be clarified. The Positive Behavior Support Specialist, also present during the interview, stated the facility received recent education related to behavioral documentation and all assessments and plans would be revised.</p> <p>The facility failed to ensure Individual #2's Behavioral Assessment contained accurate, comprehensive information on which to base program decisions.</p>	W 214		

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W 223	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include social development.</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 individuals' CFAs included comprehensive information related to their leisure activities for 1 of 3 individuals (Individual #2) whose CFAs were reviewed. This failure resulted in a lack of information and the potential for preferred activities/items to not be available in the facility. The findings include:</p> <p>1. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder.</p> <p>Individual #2's Behavioral Assessment for disruptive behavior, dated 4/1/14, documented Individual #2's disruptive behavior was attributed to a leisure skills deficit.</p> <p>However, Individual #2's CFA contained a section for Home Leisure, which contained 19 assessment items with an associated prompt level that was rated from 1 - 7. Two items were marked not applicable. The remaining 17 items were all marked '1' for independent. The 17 items Individual #2 was marked independent with included "Selects something to do at home for fun when given a choice" and "Tries new leisure activities before stating whether he or she enjoys them."</p> <p>During an interview on 8/22/14 from 9:02 a.m. -</p>	W 223			

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W 223	Continued From page 17 1:12 p.m., the QIDP stated the assessment was inaccurate and Individual #2's leisure skills needed to be re-assessed.	W 223			
W 249	The facility failed to ensure Individual #2's CFA included comprehensive information regarding her home leisure skills. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 2 of 3 individuals (Individuals #1 and #2) whose records were reviewed. This resulted in individuals not having access to visual schedules. The findings include: 1. Individual #1 and Individual #2's behavior plans were reviewed and included instructions for materials not in use, as follows: a. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation. Individual #1's record included a Positive Behavior Support	W 249			

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W 249	<p>Continued From page 18</p> <p>Intervention Plan, dated 5/1/14, which stated Individual #1 "...will use her visual schedule in the home including keeping a calendar..." Additionally, the plan stated the schedule was to be used as follows:</p> <ul style="list-style-type: none"> - to offer Individual #1 different activities to increase her independence in decision making; - to prepare her for transitions during the day, especially shift changes; and - as a tool for staff to refer Individual #1 to throughout the day. <p>b. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder. Individual #2's record included a Positive Behavior Support Intervention Plan, dated 5/1/14, which stated staff were to "...refer [Individual #2] to her visual schedule throughout the day and encourage her to use scheduling tools..." The plan stated Individual #2's schedule should be used as follows:</p> <ul style="list-style-type: none"> - to be "actively involved in her active treatment schedule...using a daily schedule" in the home; - to be offered different activities based on the schedule to increase independence; and - to help prepare for transitions during the day, especially shift changes. <p>However, during observations at the facility on 8/18/14 and 8/19/14 for a cumulative of 3 hours, a visual schedule and calendar for Individual #1 or Individual #2 could not be found.</p> <p>Direct care staff were asked about visual schedules during interviews conducted on 8/21/14 with the following results:</p>	W 249			

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W 249	Continued From page 19 - Staff A stated individuals' schedules were taped up at the day program to be visually visible. - Staff B stated each individual had a morning, evening and day treatment schedule in their records. - Staff C stated the facility had a big calendar hung where the daily outings were documented. - Staff D stated she did not think the individuals had visual schedules. During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1 and Individual #2 should have a visual schedule. The facility failed to ensure individuals were provided with program materials in accordance with plans.	W 249			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. 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 1 of 3 individuals (Individual #1) whose program data was reviewed. That failure had the potential to impede the ability of the treatment team in	W 252			

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W 252	<p>Continued From page 20</p> <p>evaluating the effectiveness of programmatic techniques. The findings include:</p> <p>1. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation.</p> <p>Individual #1's record included a Positive Behavior Support Intervention Plan, dated 5/1/14, for disruptive behavior. The plan defined disruptive behavior as swearing, lying, flipping others off and being rude to others.</p> <p>Individual #1's plan stated staff were to offer interventions, which included the following:</p> <ul style="list-style-type: none"> - sign and verbally cue her to stop; - allow her to vent; - redirect her to an activity; - give her 5 minutes to calm; - discuss different alternatives to the behavior with her; and - ask if she needs to go to her room or quiet area. <p>The program stated ABC data would be used to track all disruptive behaviors.</p> <p>Individual #1's ABC data from 1/1/14 - 7/18/14 was reviewed. The data did not provide sufficient information related to Individual #1's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 2/3/14 at 2:30 p.m.: The "Behavior" section of the form stated "Being rude to others X3, Lying about other residents X5." <p>The "Consequence" section of the form stated</p>	W 252			

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W 252	<p>Continued From page 21</p> <p>"Spoke with [Individual #1] about all the above stated."</p> <p>However, no additional information related to the lying (what statements were made, how staff knew the statements were lies, etc.) or information related to other interventions implemented (telling her to stop, redirecting to an activity, etc.) were present.</p> <p>- 4/10/14 at 8:00 a.m.: The "Behavior" section of the form stated "Staff tried to explain to her that she can't have pop at 8oclock [sic] because its to [sic] much sugar. She got upset tried walking out the door 1X accused [Individual #4] of rapeing [sic] her said she was gunna [sic] pound [Individual #4] 1X swore 5X, slamed [sic] her door 3X."</p> <p>The "Consequence" section of the form stated "wrote her up."</p> <p>However, no additional information related to any other interventions besides writing Individual #1 up was present.</p> <p>- 5/1/14 at 5:40 p.m.: The "Behavior" section of the form listed multiple maladaptive behaviors including "flipping off" peers and staff, swearing at peers and staff, "talked about sex," hitting staff, spitting at peers and throwing items down the hallway.</p> <p>The "Consequence" section of the form stated "She went to bed, didn't earn 8oclock [sic] reinforcement."</p> <p>However, no additional information related to any interventions implemented was present.</p>	W 252			

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W 252	<p>Continued From page 22</p> <p>- 5/15/14 at 2:10 p.m.: The "Behavior" section of the form stated "Said staff kissed her 3X, said cliants [sic] were disrespecting her 10X, lying about staff and clients 15X."</p> <p>The "Consequence" section of the form stated "She worked it out herself."</p> <p>However, no additional information related to what "lying about staff and clients" meant or information related to other interventions implemented (telling her to stop, redirecting to an activity, discussing alternatives, etc) was present.</p> <p>- 6/17/14 at 1:30 p.m.: The "Behavior" section of the form stated "She was telling stories of things that were not true."</p> <p>The "Consequence" section of the form was blank.</p> <p>No additional information related to the "telling stories of things that were not true" or related to interventions provided by staff was present.</p> <p>Additionally, direct care staff were asked about documentation of Individual #1's lying behavior during interviews conducted on 8/21/14 with the following results:</p> <p>- Staff B reported Individual #1 lied fairly often, but she did not document the behavior.</p> <p>- Staff C stated Individual #1 had lied on occasion and she thought the behavior was tracked using a behavior slip, however, she had never completed one about Individual #1.</p>	W 252			

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W 252	Continued From page 23 - Staff D stated she documented the behavior on Individual #1's monthly behavior summary. Staff were not consistently collecting lying data for Individual #1's disruptive behavior. During an interview on 8/21/14 at approximately 11:30 a.m., the QIDP stated when Individual #1 told lies the behavior was not documented, but should be. The QIDP stated he recognized that staff could use additional training to comprehensively document Individual #1's maladaptive behaviors.	W 252			
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility failed to ensure Individual #1's ABC data provided sufficient information to evaluate the efficacy of her Positive Behavior Support Intervention Plan. The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 2 of 3 individuals (Individual #1 and #2) whose behavior plans were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral	W 289			

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W 289	<p>Continued From page 24 needs were met. The findings include:</p> <p>1. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation. Individual #1's behavior plans were reviewed and did not include sufficient instructions to staff, as follows:</p> <p>a. Individual #1's record included a Positive Behavior Support Intervention Plan, dated 5/1/14, for disruptive behavior. The plan defined disruptive behavior as swearing, lying, flipping others off and being rude to others.</p> <p>Individual #1's plan stated staff were to offer interventions, which included the following:</p> <ul style="list-style-type: none"> - sign and verbally cue her to stop; - allow her to vent; - redirect her to an activity; - give her 5 minutes to calm; - discuss different alternatives to the behavior with her; and - ask if she needs to go to her room or quiet area. <p>Direct care staff were asked about Individual #1's lying behavior and corresponding interventions during interviews conducted on 8/21/14 with the following results:</p> <ul style="list-style-type: none"> - Staff A stated if she suspected Individual #1 of lying, she would redirect her to a different topic. Staff A stated Individual #1 engaged in the behavior several times throughout the day and each time she would redirect Individual #1 to talk about something else. - Staff B reported if she was unable to tell if Individual #1 was telling the truth or a lie, she 	W 289			

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402
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W 289	<p>Continued From page 25</p> <p>would ask Individual #1. Staff B reported Individual #1 would admit when she was lying and Staff B could easily redirect her to another topic.</p> <p>- Staff C stated Individual #1 had lied on occasion and she redirected her to something else. Staff C stated no further interventions were required after redirection.</p> <p>- Staff D reported when Individual #1 told a story, she would ask "is that true?" Staff D stated Individual #1 would answer if the story was true or not.</p> <p>- Staff E stated when Individual #1 was calm, she would close her eyes when she lied and would admit that she told a lie. Staff E stated when Individual #1 was mad about something, she would tell lies about the staff and clients. Staff E reported she would tell Individual #1 that what she was saying was not true.</p> <p>During an interview on 8/21/14 at approximately 11:30 a.m., the QIDP stated he was aware that asking Individual #1 what was truth was an effective intervention that needed to be added into the program.</p> <p>b. Individual #1's Positive Behavior Support Intervention Plans for aggression, property destruction and disruptive behavior, all dated 5/1/14, included Individual #1 "will earn a token every 2 hours she engages in her calming activities..."</p> <p>However, during observations at the facility on 8/18/14 and 8/19/14 for a cumulative of 3 hours, no token system was noted to be implemented.</p>	W 289		
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W 289	<p>Continued From page 26</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated the token system was not in use and needed to be removed from Individual #1's plans.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1's behavior interventions needed revised. The Positive Behavior Support Specialist, also present during the interview, stated the facility received recent education related to behavioral documentation and all assessments and plans would be revised.</p> <p>The facility failed to ensure techniques to manage Individual #1's maladaptive behaviors were sufficiently incorporated into her behavior plans.</p> <p>2. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder. Individual #2's behavior plans were reviewed and did not include sufficient instructions to staff, as follows:</p> <p>a. Individual #2's Behavioral Assessment, dated 4/1/14, documented she engaged in elopement, defined as leaving the day program area or facility without staff permission.</p> <p>Individual #2's Positive Behavior Support Intervention Plan for elopement, dated 5/1/14, instructed staff to follow Individual #2 closely, attempt to calm her down, provide verbal cues to talk, problem solve or cope as needed and to physically intervene if needed for Individual #2's safety. The instructions did not include any information related to what staff were to do if Individual #2 refused to return to the facility or if</p>	W 289			

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W 289	<p>Continued From page 27</p> <p>staff did not see Individual #2 elope and were unable to follow.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #2 left the day program without staff knowing regularly and she would typically visit the QIDP's office.</p> <p>b. Individual #2's Written Informed Consent for her behavior plan, dated 5/2/14, documented her "behavior management program focuses on positive intervention strategies, such as verbal praise, special one-on-one time with staff...special outings..."</p> <p>However, no information related to special one-on-one time or outings could be found in Individual #2's behavior plans.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #2's behavior interventions needed revised. The Positive Behavior Support Specialist, also present during the interview, stated the facility received recent education related to behavioral documentation and all assessments and plans would be revised.</p> <p>d. Individual #2's Positive Behavior Support Intervention Plans for property destruction and disruptive behavior, both dated 5/1/14, included Individual #2 "will earn a token every 4 hours for expressing her emotions..."</p> <p>However, during observations at the facility on 8/18/14 and 8/19/14 for a cumulative of 3 hours, no token system was noted to be implemented.</p> <p>During an interview on 8/22/14 from 9:02 a.m. -</p>	W 289			

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W 289	Continued From page 28 1:12 p.m., the QIDP stated the token system was not in use and needed to be removed from Individual #2's plans.	W 289			
W 312	The facility failed to ensure techniques to manage Individual #2's maladaptive behaviors were sufficiently incorporated into her behavior plans. 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. 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 individual's IPP that was 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 the implementation of plans related to how the drugs may be changed in relation to progress or regression. The findings include: 1. Individual #3 was a 53 year old female with diagnoses including moderate mental retardation. Her Psychotropic Medication Plan, dated 3/5/14, documented she was taking Celexa (an antidepressant drug) for depression. Depressive	W 312			

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W 312	<p>Continued From page 29</p> <p>symptoms were described as mood disturbance, onset or increase of SIB, social withdrawal, and increase in aggressiveness.</p> <p>Individual #3's Psychotropic Medication Plan stated Celexa would be increased "when depression incidents increased."</p> <p>In an interview on 8/22/14 from 9:02 - 1:12 p.m., the QIDP said the plan should have specifically addressed the number of depression incidents, as well as specifying a time frame during which data for depression incidents would be collected prior to drug dosage being increased.</p> <p>The facility failed to ensure a comprehensive psychotropic medication plan was in place for Individual #3's behavior modifying drug.</p> <p>2. Individual #1's IPP, dated 9/19/13, documented she was a 26 year old female whose diagnoses included moderate mental retardation and anxiety disorder.</p> <p>Individual #1's record contained two Psychotropic Medication Plans, undated, which documented Individual #1 received Klonopin (an anticonvulsant drug), Celexa (an antidepressant drug), Clozaril (an antipsychotic drug) and Lithium (an antimanic drug).</p> <p>a. Individual #1's Klonopin Written Informed Consent, dated 8/1/13, documented "Klonopin is needed to stabilize mood [and] decrease anxiety/aggression." However, the Psychotropic Medication Plan for Klonopin documented the medication was prescribed for only aggression and had criteria specific to the behavior.</p>	W 312			

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W 312	<p>Continued From page 30</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1's Klonopin was used for both anxiety and aggression and criteria related to anxiety needed to be added to the plan.</p> <p>b. The plan for Individual #1's Klonopin, Clozaril and Celexa documented the medications would be consider for an increase "when aggressive behavior incidents increase." The plan for Lithium documented it would be considered for an increase "when disruptive behavior incidents increase."</p> <p>However, the plans did not include any additional information related to when the medication would be considered for increase (when incidents/symptoms increased by what amount, when incidents/symptoms maintained a higher level for how long, etc.).</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated medications would not be considered for increase unless the behaviors changed by a significant amount and he would clarify the information in the plans.</p> <p>c. Individual #1's Lithium Written Informed Consent, dated 5/8/14, documented the medication was to "Stabilize mood [and] decrease episodes of aggression, agitation and anxiety." However, Individual #1's Psychotropic Medication Plan documented Lithium was prescribed for disruptive behavior.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Individual #1's Lithium was used for only anxiety. The QIDP stated the medication reduction plan needed to be revised.</p>	W 312			

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W 312	<p>Continued From page 31</p> <p>The facility failed to ensure an accurate, comprehensive psychotropic medication plan was in place for each of Individual #1's behavior modifying drugs.</p> <p>3. Individual #2's IPP, dated 4/17/14, documented she was a 16 year old female whose diagnoses included "intellectual deficiency moderate" and seizure disorder.</p> <p>Individual #2's included three Psychotropic Medication Plans which documented Individual #2 received Tenex (an antihypertensive drug), Abilify (an antipsychotic drug) and Vistaril (an anxiolytic drug).</p> <p>a. Individual #2's MARs from 11/2013 - 8/2014 were reviewed. The MARs documented Individual #1 received Tenex for tardive dyskinesia (involuntary, repetitive body movements). However, Individual #1's Psychotropic Medication Plan for Tenex, dated 12/5/13, documented the medication was prescribed for aggression.</p> <p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated Tenex was used for tardive dyskinesia and the medication reduction plan needed to be changed.</p> <p>b. Individual #1's Psychotropic Medication Plan for Abilify, undated, documented the medication would be considered for an increase when "behavior incidents increase." The Psychotropic Medication Plan for Vistaril, dated 12/15/13, documented the medication would be considered for an increase "if sleeping decreases."</p>	W 312			

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W 312	Continued From page 32 However, the plans did not include any additional information related to when the medication would be considered for increase (when incidents/sleep changed by what amount, when incidents/sleep maintained the changed level for how long, etc.). During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the QIDP stated medications would not be considered for increase unless the behaviors changed by a significant amount and he would clarify the information in the plans. The facility failed to ensure an accurate, comprehensive psychotropic medication plan was in place for each of Individual #2's behavior modifying drugs.	W 312		
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 3 individuals (Individual #1) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include: 1. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation.	W 325		

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W 325	Continued From page 33 Individual #1's record included Physician's Telephone Orders, dated 1/8/14, requesting CBC levels to be measured each month. However, monthly lab levels for March, April or May 2014 could not be found in Individual #1's record. During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the LPN stated she would contact the pharmacy for copies of the CBC labs. In a follow-up fax on 8/25/14, the nurse's assistant documented they did not have the identified labs.	W 325		
W 336	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 that the facility failed to ensure nursing reviews had been 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: 1. Individual #1 - #3's medical records were	W 336		

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W 336	Continued From page 34 reviewed. Individual #1 - #3's records did not include a completed assessment 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 the fourth quarter reviews had been missed.	W 336		
W 361	The facility failed to ensure nursing reviews had been completed on a quarterly basis. 483.460(i) PHARMACY SERVICES The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the provision of routine drugs and biologicals was maintained for 2 of 3 individuals (Individuals #2 and #3) whose medical records were reviewed. This resulted in individuals not consistently receiving scheduled drugs and biologicals due to unavailability. The findings include: 1. The facility utilized the back of the MAR to document medications not received and the reason they were not received. This was done by noting the date, time, medication, comment, and staff initials. MARs were reviewed and documented medications were not consistently administered due to unavailability, as follows:	W 361		

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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #2 SUNNYBROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402	
(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 361	<p>Continued From page 35</p> <p>a. Individual #3 was a 53 year old female with diagnoses including chronic constipation.</p> <p>Individual #3's MARs, dated 2/2014 - 7/2014, were reviewed and documented Individual #3 was to have received Chronulac Syrup (a laxative drug) 2 tablespoons, twice a day for constipation.</p> <p>Individual #3's MARs documented Individual #3 did not receive Chronulac Syrup, due to unavailability, on the following days during 2014: 2/4, 2/5, 3/16, 3/17, 4/27, 4/28, 5/21, 7/1, 7/2, 7/19, 7/20, and 7/21.</p> <p>In an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the LPN said two bottles of Chronulac Syrup were ordered from the pharmacy at a time. She said staff was directed to contact her when the second bottle of Chronulac Syrup was getting low. The LPN stated the facility had continuous access to pharmacy services for refilling medications and Individual #3 should not have missed the medication due to unavailability.</p> <p>The facility failed to ensure all drugs and biologicals were provided as prescribed.</p> <p>b. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation.</p> <p>Individual #1's MARs, dated 11/2013 - 8/2014, were reviewed and documented she was to receive Clozaril (an antipsychotic drug) 300 mg at bedtime.</p> <p>However, the MARs documented Individual #1 did not receive Clozaril 3/30/14 - 4/2/14 due to the medication being unavailable in that timeframe.</p>	W 361		

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W 361	Continued From page 36	W 361		
W 362	<p>During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the LPN stated there was no Clozaril available for individual #1 from 3/30/14 - 4/2/14 because the pharmacy was on back order and the medication was not available anywhere else in town.</p> <p>The facility failed to ensure all drugs and biologicals were provided as prescribed.</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW</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 LPN stated the pharmacy did not complete second quarter reviews.</p>	W 362		

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W 362	Continued From page 37	W 362		
W 365	<p>The facility failed to ensure quarterly pharmacy reviews were completed for Individuals #1 - #3.</p> <p>483.460(j)(4) DRUG REGIMEN REVIEW</p> <p>An individual medication administration record must be maintained for each client.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an accurate medication administration record was maintained for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in a lack of documentation to ensure physician's orders were followed. The findings include:</p> <p>1. Individual #1's IPP, dated 9/9/13, documented she was a 26 year old female whose diagnoses included mild mental retardation.</p> <p>Individual #1's record included Physician's Telephone Orders, dated 3/5/14, which documented Individual #1 was prescribed Lithium (an antimanic drug) 300 mg each day. A second order, dated 6/4/14, documented Individual #1's Lithium was increased to twice daily, for a total of 600 mg each day. Individual #1's MARs, dated 6/2014 - 8/2014, were reviewed and documented the following:</p> <p>a. Individual #1's 6/2014 MAR documented Individual #1 was to receive Lithium 300 mg each evening. The MAR did not include any documentation related to the 6/4/14 change of the Lithium order.</p>	W 365		

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W 365	Continued From page 38 b. Individual #1's 7/2014 MAR documented Individual #1 was to receive Lithium 300 mg twice daily. The MAR included two lines for documentation of administration, one labeled 7:00 a.m. and the other labeled 9:00 p.m. The 7:00 a.m. administration line had been initialed by staff 7/1/14 - 7/3/14. However, the entire line for 7:00 a.m. had been crossed out and the MAR did not contain any additional documentation (e.g. the reason for crossing out the line or documentation of administration after 7/3/14). Additionally, the MAR included a handwritten note, undated, which documented "AM Lithium 300 mg has been stopped [LPN] notified." Individual #1's 8/2014 MAR documented Individual #1 was to receive Lithium 300 mg twice daily and included two lines for the different administration times. During an interview on 8/22/14 from 9:02 a.m. - 1:12 p.m., the LPN stated she knew the Lithium was administered as ordered after the 6/4/14 increase but she did not know why the administration was not accurately documented on the 6/2014 and 7/2014 MARs. The facility failed to keep an accurate record of Individual #1's medication administration.	W 365		
W 434	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions.	W 434		

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W 434	Continued From page 39 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the failed to ensure the facility floor was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in a potential increase in fall risks and the creation of unsanitary conditions. The findings include: 1. During an environmental review on 8/20/14 from 10:35 - 11:00 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 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." 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. 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.	W 434		

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W 434	Continued From page 40 The facility failed to ensure the kitchen vinyl flooring was maintained in a safe and sanitary condition.	W 434			

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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	M 000		
MM112	16.03.11.050.01(d) Residential Facility The residential facility is to admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. This Rule is not met as evidenced by: Refer to W223.	MM112		
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file	MM197		

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TITLE

QIDP

(X8) DATE

9-22-14

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MM197	Continued From page 1 in the facility; and This Rule is not met as evidenced by: Refer to W289 and W312.	MM197		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W249.	MM212		
MM298	16.03.11.100.06(e) Storage Areas, Attics, Basements Storage areas, attics, basements, and grounds must be kept free from refuse, litter, weeds, or other items detrimental to the health, safety, or welfare of the residents. This Rule is not met as evidenced by: Refer to W434.	MM298		
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.	MM380		

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MM380	<p>Continued From page 2</p> <p>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 6 of 6 individuals (Individuals #1 - #6) 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 8/20/14 from 10:35 - 11:10 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> - The door to Individual #2 and Individual #4's bedroom had a broken upper right panel and was broken along the bottom and outside edge. It had been glued and taped together. - The metal seam threshold connecting the flooring in Individual #1 and Individual #3's bedroom to the flooring in their bathroom was partially detached from the floor. - There were no less than 10 chips and/or scratches in the paint of the main bathroom. - On the inner side of the main bathroom door, an approximately 2 foot strip of paint had peeled off. - Inside the main bathroom a wall edge was chipped down to the metal bracket in an approximately 2 inch area. - The caulking around the base of the toilet was blackened with dirt. - The self-cleaning oven floor was covered with ash and debris. - The drawer beneath the oven contained a large amount of food debris. 	MM380		
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MM380	<p>Continued From page 3</p> <ul style="list-style-type: none"> - The fence gate leading to the back yard on the north side of the house was broken from both hinges and propped against the fence. - The canopy from a porch swing was torn and had been removed from the swing and propped against the house. - A large pile of dead tree branches were piled in the back yard. <p>The facility maintenance person was present during the environmental review and acknowledged the needed repairs.</p> <p>The facility failed to ensure the environment was kept clean and repairs were completed and maintained.</p>	MM380		
MM412	<p>16.03.11.120.04(m) Furniture and Equipment</p> <p>All furniture and equipment must be maintained in 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 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in individuals' seating being kept in ill-repair. The findings include:</p> <p>During an environmental review on 8/20/14 from 10:35 - 11:10 a.m., the following was noted:</p> <ul style="list-style-type: none"> - Two fabric couches in the living room were noted to be severely stained on all seating 	MM412		

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MM412	<p>Continued From page 4 surfaces.</p> <p>Additionally, when seated on the couches, the surveyor noted the couch cushions receded to the couch frames, providing no seated support or comfort and making it difficult to return to a standing position from the couches.</p> <p>- The bottom drawer of Individual #1's dresser was off the tracks and did not have back stops to prevent the drawer from falling forward when opened.</p> <p>- All three drawers of Individual #4's dresser were off the tracks and did not have back stops to prevent the drawers from falling forward when opened.</p> <p>The facility maintenance person was present during the environmental review and acknowledged the needed cleaning and repair of the furniture.</p> <p>The facility failed to ensure furniture was kept in a sanitary condition and in good repair.</p>	MM412		
MM520	<p>16.03.11.200.03(a) Establishing and Implementing polices</p> <p>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.</p>	MM520		

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MM561	Continued From page 5	MM561		
MM561	16.03.11.210.04(e) Behavior Incidents Records of significant behavior incidents; and This Rule is not met as evidenced by: Refer to W252.	MM561		
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 W365.	MM570		
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		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W212 and W214.	MM730		
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations	MM750		

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MM750	Continued From page 6 Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750		
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		
MM761	16.03.11.270.03(a) Providing for Administration of Medication Providing for the administration of any resident's medication where a need for professional judgment of adjusted schedule or response is anticipated and/or encountered; This Rule is not met as evidenced by: Refer to W361.	MM761		
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336.	MM766		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G064	(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 #2 SUNNYBRC	STREET ADDRESS, CITY, STATE, ZIP CODE 3245 SUNNYBROOK LANE IDAHO FALLS, ID 83402
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM859	Continued From page 7	MM859		
MM859	<p>16.03.11.270.08(f)(i) Supervision of Training and Habilitation</p> <p>Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and</p> <p>This Rule is not met as evidenced by: Refer to W120.</p>	MM859		

Survey Plan of Correction dated 08/26/2014

UPDATED 10/31/2014

Sunnybrook Group Home

09/16/2014

W104- Sunnybrook will ensure governing body will exercise general policy, budget and operating direction over the facility.

Training on the Governing Body Policy has been conducted with all staff. This will include but not be limited to the Corporate Entity.

Refer to W159

Refer to W120

Refer to W124

Refer to W214

Refer to W223

Refer to W249

Refer to W252

Refer to W289

Refer to W312

W120- All plans and assessments will be reviewed more thoroughly by QIDP and AQIDP's through quarterly peer reviews and IDT meetings. This will be completed by October 25, 2014 by QIDP.

Counseling services have been explored and coordinated for Individual #2 by QIDP with assistance of parent/legal guardian ensuring services are delivered to Individual #2. This was done October 8, 2014.

- Yes documentation is available for individual #2 counseling. This began on Oct 8th with her initial visit. She has had another visit on Oct 15th and is scheduled for today, Oct 29th. She has a standing appointment on Wednesdays at 3:00 p.m. QIDP sent correspondence to therapist requesting monthly progress notes on 10/29/2014.
- Will discuss at behavior meetings, IDT meetings annually or team meetings as deemed necessary for any future individuals needing counseling services.
- QIDP will be responsible to ensure appointments are met and progress notes obtained and reviewed monthly.

W124- QIDP and CLPN will review all psychotropic consents with the med reduction plan, MARS, and MD notes for accuracy monthly before the new consents are sent to guardians and HRC. Peer review, notes will be checked. This will be completed by October 25, 2014 and will be a continuous procedure.

- Consents have been reviewed at peer review. All future psych med changes will be reviewed by the team and consents obtained by LPN no later than 24 hours. Copy of consent given to QIDP for oversight.
- QA – team reviews resident records on record review form, this is completed and reviewed by QIDP.

W159- A quarterly peer review will be scheduled on facility calendar and a checklist will be utilized to assure all items are complete and correct. This has been completed by AQIDP/QIDP.

Sunnybrook will ensure each individual's active treatment program will be integrated, coordinated and monitored by QIDP.

Refer to W120
Refer to W124
Refer to W214
Refer to W223
Refer to W249
Refer to W252
Refer to W289
Refer to W312

W212- 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 psychology will also be educated on the importance of on-going review of medications and diagnosis's. This will be completed by October 25, 2014 by the QIDP/AQIDP.

- Individual #2 diagnoses from Psychologist have been obtained.
- A copy of psychological evaluation will be sent to the consultants and as updates occur, a revised copy of psychological evaluation will be sent to them.

W214- refer to W212. QIDP will receive formal training in application of positive behavior support plan development and functional behavioral assessments. This will be completed by October 25, 2014 by QIDP. This will be done on a continuous basis.

- Assessments for Individual #1 and #2 have been revised. All PBS training will be completed by PBS Coordinator on an on-going basis. QIDP will meet weekly for training on Functional PBS Assessments.

W223- Functional Behavioral Assessments will be completed by QIDP. This will be completed by October 25, 2014 by QIDP. These will be done on a continuous basis.

- Individual #2 CFA has been revised. QIDP and home staff will complete CFA and Functional Behavior Assessments prior to IDT meetings to ensure all components and areas are completed accurately and for consistency.

W249- QIDP will create visual schedules for each individual in the home and then all staff will be trained extensively in the utilization of them. Lead staff in the home will report to QIDP weekly of any program materials and supplies that are needed to ensure individuals programs are implemented. Monthly team meetings conducted will also report items needed for individuals in the home and program implementation. This is being completed and will be done by November 7 by QIDP/Lead DSP's in the home. Monthly meeting for October was held on 10/20/2014.

W252- QIDP will train staff on ABC documentation and tracking behaviors accurately. This will be completed by October 25, 2014 by QIDP and monitored monthly and new staff will be trained as they are hired by QIDP and PBS team.

W289- refer to W252. Also QIDP will conduct on-going PBS training weekly with staff in the home including defining behavioral definitions and revise PBSP to identify effective responses to the maladaptive behavior. This will be completed by October 25, 2014 and continue weekly by QIDP/ or PBS team.

- Behavior Plans have been revised. Functional Behavior Assessments will be revised as needed as information is obtained through monthly behavior meetings.

W312- refer to W212- This will be completed by October 25, 2014 by CLPN.

- Existing plans revised and section deleted in psych med plans.
- See 124

W325- Monthly lab draws are placed on google calendar with set reminders and will be placed on monthly home calendars. This will be completed by October 1, 2014 by CLPN.

- Double check thru filing means the assistant makes sure all MD, pharmacy reviews and nursing reviews are accounted for. If not, CLPN (charge licensed practical nurse) will be notified immediately.

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.

W361- Pharmacy has agreed to keep on stock routine medications so there is always a supply available. This will be completed by October 1, 2014 by CLPN.

- All medication cabinets are double locked. RSO PRN medications are to be checked quarterly for expiration by the RN.

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.

W365- CLPN will ensure that all new orders or drug changes will be changed on the MAR and recap immediately after receiving the order. This will be completed by October 1, 2014 by CLPN.

- Ind#1 MAR has been changed to reflect current orders and diagnosis.
- As soon as the new order comes in, the physician's recaps and MARS will be changed immediately with information of change sent to the home.

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.

MM112- refer to W223

MM164- refer to W124

MM197- refer to W289 and W312

MM212- refer to W249

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 October 25, 2014 by the city director.

MM561- refer to W252

MM570- refer to W365

MM725- refer to W104

MM730- refer to W212 and W214

MM750- refer to W325

MM758- refer to W362

MM761- refer to W361

MM766- refer to W336

MM859- refer to W120