



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
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FAX 208-364-1888

September 10, 2014

Rex Redden, Administrator
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

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SEP 29 2014

DIV OF LIC & CERT

RE: Idaho Falls Group Home #1 Bellin, Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #1 Bellin, which was conducted on September 8, 2014.

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

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

Rex Redden, Administrator
September 10, 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 23, 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 23, 2014. If a request for informal dispute resolution is received after September 23, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures

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

PRINTED: 09/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/08/2014
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1664 SOUTH BELLIN IDAHO FALLS, ID 83405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 9/2/14 to 9/8/14. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Michael Case, LSW, QIDP Common abbreviations used in this report are: HCA - Health Care Assistant HCL - Hydrochloric Acid ITTP - Interdisciplinary Treatment Team Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QIDP - Qualified Intellectual Disabilities Professional	W 000			
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. 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' ITTPs that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication	W 312	W 312 1. The medication reduction plan for the individual found to have been affected by this deficient practice will be revised to ensure that the reduction criteria is accurately incorporated into the individual's plan. 2. All medication reduction plans for all individuals in all facilities will be reviewed. If it is found that a medication reduction criteria in not accurately incorporated into a plan, the medication reduction plan will be revised.		

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrators

9/26/14

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 312	<p>Continued From page 1</p> <p>reduction plans were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified the drug usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's 10/24/13 ITTP stated she was a 37 year old female whose diagnoses included profound mental retardation and autism. Her Physician's Order, signed by the physician on 7/31/14, stated she received Paxil (an antidepressant drug) 10 mg Wednesday - Monday for self-injurious behavior.</p> <p>Individual #1's Medication Reduction Plan, dated 10/24/13, stated Paxil was to decrease hand biting, eye pressing, and head bumping. The plan stated "The Treatment Team will discuss an annual attempt to reduce [Individual #1's] medication in October, 2014. Should [Individual #1] meet criteria in regards to any of her behavioral objectives listed below, the team will recommend to [Individual #1's] physician a reduction in her Paxil."</p> <p>The behavioral objectives were as follows: - Hand biting = 0 episodes per month for 12 consecutive months; - Eye pressing = 1000 episodes or less per month for 12 consecutive months; and - Head bumping = 0 episodes per month for 12 consecutive months.</p> <p>As written, a medication reduction would be recommended should Individual #1 meet any of the criteria.</p> <p>Individual #1's behavioral data from 1/1/13 - 7/31/14 was reviewed and documented Individual</p>	W 312	<p>W 312 cont'd</p> <p>3. The medication reduction plans will be reviewed for all individuals on a quarterly basis to ensure accuracy of reduction criteria.</p> <p>4. The QIDP will conduct quarterly chart reviews to ensure that all medication reduction plans are accurately incorporated into a plan.</p> <p>5. Target date for completion will be November 7, 2014</p>		

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W 312	Continued From page 2 #1 had engaged in hand biting 1 time a month in January, April, and June of 2013. All other months documented 0 episodes. However, documentation of a reduction in Individual #1's Paxil since 2011 could not be found. During an interview on 9/4/14 from 3:00 - 4:00 p.m., the QIDP stated the reduction criteria for hand biting had been changed from 10 episodes or less per month to 0 episodes per month for 12 months in October 2013. The QIDP stated Paxil was currently tied to all three behaviors, but was primarily used due to Individual #1's eye pressing. The QIDP stated the plan needed to be revised and clarified. The facility failed to ensure reduction criteria for Individual #1's Paxil was accurately incorporated into a plan.	W 312			
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain special studies as recommended for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in an individual not receiving Vitamin D screening as recommended. The findings include: 1. Individual #2's 10/24/13 ITTP stated she was a	W 326	W 326 1. The Vitamin D level for the individual affected by this deficient practice was drawn. 2. All orders for labs for all individuals in all facilities will be reviewed to ensure that all labs have been drawn as ordered by the physician.		

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W 326	Continued From page 3 39 year old female whose diagnoses included profound mental retardation, cerebral palsy with spastic quadriplegia, seizure disorder, scoliosis, and osteopenia. Individual #2's record included a Physician's Order, signed by the physician on 3/28/14, which stated a Vitamin D level blood test was to be completed biannually. However, Individual #2's record did not include documentation that a Vitamin D level had been completed. During an interview on 9/4/14 from 3:00 - 4:00 p.m., the HCA stated the Vitamin D level had not been completed due to an oversight. The facility failed to ensure Individual #2 received a Vitamin D level blood test as ordered by her physician.	W 326	W 326 cont'd 3. The Medical Coordinator will review all physicians orders monthly and cross reference them with the labs to ensure that all labs were drawn for the individual. 4. The Medical Coordinator will review the clients charts quarterly to ensure that all clients have had the appropriate labs drawn. 5. Target date for completion will be November 7, 2014.		
W 353	483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed including radiographs when indicated and detection of manifestations of systemic disease. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a periodic comprehensive dental evaluation was completed for 1 of 4 individuals (Individual #1) whose dental records were reviewed. This resulted in the potential for an individual's dental	W 353	W 353 1. A semi-annual dental exam has been scheduled for the individual found to be affected by this deficient practice. Prior to the appointment, the treatment team will meet to discuss appropriate less restrictive interventions to try with the individual in order to attempt to obtain dental x-rays.		

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W 353	Continued From page 4 needs to be unidentified and untreated. The findings include: 1. Individual #1's 10/24/13 ITTP stated she was a 37 year old female whose diagnoses included profound mental retardation and autism. Her record included a dental note, dated 5/28/14, which stated Individual #1 would not allow anyone to look in her mouth and that x-rays had not been obtained. During an interview on 9/4/14 from 3:00 - 4:00 p.m., the HCA stated Individual #1's last exam with x-rays was completed 10/17/12. The HCA stated Individual #1 required general anesthesia for thorough exams and the dentist would not take her in yearly. The facility failed to ensure Individual #1 had a yearly comprehensive dental examination.	W 353	W 353 cont'd 2. This has the potential to affect all residents in all the facilities. The Medical Coordinator will review all dental examination notes for the past year and will notify the QIDP of any issues or concerns that arise from any dental exams. If any issues or concerns are noted, the Treatment Team will meet to discuss alternative less restrictive methods that may be used in order to obtain a comprehensive dental examination. A follow-up dental examination will then be scheduled and the less restrictive methods will be attempted. If this is not successful then the Treatment Team will meet again to discuss the possibility of implementing a more restrictive procedure to ensure that comprehensive dental exams are completed for each individual.	
W 361	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 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual not consistently receiving	W 361	3. The QIDP will review and initial all dental examination notes once they have been obtained by the Medical Coordinator to ensure that a comprehensive dental examination has occurred for each individual. 4. The QIDP and AQIDP's will review the clients charts quarterly to ensure that all clients have received comprehensive dental examinations. 5. Target date for completion will be November 7, 2014.	

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W 361	<p>Continued From page 5</p> <p>scheduled drugs and biologicals due to unavailability. The findings include:</p> <p>1. Individual #1's 10/24/13 ITTP stated she was a 37 year old female whose diagnoses included profound mental retardation and autism.</p> <p>Individual #1's Physician's Order, signed by the physician on 7/31/14, documented her medications and treatments included the following:</p> <ul style="list-style-type: none"> - Calcipotriene ointment 0.005 (a topical dermatological drug) applied 2 times a day; - Hydrophor ointment (a topical dermatological treatment) applied 5 times daily; - Pataday 0.2% (an antihistamine drug) 1 drop to both eyes once daily; and - Azelastine HCL 137 mcg/ml (an antihistamine drug) 2 sprays to each nostril twice daily. <p>Individual #1's MARs for 1/1/14 - 8/31/14 were reviewed and documented she did not receive scheduled drugs and biologicals due to unavailability, as follows:</p> <ul style="list-style-type: none"> - Calcipotriene: 8/1 - Hydrophor: 8/1 - Pataday: 2/8 - 2/10, 2/26 - 2/28, 5/7, 5/8 and 8/7 - Azelastine: 4/24 - 4/30, 5/2, 5/4, 8/14, and 8/15 <p>During an interview on 9/4/14 from 3:00 - 4:00 p.m., the HCA and LPN both stated drugs were supposed to be reordered a week before they were depleted. The HCA stated the pharmacy would only refill Azelastine every so many days and not earlier due to the cost. The HCA stated this became problematic if staff attempted to administer the drops and Individual #1 turned her</p>	W 361	<p>W 361</p> <ol style="list-style-type: none"> 1. We increased the dose for the individual that was found to be affected by this deficient practice. We prior authorized through Medicaid and now the facility is receiving two bottles instead of one. 2. All individuals in all facilities have the potential to be affected by this deficient practice. All individuals medications have been reviewed and any medications that have the potential of running out before the end of the month have been prior authorized now through Medicaid so the facilities will have enough drugs and biologicals on hand at all times. 3. The HCA and Medical Coordinator will conduct weekly checks of the medications at all facilities to ensure that there are enough medications on hand at all times for all individuals. 4. When a physician orders a new medication, the Medical Coordinator and HCA will ensure that the pharmacy is aware that we need to maintain enough drugs and biologicals for the facility. The Medical Coordinator and HCA will ensure the physician orders enough of a dose to last for a month, and that the pharmacy receives prior authorization from Medicaid for an increased supply if needed. 5. Target date for completion will be November 7, 2014. 		

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W 361	Continued From page 6 head causing the drop to be lost. The facility failed to ensure routine drugs and biologicals were maintained for Individual #1.	W 361			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: IDAHO FALLS GROUP HOME #1 BELLIN
STREET ADDRESS, CITY, STATE, ZIP CODE: 1664 SOUTH BELLIN IDAHO FALLS, ID 83405

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing survey conducted from 9/2/14 to 9/8/14. The survey was conducted by: Karen Marshall, MS, RD, LD, Team Lead Michael Case, LSW, QIDP	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	MM197 Refer to W 312	
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, it was determined the facility failed to ensure the facility was kept in good repair for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the	MM380	MM380 1. The window in the back bathroom has been ordered and will be replaced. A damage report for the toilet seat in the first bathroom on the right that was missing paint and had exposed wood has been submitted to maintenance personnel. A damage report was submitted for the cracked tiles in the window in the living room to maintenance personnel. 2. An environmental review will be completed for all facilities to ensure there are no environmental issues of this nature at other homes.	

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

TITLE

(X8) DATE

STATE FORM *Alex A Redden*

6899

Administrator
G1SZ11

9/26/14
If continuation sheet 1 of 3

Bureau of Facility Standards

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MM380	Continued From page 1 facility on 9/5/14 from 1:26 - 2:07 p.m. During that time, the following was noted: - The lower window in the bathroom at the end of the hall had a crack that extended approximately half the length of the window. - The toilet seat in the first bathroom on the right in the hall was missing paint and had exposed wood covering approximately 25 percent of the surface. - The seating area in the window in the living room had cracked tiles. The facility failed to ensure the environment was kept clean and repairs were completed and maintained.	MM380	MM380 cont'd 3. Maintenance personnel will complete a monthly inspection checklist for all facilities. The checklist will include a review of all windows, tiles, etc. 4. Maintenance personnel will submit the monthly inspection checklists to the Administrator for any follow-up repairs that need to be made for all facilities. 5. Target date for completion will be November 7, 2014.	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W326.	MM735	MM735 Refer to W326	
MM782	16.03.11.270.04(a)(i) Extraoral and Intraoral Examination A complete extraoral and intraoral examination must be performed, utilizing all diagnostic aids necessary to properly evaluate the resident's oral	MM782	MM782 Refer to W 353	

Bureau of Facility Standards

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MM782	Continued From page 2 condition. This Rule is not met as evidenced by: Refer to W353.	MM782		