



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 11, 2014

Rex Redden, Administrator
Idaho Falls Group Home #2 Wanda
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #2 Wanda, Provider #13G029

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #2 Wanda, 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 11, 2014
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **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

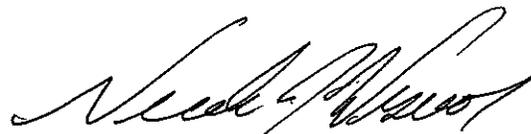
Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

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: 13G029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2014
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #2 WANDA			STREET ADDRESS, CITY, STATE, ZIP CODE 4360 WANDA STREET AMMON, ID 83406		
(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 and complaint investigation 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: AQIDP - Assistant Qualified Intellectual Disabilities Professional HCA - Health Care Assistant ITTP - Interdisciplinary Treatment Team Plan OCD - Obsessive Compulsive Disorder QIDP - Qualified Intellectual Disabilities Professional SSRI - Selective Serotonin Reuptake Inhibitor	W 000			
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure sensorimotor assessments were updated as needed and contained comprehensive information for 1 of 4 individuals (Individual #2) whose assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's 10/24/13 ITTP stated she was a	W 218	W 218 1. The PT assessment for the individual found to be affected by this deficient practice has been updated to incorporate having the individual walk 10 steps every time she moves from one sitting position to another. 2. The PT assessments for all individuals in all facilities will be reviewed to ensure that they accurately reflect the needs of all individuals in all facilities. If any inconsistencies are found, the individual will be scheduled with the PT to revise the assessment.		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dev A Redder TITLE Administrator (X8) DATE 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 218	<p>Continued From page 1</p> <p>56 year old female whose diagnoses included profound mental retardation, seizure disorder, and hip and knee contractures.</p> <p>An observation was conducted at the facility on 9/3/14 from 1:30 - 2:00 p.m. During that time, Individual #2 was observed to be sitting on a couch waiting to leave the facility. A direct care staff placed a wheel chair within 2 feet of Individual #2, then utilized a gait belt to assist her to stand. A second direct care staff informed the staff working with Individual #2 that she was supposed to walk 10 steps to her wheel chair every time she was transferred and said the wheel chair needed to be moved further back.</p> <p>Individual #2's Physical Therapy Assessment, dated 7/10/14, stated she had problems with ambulation and needed to be assisted in all transfers and short distance ambulation. The Physical Therapy Assessment stated Individual #2 should walk 5 to 10 feet daily.</p> <p>However, Individual #2's record did not include information related to walking 5 to 10 feet (an objective, program, data, etc.).</p> <p>During an interview on 9/4/14 from 4:00 - 5:30 p.m., the QIDP stated additional information related to Individual #2's physical therapy would be submitted to the survey team.</p> <p>On 9/8/14, the facility faxed information to the survey team that included a program stating Individual #2 was to walk 10 steps between all activities (from one sitting position to the next).</p> <p>During a telephone interview on 9/9/14 from 11:15 - 11:20 a.m., the QIDP stated Individual #2's</p>	W 218	<p>W 218 cont'd</p> <p>3. The QIDP will review all PT assessments for accuracy upon receipt of the assessment. If any changes need to be made to the assessment, the HCA will schedule another appointment for the individual with the physical therapist.</p> <p>4. The QIDP and AQIDP's will conduct quarterly chart reviews to ensure that all PT assessments are an accurate reflection of what the individuals in the facilities are supposed to be doing.</p> <p>5. Target date for completion will be November 7, 2014</p>		

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W 218	Continued From page 2 physical therapy assessment was inaccurate and needed to be updated. The QIDP stated Individual #2 was to walk 10 steps every time she transferred from one sitting position to another, such as moving from the couch to her wheelchair. The facility failed to ensure Individual #2's physical therapy assessment contained accurate information.	W 218			
W 317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used to control behavioral symptoms were gradually withdrawn at least annually for 1 of 4 individuals (Individual #3) who received behavior modifying drugs. This resulted in the potential for an individual to continue receiving a drug that was ineffective or unnecessary. The findings include: 1. Individual #3's 10/24/13 ITTP stated she was a 56 year old female whose diagnoses included profound mental retardation, seizure disorder, and OCD. Her Physician's Order, signed by the physician on 7/31/14, stated she received Lexapro (an antidepressant drug) 15 mg in the evening Saturday - Thursday for OCD. The drug was held on Fridays.	W 317	W 317 1. A medication reduction will be attempted for the individual found to be affected by this deficient practice. Intensity, frequency, and severity of behaviors will be tracked closely during the reduction to see if contraindication is justified. 2. All medication reduction plans for all individuals in all facilities will be reviewed. If it is found that a medication reduction needs to be attempted, the treatment team will meet to discuss the reduction. If a reduction is justified, one will be attempted for the individual. 3. The medication reduction plans will be reviewed for all individuals on a quarterly basis to ensure an individual is not due for a reduction. 4. The QIDP will conduct quarterly chart reviews to ensure that any medications that need to be reduced are reviewed with the treatment team in a timely manner and that a reduction is attempted if the team is in agreement. 5. Target date for completion will be November 7, 2014		

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W 317	<p>Continued From page 3</p> <p>Individual #3's Medication Reduction Plan, dated 10/24/13, stated she received Lexapro 15 mg daily with the dose held every Friday for the diagnosis of OGD-exhibited by ear flicking.</p> <p>Individual #3's behavioral summary data from 1/1/13 - 7/31/14 was reviewed. With the exception of 9/2013, Individual #3's ear flicking behavior did not exceed 150 episodes per month and ranged anywhere from 0 - 133 episodes, with an overall average of 55 episodes per month.</p> <p>However, the last attempted reduction for the drug was prior to 7/13/10.</p> <p>During an interview on 9/4/14 from 4:00 - 5:30 p.m., the QIDP stated the psychiatrist did not want to decrease the drug as Individual #3 had a difficult time during the previous reduction. When asked about evidence to support a reduction of the drug being contraindicated, the QIDP stated she would locate the previous psychiatric notes.</p> <p>On 9/8/14, the following was faxed to the survey team:</p> <ul style="list-style-type: none"> - A physician's visit note, dated 7/13/10, stated Individual #3 "did not do well with further reduction of her Lexapro, and I feel she is likely to remain at 15mg qD [daily] except for Fridays indefinitely." The note further stated "We tried to drop the Lexapro to hold every Tuesday in addition to every Friday. At the two-held-dose level she started to return to her old behaviors, ear-flicking, self-injury and irritability." - Two physician's visit notes, dated 9/24/10 and 11/19/10, both stated "We tried to drop the Lexapro to hold every Tuesday in addition to 	W 317			

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W 317	Continued From page 4 every Friday. At the two-held-dose level she started to return to her old behaviors, ear-flicking, self-injury and irritability. She is back to 15mg qD [daily] except for Fridays. She has not YET [sic] returned to her baseline, and she has continued her right ear flick and hair pulling. She is well for her non-verbal baseline. But, this appears to be a hard floor for SSRI treatment. I do not see it being likely that she can drop the dose." No additional information regarding the intensity, frequency, or severity of the behavior was present to justify further drug reduction was contraindicated. Additionally, no information regarding less restrictive interventions implemented to assist Individual #3 during the medication reduction was present. The facility failed to ensure medication reductions occurred, or data existed to support a contraindication, for Individual #3's behavior modifying drug.	W 317			
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 for 2 of 4 individuals (Individuals #1 and #4) whose medical records were reviewed. This resulted in individuals not receiving screenings in accordance with their needs. The findings include:	W 326	W 326 1. A bone density scan has been scheduled for the individual affected by this deficient practice. 2. All individuals have the potential to be affected by this practice. The Medical Coordinator will review all individuals medications in all facilities. Any individuals that are taking any medication that could compromise bone density, and that requires a bone density screening, and the individual has been on it for more than 3-5 years will be scheduled for a bone density scan if they have already not been completed.		

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W 326	<p>Continued From page 5</p> <p>1. Individual #1's 6/19/14 ITTP stated she was a 42 year old female whose diagnoses included severe mental retardation, keratoconus (a degenerative eye disorder), anxiety disorder, dysmenorrheal (a medical condition of pain during menstruation that interferes with daily activities), and history of constipation.</p> <p>Individual #1's 8/2014 Physician's Order sheet contained an order for Medroxyprogesterone (an estrogen drug commonly known as Depo-Provera) 150 mg per milliliter every 3 months.</p> <p>The 2014 Nursing Drug Handbook documented Depo-Provera may cause a significant loss of bone mineral density and loss was greater with increasing duration of use and may not be reversible.</p> <p>Individual #1's record did not contain results of a bone mineral density screening.</p> <p>During an interview on 9/4/14 from 4:00 to 5:30 p.m., the HCA stated Individual #1 had been taking Depo-Provera since 2012 and a bone mineral density screening had not been completed.</p> <p>The facility failed to ensure a bone mineral density screening was completed for Individual #1 who received a medication that placed her at risk for significant bone mineral density loss.</p> <p>2. Individual #4's 4/24/14 ITTP stated he was a 35 year old male whose diagnoses included profound mental retardation, cerebral palsy, and osteoporosis.</p>	W 326	<p>W 326 cont'd</p> <p>3. If an individual is started on a medication that could require a bone density scan, the Medical Coordinator will add bone density scans to her annual calendar as a reminder that the scan needs to be completed within 3-5 years.</p> <p>4. The QIDP will conduct quarterly chart reviews to ensure that any individuals taking any medications that can compromise body density have received bone density scans within the appropriate time frame.</p> <p>5. Target date for completion will be November 7, 2014</p>	

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W 326	Continued From page 6 Individual #4's 5/2014 Physician's Order sheet contained, under the Laboratory section, "...Vit [Vitamin] D level..." His record contained laboratory data analysis, dated 6/2/14. However, the 6/2/14 laboratory analysis did not contain a Vitamin D level. During an interview on 9/4/14 from 4:00 - 5:30 p.m., the HCA reviewed Individual #4's 6/2/14 laboratory analysis and stated his Vitamin D level had not been determined. The facility failed to ensure Individual #4's Vitamin D level was determined as ordered by the physician.	W 326			
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 the facility failed to ensure nursing reviews were completed on a quarterly basis for 1 of 4 individuals (Individual #1) 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's 6/19/14 ITTP stated she was a 42 year old female whose diagnoses included severe mental retardation, keratoconus (a degenerative eye disorder), anxiety disorder,	W 336	W 336 1. The facility had a change in the RN consultant position during the months of February and March, 2014. This is the time frame that the quarterly nursing assessment was missing from. The Medical Coordinator is tracking the due date of all quarterly assessments. The Medical Coordinator is now sending correspondence via text message to the RN consultant reminding her of the quarterly assessments that are due that month. 2. All individuals have the potential to be affected by this practice. The Medical Coordinator will review the quarterly nursing assessment schedule with the RN consultant to ensure she is aware of when the assessments are due.		

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W 336	Continued From page 7 dysmenorrheal (a medical condition of pain during menstruation that interferes with daily activities), and history of constipation. Individual #1's record documented quarterly nursing reviews were completed on 9/24/13, 12/16/13, and 6/16/14. A completed review for the first quarter (January, February, March) of 2014 was not located in her record. During an interview on 9/4/14 from 4:00 - 5:30 p.m., the HCA stated the nursing review for the first quarter of 2014 was missed. The nurse was doing every other month and did not utilize the monthly schedule. The facility failed to ensure nursing reviews had been completed on a quarterly basis.	W 336	W 336 cont'd 3. The RN consultant will submit completed quarterly nursing summaries to the Medical Coordinator once they are complete. The Medical Coordinator will check the nursing assessments against the schedule to ensure that all quarterly assessments that were due for the month were completed. 4. The QIDP will conduct quarterly chart reviews to ensure that all quarterly nursing assessments have been completed in the appropriate time frame. 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 2 of 4 individuals (Individuals #2 and #3) whose dental records were reviewed. This resulted in the potential for individuals' dental needs to be unidentified and untreated. The findings include:	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 8 1. Individual #2's 10/24/13 ITTP stated she was a 56 year old female whose diagnoses included profound mental retardation and seizure disorder. Her record included a dental note, dated 1/9/14, which stated x-rays had not been obtained as Individual #2 was not cooperative. During an interview on 9/4/14 from 4:00 - 5:30 p.m., the HCA stated Individual #2's last exam with x-rays was completed in 2011. 2. Individual #3's 10/24/13 ITTP stated she was a 56 year old female whose diagnoses included profound mental retardation, seizure disorder, and OCD. Her record included a dental note, dated 7/9/14, which stated x-rays had not been obtained as Individual #3 was not cooperative. Her record documented the last dental x-rays had been obtained 11/21/12. During an interview on 9/4/14 from 4:00 - 5:30 p.m., the HCA stated Individual #3 had difficulty with dental exams. The facility failed to ensure Individuals #2 and #3 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. 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	
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.	W 426		

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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
W 426	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 8 of 8 individuals (Individuals #1 - #8) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include:</p> <p>1. An environmental review was conducted on 9/3/14 from 9:30 - 10:40 a.m. During that time, water temperatures were as follows:</p> <p>Front bathroom - 113.5 degrees Fahrenheit Back bathroom - 114.0 degrees Fahrenheit</p> <p>The AQIDP, who was present during the environmental review, stated none of the individuals could independently regulate the water temperatures. The AQIDP was notified of the high water temperatures.</p> <p>The facility failed to ensure water temperatures were maintained at 110 degrees Fahrenheit or below for Individuals #1 - #8.</p> <p>Note: Water temperatures were re-checked on 9/4/14 at 5:50 p.m. and found to be within an acceptable range.</p>	W 426	<p>W426</p> <ol style="list-style-type: none"> 1. All thermometers for taking water temperatures will be calibrated for correct temp. Training has been done with all supervisors regarding how to take water temperatures accurately. All water temperatures will be checked daily by the night shift at the home. Temperature will also be taken during the monthly home inspections which are completed by maintenance personnel. Any temperatures that are over 110 will be reported to the administration for adjustment 2. This has the potential to affect all clients in the home and will be corrected as indicated above. 3. All water temperatures will be checked daily by the night shift at the home. Temperature will also be taken during the monthly home inspections by the maintenance personnel. Any temperatures that are over 110 will be reported to the administration for adjustment. 4. Supervisors or charge persons will check the water temperature sheets daily to be sure that adjustments are being made as needed to the temperature. They will report all incidents of high temperature readings to the AQIDP/QIDP for follow up. 5. Target date for completion will be November 7, 2014 	

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing survey and complaint investigation 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 W317.	MM197	MM197 Refer to W 317	
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. Damage reports have been submitted to maintenance personnel for all damage noted during the environmental review. All repairs to the facility will be made. 2. An environmental review will be completed for all facilities to ensure there are no environmental issues of this nature at other homes. If any issues are found, repairs will be made. 3. Maintenance personnel will complete a monthly inspection checklist for all facilities. The checklist will include a review of issues that were noted during the environmental review.	

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dex A Redden</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/26/14</i>
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MM380	<p>Continued From page 1</p> <p>facility on 9/3/14 from 9:30 - 10:40 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> - The wall behind the front door had a patched area, approximately 12 inches by 5 inches, that was cracked and missing paint. - The knob on the door leading to the back yard from the end of the hallway was loose, and the mounting screw was sticking up approximately 1/2 inch. - The light fixture outside the back door was missing and the capped wires were hanging out of the hole. - The air vent in the baseboard under the kitchen sink was rusted and missing paint. - The corner edge of the wall to the left of the back kitchen door was patched approximately 12 inches high and extending 4 inches across each wall, and was missing paint. - There was a 1 inch by 3 inch section of wall between the dining room windows that was missing plaster and paint, and the underlying metal was exposed. - There was a 4 foot by 1 inch section on the back dining room wall that was missing paint and plaster where the dining room chairs struck the wall. Additionally, there were two 3 inch by 3 inch, two 4 inch by 4 inch, and one 6 inch by 6 inch patched sections of the same wall that were missing paint. - The corner edge of the wall where the dining area joined the hallway was missing paint and plaster approximately 2 feet in height. 	MM380	<p>MM380 cont'd</p> <p>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.</p> <p>5. Target date for completion will be November 7, 2014.</p>	

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MM380	<p>Continued From page 2</p> <ul style="list-style-type: none"> - The caulking around the baseboards and toilet in the powder room was cracked, peeling and had a black build up. Additionally, sections of the flooring were separating and starting to roll around the edges. - The right front leg of the wicker chair in the bedroom shared by Individuals #1 and #8 was unwound exposing the wood underneath. - The wall behind the door in the bedroom shared by Individuals #1 and #8 had a 2 inch by 2 inch patched area that was missing paint. - The blind on the right side window in the bedroom shared by Individuals #2 and #3 contained multiple broken slats. The window sills on both the right and left side windows were gouged and missing plaster and paint. - The wooden nightstand between the beds in the bedroom shared by Individuals #2 and #3 had graffiti written on the top in red marker. - The window sill in the room shared by Individuals #4 and #6 had a wet spot near the opening, and the plaster was missing, exposing the supporting structure underneath for approximately 6 inches. A piece of paper had been taped over the hole. - The caulking around the toilet, tub, and baseboards of the bathroom at the end of the hall was cracked and peeling, and had a black build up. Additionally, the window blind had multiple broken slats, and the wall around the window was patched and missing paint. - The caulking around the tub, toilet and 	MM380		

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MM380	Continued From page 3 baseboards in the front bathroom was cracked and peeling, and the flooring along the wall between the tub and sink was peeling at the edge. - The back concrete patio contained multiple cracks and heaves up to 2 inches in height creating a trip hazard. The facility failed to ensure the facility was kept in good repair.	MM380		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W218.	MM724	MM724 Refer to W 218	
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations 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 W326.	MM750	MM750 Refer to W 326	
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and	MM766	MM766 Refer to W 336	

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MM766	Continued From page 4 This Rule is not met as evidenced by: Refer to W336.	MM766		
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 condition. This Rule is not met as evidenced by: Refer to W353.	MM782	MM782 Refer to W 353	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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September 11, 2014

Rex Redden, Administrator
Idaho Falls Group Home #2 Wanda
P.O. Box 50457
Idaho Falls, ID 83405-0457

Provider #13G029

Dear Mr. Redden:

On **September 8, 2014**, a complaint survey was conducted at Idaho Falls Group Home #2 Wanda. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006586

Allegation #1: Individuals' beds are not maintained and are in need of repair.

Findings #1: An unannounced on-site investigation survey was conducted from 9/2/14 to 9/8/14. During that time, record reviews and observations were completed with the following results:

The facility's Accident/Incident injury reports from 6/1/14 to 9/1/14 were reviewed. The reports did not document any issues related to individuals' beds.

The facility housed 8 individuals. During an environmental observation on 9/3/14 from 9:30 - 10:40 a.m., all the individuals' beds were reviewed, including mattresses, frames, and linens. All mattresses were noted to be in good repair, fitted with water proof coverings, mattress pads, and appropriate bedding.

Individuals' beds were noted to be in good repair. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Communication is not consistent with what individuals' guardians have requested.

Findings #2: An unannounced on-site investigation survey was conducted from 9/2/14 to 9/8/14. During that time, record reviews and staff and guardian interviews were completed with the following results: The facility utilized a "Parent/Guardian Contact List" form, completed by the guardian, to document what guardians wanted to be notified of. The form included standardized information related to medical and behavioral issues, as well as a section for the guardian to list additional requests.

Additionally, the facility utilized a "Parent Contact Log" to document the date, reason, and staff initials when a guardian was contacted.

Four individuals were selected for review. Each individual's record documented guardians had been contacted in accordance with their written requests for notification.

Interviews were conducted with the Qualified Intellectual Disabilities Professional (QIDP) and Assistant Qualified Intellectual Disabilities Professional (AQIDP) on 9/4/14 from 4:00 - 5:30 p.m. Both the QIDP and AQIDP stated guardian contact was completed and documented in accordance with the guardians' written requests for information.

Additionally, two of the four individuals' guardians were interviewed on 9/5/14 between 10:13 - 10:25 a.m. Both guardians stated they received contact from the facility in accordance with their wishes and had no concerns related to contact from the facility.

It could not be established that the facility was not providing contact with guardians in accordance with their written requests. Therefore, due to a lack of sufficient evidence the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals' physical therapy recommendations were not implemented.

Findings #3: An unannounced on-site investigation survey was conducted from 9/2/14 to 9/8/14. During that time, observations, record reviews, and staff interviews were completed with the following results:

Observations were conducted at the facility on 9/2/14 from 2:45 - 3:32 p.m. and 5:55 - 6:50 p.m., and on 9/3/14 from 9:30 - 10:40 a.m. and from 1:30 - 2:00 p.m. During those observations, all individuals were observed to walk with assistance and participate in physical therapy exercises.

During the observation on 9/3/14 from 1:30 - 2:00 p.m., one individual was observed to be sitting on a couch waiting to leave the facility. A direct care staff placed a wheel chair within 2 feet of the individual, then utilized a gait belt to assist her to stand. A second direct care staff informed the staff working with the individual that she was supposed to walk 10 steps to her wheel chair every time she was transferred and said the wheel chair needed to be moved further back.

Rex Redden, Administrator
September 11, 2014
Page 3 of 3

Four individuals were selected for review, including the individual observed on 9/3/14 from 1:30 - 2:00 p.m. All four individuals records documented physical therapy evaluations and recommendations. All four individuals records included programs coordinating with those recommendations.

The record of the individual observed on 9/3/14 from 1:30 - 2:00 p.m. included a Physical Therapy Assessment, dated 7/10/14, which stated she had problems with ambulation and needed to be assisted in all transfers and short distance ambulation. The Physical Therapy Assessment stated the individual should walk 5 to 10 feet daily.

However, the individual's record did not include information related to walking 5 to 10 feet (an objective, program, data, etc.).

During an interview on 9/4/14 from 4:00 - 5:30 p.m., the Qualified Intellectual Disabilities Professional (QIDP) stated the individual's program should be to walk 10 steps when transferred. During a follow-up interview on 9/9/14 from 11:15 - 11:20 a.m., the QIDP stated the individual's Physical Therapy Assessment was inaccurate and needed to be revised.

The individual's Physical Therapy Assessment did not accurately reflect what the individual was to be working on regarding ambulation. Therefore, the allegation was substantiated and deficient practice was identified at W218.

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

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

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

Sincerely,


KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt