



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

October 17, 2013

Russell McCoy, Administrator  
Church Hill Downs  
415 South Arthur  
Pocatello, ID 83204

RE: Church Hill Downs, Provider #13G043

Dear Mr. McCoy:

This is to advise you of the findings of the Initial Medicaid/Licensure survey of Church Hill Downs, which was conducted on October 10, 2013.

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; and,
5. Include dates when corrective action 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

Russell McCoy, Administrator  
October 17, 2013  
Page 2 of 2

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 **October 30, 2013**, 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](http://www.icfmr.dhw.idaho.gov)

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

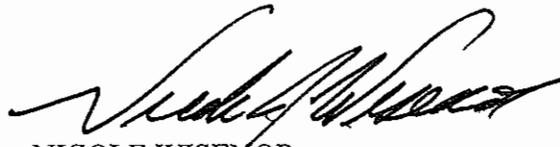
This request must be received by October 30, 2013. If a request for informal dispute resolution is received after October 30, 2013, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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 HENSCHER  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pt  
Enclosures



DEVELOPMENTAL  
OPTIONS

PROMOTING FUNCTIONAL INDEPENDENCE THROUGH PERSON-CENTERED SERVICES

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October 25, 2013

Ms. Nicole Wisenor, Supervisor  
Non-Long Term Care  
Department of Health and Welfare  
Division of Medicaid  
Bureau of Facility Standards  
P. O. Box 83720  
Boise, ID 83720-0036

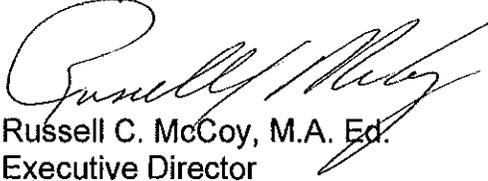
RECEIVED  
OCT 28 2013  
FACILITY STANDARDS

Dear Nicole:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Church Hill Downs Group Home from the survey completed October 10, 2013. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed above.

Sincerely,



Russell C. McCoy, M.A. Ed.  
Executive Director

Enclosures

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

PRINTED: 10/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHURCH HILL DOWNS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1722 CHURCH HILL DOWNS POCATELLO, ID 83201</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey conducted from 10/7/13 - 10/10/13.  The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Jim Troutfetter, QIDP  Common abbreviations used in this report are: ATS - Active Treatment Specialist IPP - Individual Program Plan RPD - Residential Program Director	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each individual's need for guardianship was addressed for 2 of 4 individuals (Individuals #3 and #4) whose IPPs were reviewed. Failure to obtain guardianship did not ensure the individuals' rights were protected. The findings include:  1. Individual #3's IPP, dated 10/23/12, documented a 42 year old female whose diagnoses included severe mental retardation.  Individual #3's record included consents which	W 125	<b>W125 483.420(a)(3)</b>  For Individuals #3 and #4, the family is very involved with their individual program plan helping insure the individual's rights are protected. For any individuals in the facility who do not have legal guardians, the Qualified Intellectual Disabilities Professional will approach and work with the family to explore the option of becoming a legal guardian. This will take place on a quarterly basis. The Residential Program Director will review the documentation completed by the Qualified Intellectual Disabilities Professional. The facility will continue to encourage the family members to be involved with decision making either as an advocate or legal guardian.  Corrective Action Completion Date: December 1, 2013	<b>RECEIVED OCT 28 2013 FACILITY STANDARDS</b>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_  
*Gerald M. [Signature]* Executive Director 10/25/2013

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 125	<p>Continued From page 1 were signed by an advocate.</p> <p>No information related to legal guardianship for Individual #3 could be found.</p> <p>When asked during an interview on 10/10/13 from 10:17 - 11:03 a.m., the RPD stated Individual #3's mother indicated she was interested in guardianship, but had not followed through.</p> <p>Additionally, when asked if other options for guardianship (e.g. other family members, friends, etc.) had been pursued, the RPD stated Individual #3's mother did not want anyone else as Individual #3's guardian.</p> <p>2. Individual #4's IPP, dated 4/9/13, documented a 38 year old female whose diagnoses included moderate mental retardation.</p> <p>Individual #4's record included consents which were signed by an advocate.</p> <p>No information related to legal guardianship for Individual #4 could be found.</p> <p>When asked during an interview on 10/10/13 from 10:17 - 11:03 a.m., the RPD stated the facility contacted the Board of Guardians, but was turned down.</p> <p>When asked what other options for guardianship (e.g. other family members, friends, etc.) had been pursued, the RPD stated there was no documentation other individuals had been contacted.</p> <p>The facility failed to aggressively pursue</p>	W 125	<p>Person Responsible: Jamie L. Anthony, Residential Program Director; Joel Reep, Qualified Intellectual Disabilities Professional</p>	

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W 125  W 390	Continued From page 2 guardianship for Individuals #3 and #4. 483.460(m)(2)(i) DRUG LABELING  The facility must remove from use outdated drugs.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all outdated drugs and biologicals were removed from use for 8 of 8 individuals (Individuals #1 - #8) whose biologicals were reviewed. This placed individuals residing at the facility at risk of being treated with ineffective medications. The findings include:  1. An environmental review was done on 10/8/13 from 1:37 - 2:05 p.m. The review included a medication cabinet inspection where the following expired biologicals were found:  - 2 tubes of Clotrimazole-Betamethason expired 4/13 and 5/13, prescribed for Individual #5 - 2 tubes of Triamcinolone .1% cream expired 2/13 and 4/13, prescribed for Individual #5 - 1 tube of Lidocaine and Prilocaine Cream 2.5% expired 1/10 for general facility use - 1 tube of Cortisporin Ointment expired 9/13, prescribed for Individual #1 - 1 tube of Cortisporin Ointment expired 9/13, prescribed for Individual #4  The ATS, who was present at the time of the medication review, confirmed the presence of the expired biologicals. The ATS removed the items in question and set them aside to be disposed of.	W 125  W 390	<b>W390 483.460(m)(2)(i)</b>  The nursing staff will complete a monthly review of the medication cabinet ensuring that all expired medications are removed and discarded. This will be documented on a medication cabinet review form and reviewed by the Executive Director on a monthly basis.  Corrective Action Completion Date: December 1, 2013  Person Responsible: Christy Day, Lead, LPN; Russell C. McCoy, Executive Director  <i>Pen &amp; Ink Change: The LLPN disposed of the expired medications found on 10.8.13. The LLPN checked all medications for all individuals to ensure all expired medications were removed and dispose of. Per RPD on 11.4.13. </i>	

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W 390	Continued From page 3 The facility failed to remove expired biologicals from use.	W 390		

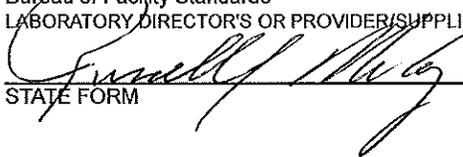
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2013</b>
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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensure survey conducted from 10/7/13 - 10/10/13.  The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Jim Troutfetter, QIDP	M 000		
MM221	16.03.11.080.01(a) Parent or Legal Guardian is unwilling  The resident's parent or legal guardian is unable or unwilling to participate or is unavailable after reasonable efforts to contact them; and This Rule is not met as evidenced by: Refer to W125.	MM221	<b>MM221 16.03.11.080.01(a)</b> Refer to W125	
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. During an environmental review conducted on 10/8/13 from 1:37 - 2:05 p.m., the following was	MM380	<b>MM380 16.03.11.120.03(a)</b> All environmental concerns cited in the report will be fixed to be in good repair.  Corrective Action Completion Date: December 1, 2013  Person Responsible: Jesse Atwell, Physical Facilities Manager	

**RECEIVED**  
**OCT 28 2013**  
**FACILITY STANDARDS**

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>10/25/2013</b>
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Bureau of Facility Standards

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MM380

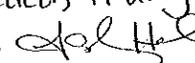
Continued From page 1 noted:

- The toilet seat was loose in the bathroom next to the laundry area.
- There was approximately 2 1/2 pieces of trim tile missing below the shower valve in the bathroom on the east side of the hallway.
- There was broken and loose tile on the outside base of the shower in the bathroom on the east side of the hallway.
- Individual #4's dresser had 5 drawers, none of which were on tracks.
- Individual #3's nightstand was missing a handle of the bottom drawer.
- Individual #1's dresser had 5 drawers, none of which were on tracks.
- The right door of the left cupboard above the washer and dryer was split at the base.

The facility failed to maintain the building and equipment in good repair.

MM380

*Pen & Ink Change: The Physical & Facilities Manager has inspected the facility for additional repairs needed & will continue to do so on a monthly basis.*

*The ATS will inspect the facility monthly and document any additional repairs needed, if any. Per RPD on 11-4-13. *

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:

MM758

**MM758 16.03.11.270.02(f)(iv)**  
Please refer to W390

Bureau of Facility Standards

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MM758	Continued From page 2 Refer to W390.	MM758		