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 18, 2013

Russell McCoy, Administrator
South Bannock Group Home
415 South Arthur
Pocatello, ID 83204-3317

RE: South Bannock Group Home, Provider #13G015

Dear Mr. McCoy:

This is to advise you of the findings of the Initial Medicaid/Licensure survey of South Bannock Group Home, 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

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

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 HENSCHEID
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

October 25, 2013

RECEIVED
OCT 28 2013
FACILITY STANDARDS

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

Dear Nicole:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for South Bannock 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

Russell C. McCoy, Executive Director • rmccoy@ida.net
415 South Arthur • Pocatello, Idaho 83204 • Phone (208) 233-6833 • Fax (208) 233-6842 • doptions@ida.net • www.developmentaloptions.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G015		10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH BANNOCK GROUP HOME	3875 SOUTH BANNOCK HIGHWAY POCATELLO, ID 83201

(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 DVR - Digital Video Recorder HS - bedtime IPP - Individual Program Plan LLPN - Lead Licensed Practical Nurse MAR - Medication Administration Record RPD - Residential Program Director SIB - Self-Injurious Behavior SIR - Significant Incident Report ST - Support Trainer	W 000	RECEIVED OCT 28 2013 FACILITY STANDARDS	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 2 of 4 individuals (Individuals #1 and #2) whose records were reviewed. This resulted in a lack of complete and accurate information in individuals' records. The findings include:	W 111	**W111 483.410(c)(1)** For Individual #2 and all other individuals in the facility, the Lead LPN will be more detailed in her documentation to reflect the instructions given to staff as well as the date in which she assessed the individual for injuries. For Individual #2 and all other individuals in the facility, the Residential Program Director will give the Active Treatment Specialist training regarding the review of a Significant Incident Report to catch errors made by staff members.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[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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W 111	Continued From page 1 1. Individual #2's IPP, dated 1/8/13, documented he was a 64 year old male whose diagnoses included severe mental retardation. The facility's SIRs, dated 6/2013 - 9/2013, were reviewed. The reports lacked complete documentation related to Individual #2's head banging and subsequent medical care (e.g. nurse examination, neurological check, etc.). Examples included, but were not limited to, the following: - 6/28/13 at 1:30 p.m.: Individual #2 "started to hit his head and bite his arm so I restrained him..." On 7/9/13, the LLPN documented "no injury noted from restraint." The SIR did not contain any information related to the intensity of the hits or any documented evidence of medical examination or monitoring for potential neurological damage. - 7/18/13 at 4:43 p.m.: Individual #2 "was hitting his head with his fist and against the wall." On 7/22/13, the LLPN documented "no injury to [Individual #2] noted from this incident." The SIR did not contain any information related to the intensity of the head hits. Further, the SIR did not contain any documentation related to medical examination or monitoring for potential neurological damage. - 8/15/13 at 9:24 a.m.: Individual #2 "began to hit his head." On 8/22/13, the LLPN documented "did re-open scab on right knee and scab back [sic] of head - both cleaned." The SIR did not contain any documentation that Individual #2 was examined or monitored for signs and symptoms of neurological damage in the seven days prior to the LLPN SIR review.	W 111	The treatment team will review all of the Significant Incident Reports for completeness and accuracy of information. This review will take place on a monthly basis. Please refer to W214 Please refer to W365 Please refer to W369 Corrective Action Completion Date: December 1, 2013 Person Responsible: Jamie L. Anthony, Residential Program Director; Christy Day, Lead LPN	

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W 111	Continued From page 2 - 8/22/13 at 2:13 p.m.: Individual #2 hit himself "on side of face, head [sic]" resulting in restraint. Further, the SIR documented "red marks on side of face." On 8/28/13, the LLPN documented "no injury from restraint noted...had redness left side of face - redness gone within 4 hours." The SIR did not contain any documentation that Individual #2 was examined or monitored for signs and symptoms of neurological damage in the six days prior to the LLPN SIR review. During an interview on 10/10/13 from 9:35 - 10:17, the LLPN stated when staff notified her of a head hit she immediately asked questions clarifying details of the incident (e.g. intensity, how: with hand, on wall, etc.). Further, the LLPN stated she instructed staff to monitor the individual and she physically examined them within 24 hours. The LLPN stated her documentation could be more detailed to reflect those procedures. Additionally, the RPD stated during the same interview that direct care staff should have included more detail on the SIRs and the ATS should have caught the mistakes in her review. The RPD stated she would retrain the ATS to ensure direct care staff documented a detailed depiction of significant incidents. The facility failed to maintain comprehensive documentation related to Individual #2's head hits. 3. Refer to W214 as it relates to the facility's failure to maintain a current, accurate Behavior Assessment for Individual #2. 4. Refer to W365 as it relates to the facility's	W 111		

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W 111	Continued From page 3 failure to maintain accurate medication administration records for Individual #1. 4. Refer to W369 as it relates to the facility's failure to document Individual #2's administered medications in accordance with Physician's Orders.	W 111		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a thorough investigation was conducted, which directly impacted 2 of 3 individuals (Individuals #1 and #7) for whom an investigation was completed, and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include: 1. Individual #7's Initial Plan of Care, dated 12/5/12, documented he was a 61 year old male whose diagnoses included severe mental retardation. Individual #1's IPP, dated 8/6/13, documented a 42 year old male whose diagnoses included profound mental retardation. An investigation report, completed and signed by the RPD on 12/13/12, documented on 12/7/13, the ATS contacted the RPD and told her ST B had reported an allegation of abuse. ST B alleged that during the 12/6/13 graveyard shift she worked with ST A, ST A engaged in various	W 154	**W154 483.420(d)(3)** Staff members are trained to report any incidents of abuse, neglect or mistreatment immediately. In the event of an allegation, the investigator will interview other staff members and video to determine if the incident was isolated or ongoing for other staff failing to report. This will be completed when an allegation is made and will be reviewed by the Executive Director upon completion within five business days of the report. Corrective Action Completion Date: November 1, 2013 Person Responsible: Jamie L. Anthony, Residential Program Director; Russell C. McCoy, Executive Director	

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W 154	Continued From page 4 acts of abuse. Examples included, but were not limited to: - ST B reported she heard through the restroom door, ST A yell at Individual #1 and say "'If you can hit yourself, what's wrong with me hitting you?!'" ST B wrote in her signed statement she was "not sure if she was really hitting him or not." - ST B alleged that she witnessed ST A repeatedly punch Individual #7 and flick his nose while making negative comments. - ST B alleged when she passed Individual #7's bedroom she saw ST A "kick him approximately six times on his left side." The facility's policy, dated 7/1/11, titled Electronic Monitoring of Residents' Home, documented cameras within the facility's common areas recorded "up to one week of video footage" on a DVR. During an interview on 10/10/13 from 9:09 - 9:15 a.m., the RPD stated ST A was employed with the company for at least a year. The RPD completed a brief review of the facility's as worked schedules from the past year and stated ST A had worked with at least one other staff during her employment. The investigation did not include any information to determine if the incidents were isolated to one shift or was ongoing with the potential for other staff failing to report. The RPD stated during an interview on 10/10/13 from 9:09 - 9:15 a.m., the focus of the investigation was the 12/6/13 graveyard shift. She stated surveillance footage from any other shift was not reviewed and no one else was	W 154		

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W 154	Continued From page 5 interviewed, including the one staff determined to have worked with ST A. The facility failed to thoroughly investigate the allegations of abuse involving Individuals #1 and #7.	W 154		
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 was determined the facility failed to ensure behavior assessments contained accurate and comprehensive information for 1 of 3 individuals (Individual #2) whose behavioral interventions were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's 1/8/13 IPP documented he was a 64 year old male whose diagnoses included severe mental retardation, mood disorder, obsessive compulsive disorder, pervasive developmental disorder and dementia. Individual #2's Behavior Management Assessment, dated 6/14/12, was reviewed. The Assessment did not include accurate, comprehensive information, as follows: a. Individual #2's Behavior Assessment documented Individual #2 "has been diagnosed with dementia (Alzheimer)." No information related to Individual #2's other diagnoses was	W 214	**W214 483.440(c)(3)(iii)** For Individual #2, the behavior assessment will be updated to include all of his diagnosis information, removal of behaviors that were discontinued by the treatment team, updated information on psychotropic medications, if his dietary restrictions impact his behaviors and preferences that may affect his behaviors. The behavior assessments for the other individuals in the facility will be reviewed for accuracy and modified as needed. To avoid future problems, the behavior assessment will be updated within thirty days of significant changes (i.e. discontinuation of behaviors). Corrective Action Completion Date: December 1, 2013 Person Responsible: Jamie L. Anthony, Residential Program Director Pen & Ink Change: The RPD will complete record reviews quarterly to ensure behavior assessments have been revised as needed. Per RPD on 11.4.13.	

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W 214	Continued From page 6 included in the Assessment. b. Individual #2's record included meeting notes, dated 7/24/13, which stated the team was discontinuing two behavior objectives; refusal to comply with medical tasks and refusal to comply with programs. However, Individual #2's Behavior Assessment documented Individual #2 engaged in "seven behaviors which are considered maladaptive. These behaviors include... refusing programmatic tasks, refusing medical tasks..." The Behavior Assessment did not include any information related to the discontinuation of the two behavior objectives. c. Individual #2's Behavior Assessment documented he took the following psychotropic medications: Depakote (an anticonvulsant drug), Zyprexa (an antipsychotic drug), Zoloft (an antidepressant drug) and Ativan (an anxiolytic drug). A handwritten note, signed by the RPD and dated 2/2013, documented Zoloft had been discontinued and replaced with Cymbalta (an antidepressant drug). Additionally, Individual #2's Medication Reduction Plan, dated 7/31/13, documented Individual #2 received Haldol (an antipsychotic drug) since 6/19/12. However, no information related to the use of Haldol or how the Zoloft or Cymbalta affected his behavior was included in the Behavior Assessment. d. Individual #2's IPP documented Individual #2 "has diet restrictions which restrict him from eating foods he enjoys." However, no information related to Individual #2's diet restrictions and how	W 214		

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W 214	Continued From page 7 they affected Individual #2's behavior was included in the Assessment. e. Individual #2's IPP documented Individual #2 "prefers the company of the male residents in the house." The IPP further documented Individual #2 "seems to prefer working with female staff." However, no information related to these preferences was included in the Assessment. During an interview on 10/10/13 from 9:35 - 10:17 a.m., the RPD stated the 6/14/12 Behavior Assessment was the most current assessment and did not include the identified information. The RPD stated Individual #2's Behavior Assessment needed updated and she had already begun a new assessment. The facility failed to ensure Individual #2's maladaptive behaviors were comprehensively and accurately assessed.	W 214		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, 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 medication administration records and physician's orders were reviewed. This resulted in a lack of documentation to ensure physician's orders were followed. The findings include:	W 365	**W365 483.460(j)(4)** For all individuals residing in the facility, the nursing staff will do a review of the MARs comparing it with the physician's orders. This will take place each month before the MARs is sent to the group home from the pharmacy. The RN will review the MARs on a quarterly basis for accuracy and oversight. Corrective Action Completion Date: December 1, 2013 Person Responsible: Christy Day, Lead LPN; Teresa Dixon, RN	

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W 365	Continued From page 8 1. Individual #1's IPP, dated 8/6/13, documented a 42 year old male whose diagnoses included profound mental retardation. Individual #1's record included Physician's Orders, dated 8/13/13, which included "Tegretol [an anticonvulsant drug] XR 100 mg AM 200 mg PM." Individual #1's 10/2013 MAR was reviewed. Individual #1's MAR documented Individual #1 was to receive Tegretol XR 100 mg "at bedtime" and Tegretol XR 200 mg "each morning." Individual #1's Tegretol pills were reviewed and Individual #1 was receiving 100 mg in the morning and 200 mg in the evening in accordance with Physician's Orders. The LLPN stated, during an interview on 10/7/13 from 1:35 - 1:47 p.m., she was responsible for checking the MARs against Physician's Orders for accuracy and Individual #1's reversed Tegretol order was a mistake on the MAR that she did not catch. The facility failed to keep an accurate record of Individual #1's medication administration.	W 365	Pen & Ink Change: The LLPN changed the order on Individual #1's MAR, and notified the pharmacy of the correction for future MARs. Per RPD on 11.4.13	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	W 369	**W369 483.460(k)(2)** For all individuals residing in the facility, the nursing staff will do a review of the MARs comparing it with the physician's orders. This will take place each month before the MARs is sent to the group home from the pharmacy. The RN will review the	

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W 369	Continued From page 9 ensure medications were administered without error for 1 of 3 individuals (Individual #1) observed to take medications. This resulted in an individual not receiving a medication as ordered by the physician. The findings include: 1. Individual #2's 1/8/13 IPP stated he was a 64 year old male whose diagnoses included severe mental retardation. An observation was conducted at the facility on 10/8/13 from 7:25 - 8:35 a.m. During that time, Individual #2 was observed to take his morning medications. At 8:00 a.m., Individual #2 entered the medication administration area. The ST obtained Individual #2's medication container which held all pill-form medications, divided by the days of the week and administration times for each day. The ST used hand-over-hand assistance to help Individual #2 tilt his Tuesday morning medications into a medication cup. She transferred the medications into a small cup of applesauce and used hand-over-hand assistance to feed Individual #2 his medications. Individual #2's record included progress notes from his Case Manager and physician, dated 5/21/13. The Case Manager wrote that the facility's LLPN reported "since decreasing Zyprexa [an antipsychotic drug], patient is having an increase in behaviors and has been unmanageable." The physician responded, "should probably go back to previous Zyprexa dosing of 5 mg AM and 10 mg HS." Individual #2's Physician's Orders, dated 8/2013, also reflected the instructions for Zyprexa ordered in 5/2013. The Orders included "Zyprexa 5 mg AM and 10 mg PM."	W 369	MARs on a quarterly basis for accuracy and oversight. Corrective Action Completion Date: December 1, 2013 Person Responsible: Christy Day, Lead LPN; Teresa Dixon, RN	

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W 369	Continued From page 10 Individual #2's MARs, dated 6/2013 - 10/2013, were reviewed. Individual #2's 6/2013 MAR included a handwritten entry which reflected the change ordered by the physician on 5/21/13. However, when the entries were generated by the pharmacy in 7/2013, the administration of Zyprexa had flipped. Individual #2's 7/2013 MAR included Zyprexa 5 mg "Take 1 tablet once daily in the evening" and Zyprexa 10 mg "Take 1 tablet in the morning." The Zyprexa instructions were the same on the 8/2013, 9/2013 and 10/2013 MARs. The facility received new, separated, pre-filled medication containers from the pharmacy on 10/9/13. From approximately 12:15 - 1:25 p.m., Individual #2's new medication container was reviewed with the ATS. The Zyprexa in the AM boxes was labeled "R 10" and the Zyprexa in the PM boxes was labeled "R 5." The ATS confirmed the imprints on the medications. During an interview on 10/7/13 from 1:35 - 1:47 p.m., the LLPN stated she was responsible for checking the MARs against Physician's Orders for accuracy. She confirmed the 8/2013 Physician's Orders were current. The LLPN stated the discrepancy was a mistake that she did not catch and that Individual #2's medications were not being administered in accordance with Physician's Orders. The facility failed to ensure Individual #2's Zyprexa was administered without error.	W 369		
W 481	483.480(c)(2) MENUS	W 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G015		10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 481	Continued From page 11 Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, review of menus and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 2 of 6 individuals (Individuals #2 and #4) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include: 1. During a meal observation on 10/7/13 from 5:15 - 6:42 p.m., Individual #2 was noted to be served chicken, brown rice, biscuits and peaches. Individual #2 refused the meal and an ST brought him an alternative; a bowl of bran flakes with milk which Individual #2 accepted. None of the STs on shift were noted to document the meal substitutions during the observation. During an interview on 10/8/13 at 10:50 a.m. the menus were reviewed with the ATS who stated Individual #2's substitution from the previous night had not been documented, but should have been. The facility failed to ensure food actually served to Individual #2 was documented. 2. During an observation on 10/8/13 from 7:25 - 8:35 a.m., Individual #4 was observed to ask an ST if she could have cold cereal. The ST told her cold cereal needed to be a substitution for one planned menu item. The ST gave her the option of substituting for toast or potatoes and Individual #4 stated she wanted the cold cereal instead of potatoes.	W 481	**W481 483.480(c)(2)** For all individuals residing in the facility, the Active Treatment Specialist will conduct staff training regarding the expectation and requirement to document the meal substitutions. This training will be repeated on a quarterly basis. The Active Treatment Specialist will check the menu book to ensure substitutions are documented on a monthly basis. Corrective Action Completion Date: December 1, 2013 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 481	Continued From page 12 There was no documentation the menu had been changed. During an interview on 10/8/13 at 10:50 a.m. the menus were reviewed with the ATS who stated Individual #4's meal substitution had not been documented, but should have been. The facility failed to ensure accurate documentation of food actually served was kept.	W 481		

Bureau of Facility Standards

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	13G015		10/10/2013

NAME OF PROVIDER OR SUPPLIER: SOUTH BANNOCK GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 3875 SOUTH BANNOCK HIGHWAY, POCATELLO, ID 83201

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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		
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W154.	MM177	**MM177 16.03.11.075.09** Refer to W154 RECEIVED OCT 28 2013 FACILITY STANDARDS	
MM557	16.03.11.210.04(a) Reports of accidents, seizures, illnesses Reports of accidents, seizures, illnesses, treatments for the aforementioned, and immunizations; and (7-1-80) This Rule is not met as evidenced by: Refer to W111.	MM557	**MM557 16.03.11.210.04(a)** Refer to W111	
MM672	16.03.11.07(a) Menu Preparation Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be	MM672	**MM672 16.03.11.07(a)** Refer to W481 ~~**MM730 16.03.11.270.01(d)(i)**~~	

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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MM672	Continued From page 1 written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to W481.	MM672		
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 W214.	MM730	**MM730 16.03.11.270.01(d)(i)** Refer to W214	
MM757	16.03.11.270.02(f)(iii) Signed Physician's Order No resident can receive any medication unless his record contains a current and signed physician's order for such medication. This Rule is not met as evidenced by: Refer to W369.	MM757	**MM757 16.03.11.270.02(f)(iii)** Refer to W369	