



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

November 5, 2014

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 Medicaid/Licensure survey of Church Hill Downs, which was conducted on October 23, 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

Russell McCoy, Administrator  
November 5, 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 **November 17, 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](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 November 17, 2014. If a request for informal dispute resolution is received after November 17, 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,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures



Promoting Functional Independence Through Person Centered Services

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November 14, 2014

RECEIVED

NOV 20 2014

FACILITY STANDARDS

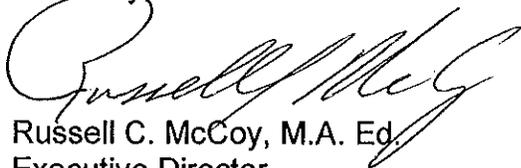
Ms. Nicole Wisenor, Supervisor  
Non-Long Term Care  
Department of Health and Welfare  
Division of Medicaid  
Bureau of Facility Standards  
P. O. Box 83720  
Boise, ID 83720-0036

Dear Nicole:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Church Hill Downs Group Home from the survey completed October 23, 2014. 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: 11/04/2014  
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>10/23/2014</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 recertification survey conducted from 10/20/14 to 10/23/14.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP  Common abbreviations used in this report are:  ABC - Antecedent, Behavior, Consequence ATS - Active Treatment Specialist IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include, as applicable, vocational skills.  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 relevant and comprehensive vocational assessment was completed for 1 of 4 individuals (Individual #3), whose vocational assessments were reviewed. This resulted in a lack of information on which to base program decisions. The findings include:  1. Individual #3's 11/14/13 IPP stated she was a 26 year old female whose diagnoses included severe mental retardation.	W 225	<b>RECEIVED</b>  <b>NOV 20 2014</b>  <b>FACILITY STANDARDS</b>  <b>W225 483.440(c)(3)(v)</b>  For Individual #3 as well as the other individuals in the facility, the vocational assessment form will be revised to incorporate information related to present and future employment options. The Qualified Intellectual Disabilities Professional will be trained on proper summarization of vocational and pre-vocational assessments/skills. The revision of the form and training methods should prevent the deficient practice from recurring.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Jamie L. Anthony, Residential Program Director	

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

TITLE

(X6) DATE

*[Signature]* *[Signature]* *11/14/2014*

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 225	Continued From page 1  The facility utilized a Comprehensive Functional Assessment document that included a "Vocational" section. The form consisted of multiple questions related to vocational skills and work tasks, including grooming and presentation, behavior in a work environment, and the ability to complete tasks. The form included space for prompt levels needed to complete a given step/task, number to times the prompt was required, a narrative section, and a place to prioritize the task. Additionally, the form included a "Vocational Interest Inventory" which consisted of a list of tasks/jobs. Staff were to document interest expressed by the individual with a "+" or "-".  A narrative section was included at the end of the document, titled "Summary of Vocational Section."  Individual #3's form was completed and signed by direct care staff on 11/4/13. In the Summary section of the form there was a hand written note that stated Individual #3 was not capable of working.  However, the form did not include any information related to why Individual #3 was incapable of working, what skills would need to be taught in order for Individual #3 to be able to work, or what if any present and future employment options were available.  During an interview on 10/23/14 from 11:50 a.m. - 12:45 p.m., the Program Director stated she trained certain direct care staff to complete the basic portions of the vocational section of the Comprehensive Functional Assessment, but it	W 225			

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W 225	Continued From page 2 was the QIDP's job to prioritize the needs identified. The Program Director stated the form would need to be revised to include information related to present and future employment options.	W 225			
W 252	The facility failed to ensure Individual #3's vocational assessment contained comprehensive information related to employment options. 483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 1 of 1 individuals (Individual #3) whose raw behavioral data was reviewed. That failure had the potential to impede the ability of the treatment team in evaluating the effectiveness of programmatic techniques. The findings include:  1. Individual #3's 11/14/13 IPP stated she was a 26 year old female whose diagnoses included severe mental retardation.  Individual #3's Behavior Management Program, revised 5/7/14, stated she engaged in self-injurious behavior, which included "slamming her head into the wall..." The Program stated staff were to document each incident using a Behavior Data Collection Sheet and include	W 252	<b>W252 483.440(e)(1)</b>  For Individual #3 as well as the other individuals in the facility, staff will receive training and correction on documentation of behavioral incidents as to obtain required information to determine efficacy of intervention strategies. The Active Treatment Specialist and Qualified Intellectual Disabilities Professional will conduct observations on behavioral incidents and ensure the staff documented correctly. This will occur at least every two weeks throughout the year.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Joel Reep, Qualified Intellectual Disabilities Professional; Adam Benner, Active Treatment Specialist		

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W 252	<p>Continued From page 3 detailed information on the ABC log.</p> <p>During an observation on 10/20/14 from 2:20 - 3:00 p.m., Individual #3 was observed to engage in maladaptive behavior in which she banged her head against the wall no less than 15 times over the course of the observation, hard enough to make an audible sound.</p> <p>Individual #3's raw behavior data was reviewed during an interview on 10/23/14 from 11:50 a.m. - 12:45 p.m. The Behavior Data Collection Sheet for 10/20/14 documented 3 tally marks in a box labeled "Self Injurious Behavior" in a column labeled "3-4p."</p> <p>The ABC log documented Individual #3 "was slapping her head, screaming, banging her head on wall."</p> <p>The documentation was not consistent with what was observed on 10/20/14.</p> <p>The QIDP, who was present for the observation, was asked about the documentation during the interview on 10/23/14 from 11:50 a.m. - 12:45 p.m. The QIDP stated the documentation was inaccurate and did not capture the maladaptive behavior he observed. The QIDP stated the Behavior Data Collection Sheet was not being completed correctly.</p> <p>The facility failed to ensure Individual #3's maladaptive behavior data provided sufficient information.</p>	W 252		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	W 263	<p><b>W263 483.440(f)(3)(ii)</b></p> <p>For Individual #1, a written consent will be sent to the guardian to obtain a signature</p>	

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W 263	<p>Continued From page 4</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the legal guardian for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior consent for a restrictive intervention. The findings include:</p> <p>1. Individual #1's IPP, dated 3/4/14, documented a 40 year old female whose diagnoses included severe mental retardation, depression and seizure disorder.</p> <p>During an observation on 10/20/14 from 2:18 - 3:44 p.m., a set of kitchen knives was noted to be locked in the medication cabinet.</p> <p>Individual #1's record was reviewed and contained a verbal consent, dated 6/30/14, for locking up the knives.</p> <p>However, Individual #1's record did not contain written consent from her legal guardian.</p> <p>During an interview on 10/23/14 from 11:50 a.m. - 12:45 p.m., the Program Director stated she had not sent out a written consent for the locking of the knives.</p> <p>The facility failed to ensure written guardian</p>	W 263	<p>that follows up with the verbal consent already obtained. A chart review will be conducted by the Residential Program Director to ensure the other individuals in the facility have appropriate consent obtained for restrictive elements. A repeat chart review will then take place in six months to ensure the deficient practice will not recur.</p> <p>Corrective Action Completion Date: December 15, 2014</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>	

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W 263	Continued From page 5 consent for locking up the knives was obtained for Individual #1.	W 263		
W 312	<b>483.450(e)(2) DRUG USAGE</b>  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' IPPs 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 #3) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without a plan that identified the drug usage and how it may change in relation to progress or regression. The findings include:  1. Individual #3's 11/14/13 IPP stated she was a 26 year old female whose diagnoses included severe mental retardation.  Individual #3's Physician's Orders, dated 8/13/14, stated she received fluvoxamine (Luvox - an antidepressant drug) 25 mg daily and Remeron (an antidepressant drug) 15 mg daily.  Individual #3's Medication Reduction Plan, dated 4/28/14, was reviewed and did not include	W 312	<b>W312 483.450(e)(2)</b>  For Individual #3 as well as the other individuals in the facility, the medication reduction plans will be revised to include an order in which drugs will be decreased if the medications target similar/like behaviors. The Residential Program Director will do a review of the revised medication reduction plans to ensure the required information is present. This will take place every six months.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Joel Reep, Qualified Intellectual Disabilities Profession; Jamie L. Anthony, Residential Program Director	

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W 312	Continued From page 6 sufficient information, as follows:  Individual #3's Medication Reduction Plan stated Luvox and Remeron were both prescribed for depression and were to reduce crying, self-injurious behaviors, and lack of sleep.  The reduction criteria for both drugs stated reduction would be considered when Individual #3 had "...20 or less episodes of self-injurious behavior for 4 out of 5 consecutive months. OR...15 or less crying episodes for 4 out of 5 consecutive months. OR...sleeps 7 or more consecutive hours per night for 90% of the nights for 4 of 5 consecutive months."  As written, if Individual #3 met criteria for self-injurious behavior, crying or sleep, both drugs would be targeted for reduction at the same time.  There was no additional information related to the order in which the drugs would be reduced included in the plan.  During an interview on 10/23/14 from 11:50 a.m. - 12:45 p.m., the Program Director stated no additional information related to the order in which Individual #3's psychotropic drugs would be targeted for reduction was present.	W 312		
W 370	483.460(k)(3) DRUG ADMINISTRATION  The facility failed to ensure Individual #3's drugs to control maladaptive behavior were appropriately incorporated into a plan.  The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits.	W 370	<b>W370 483.460(k)(3)</b> For Individual #1 and all other residents, the staff assigned will receive additional training in the procedure used for self-administration of medication. Each person	

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W 370	Continued From page 7  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered only by licensed personnel in accordance with state law for 1 of 2 individuals (Individual #1) who were observed taking medications before the evening meal. This resulted in medication being administered contrary to State law. The findings include:  1. Individual #1's 3/4/14 IPP stated she was a 40 year old female whose diagnoses included severe mental retardation, seizure disorder, and blindness. Individual #1 utilized a wheel chair for mobility.  Individual #1's Physician's Orders, dated 8/13/14, stated she was to receive Calcium (a supplemental drug) 500 mg twice daily. During an observation at the facility on 10/20/14 from 5:30 - 6:50 p.m., Individual #1 was observed to take medication prior to the evening meal.  At 6:20 p.m., a direct care staff wheeled Individual #1 to the medication administration area. The staff then punched Individual #1's calcium into a cup of applesauce. The direct care staff tapped the spoon against Individual #1's left hand, to which there was no response. The direct care staff then spoon fed the calcium to Individual #1.  With the exception of tapping the spoon against Individual #1's hand, there was no attempt to elicit Individual #1's assistance in taking her medication.	W 370	assigned to assist with self-administration of medication will be observed by a nurse or professional level supervisor at least once every six months to ensure the proper procedure is followed.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Christy Day, Lead LPN		

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W 370	<p>Continued From page 8</p> <p>Individual #1's record was reviewed and did not contain documentation of written delegation from the RN for unlicensed staff to administer Individual #1's medications.</p> <p>Idaho Administrative Code 23.01.01.490, dated 2011, defined Unlicensed Assistive Personnel (UAP) as unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses. Additionally, Idaho Administrative Code 23.01.01.490.05(e) outlined assistance with medication as including giving medication through a gastric tube and assisting with oral or topical medications.</p> <p>Further, Idaho Administrative Code 23.01.01.490.06 stated unlicensed assistive personnel were prohibited from performing any licensed nurse functions that were specifically defined in Section 54-1402, Idaho Code. Idaho Code 54-1402(3)(d) stated licensed nurses were responsible for implementing the appropriate aspects of the strategy of care as defined by the board, including administering medications and treatments as prescribed by those health care providers authorized to prescribe medication.</p> <p>During an interview on 10/23/14 from 11:50 a.m. - 12:45 p.m., the LPN stated if Individual #1 did not grasp the spoon, direct care staff were to use hand over hand assistance to help her scoop the medication. The LPN stated the direct care staff were not supposed to spoon feed medications to Individual #1.</p> <p>The facility failed to ensure unlicensed staff did not administer medications for Individual #1.</p>	W 370			

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W 426 W 426	Continued From page 9 483.470(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.  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 4 of 8 individuals (Individuals #1, #3, #5 and #6) 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:  1. An environmental review was conducted on 10/22/14 from 11:05 - 11:30 a.m. During that time, water temperatures were as follows:  Kitchen - 111.8 degrees Fahrenheit Powder room - 112.6 degrees Fahrenheit Tub room - 112.0 degrees Fahrenheit Shower room - 111.4 degrees Fahrenheit  The ATS, who was present during the environmental review, stated Individuals #1, #3, #5 and #6 were unable to independently regulate the water temperatures. The ATS was notified of the high water temperatures.  The facility failed to ensure water temperatures were maintained at 110 degrees Fahrenheit or below for Individuals #1, #3, #5 and #6.	W 426 W 426	<b>W426 483.470(d)(3)</b>  For all individuals in the facility, the water temperatures will continue to be checked on a daily basis by the direct care staff (graveyard shift). The Active Treatment Specialist will check these temperatures once a week and report any high or low temperatures to the Physical Facilities Manager for correction. This will resolve any potential for future incidents.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Adam Benner, Active Treatment Specialist		

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W 426	Continued From page 10 Note: Water temperatures were re-checked on 10/23/14 at 8:00 a.m. and found to be within an acceptable range.	W 426		
W 440	<b>483.470(i)(1) EVACUATION DRILLS</b>  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include:  1. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the graveyard shift (11:00 p.m. - 7:00 a.m.) of the second quarter (April - June) of 2014.  During an interview on 10/22/14 at 4:25 p.m., the Program Director stated the drill had not been completed due to an oversight.  The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440	<b>W440 483.470(i)(1)</b>  The evacuation drill schedule has been revised to ensure an evacuation drill is completed each quarter for each shift of staff. The Residential Program Director will track the completion of the evacuation drills on a monthly basis. Corrective Action Completion Date: December 15, 2014  Person Responsible: Jamie L. Anthony, Residential Program Director	
W 455	<b>483.470(l)(1) INFECTION CONTROL</b>  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	<b>W455 483.470(l)(1)</b>  For Individual #1 and all other residents, the staff assigned will receive additional training in the procedure used for self-administration of medication. Each person assigned to assist with self-administration of medication will be observed by a nurse or professional level supervisor at least	

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W 455	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 1 of 8 individuals (Individual #1) residing at the facility and had the potential to impact all individuals (Individuals #1 - #8) residing at the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:</p> <p>1. Individual #1's IPP, dated 3/4/14, documented a 40 year old female whose diagnoses included severe mental retardation, depression and seizure disorder.</p> <p>A medication pass observation was conducted on 10/20/14 from 2:21 - 2:55 p.m. During that time a direct care staff was observed to prepare medications in a medication cup mixed with applesauce. Individual #1 was then verbally prompted to grasp the spoon, which she resisted, and a pill was noted to fall off the spoon and onto Individual #1's pant leg.</p> <p>The direct care staff passing the medications was then noted to use the spoon to remove the pill from Individual #1's pant leg and place it back in the medication cup with the other pills and applesauce.</p> <p>At 2:34 p.m., the surveyor asked the direct care staff to stop the medication pass until replacement medications could be obtained.</p> <p>During an interview on 10/24/14 from 11:50 a.m. -</p>	W 455	<p>once every six months to ensure the proper procedure is followed.</p> <p>Corrective Action Completion Date: December 15, 2014</p> <p>Person Responsible: Christy Day, Lead LPN</p>		

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W 455	Continued From page 12 12:45 p.m., the LPN stated the direct care staff passing the medications had not followed procedures.  The facility failed to ensure infection control procedures were sufficiently implemented.	W 455			

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 10/20/14 to 10/23/14.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP	M 000		
MM066	16.03.11009 Criminal History and Background Check  009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.  01. Criminal History and Background Check. An intermediate care facility for the treatment of individuals with intellectual disabilities must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)  02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)	MM066	<b>MM066 16.03.11009</b>  For all of the Individuals in the facility, training will be given to the management staff to ensure they fully understand and implement the requirements related to criminal history and background checks. This will include ensuring staff do not work alone with an individual prior to the completion of a back ground check which will include the shadowing of potential staff members.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Jamie L. Anthony, Residential Program Director	

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

TITLE

(X6) DATE

STATE FORM

6899

CWGE11

If continuation sheet 1 of 6

*Director*

11/14/2014

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MM066	<p>Continued From page 1</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)                      b. Idaho State Police Bureau of Criminal Identification; (3-26-08)                      c. Sexual Offender Registry; (3-26-08)                      d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)                      e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)                      a. Accepting employment with a new employer; and (3-26-08)                      b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three</p>	MM066		

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MM066	<p>Continued From page 2</p> <p>Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a direct care staff did not work alone with an individual prior to the completion of a background check. That failure directly impacted 1 of 8 individuals (Individual #7) residing at the facility and had the potential to impact all individuals (Individuals #1 - #8) residing at the facility. That failure had the potential to subject individuals to inappropriate</p>	MM066		

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MM066	<p>Continued From page 3</p> <p>personnel. The findings include:</p> <p>1. An observation was conducted at the facility on 10/20/14 from 2:18 - 3:44 p.m. At 3:12 p.m., a direct care staff was noted to be alone and sitting on Individual #7's bed brushing her hair. At 3:16 p.m., the direct care staff stated she was at the facility from 1:00 - 3:00 p.m. to shadow other staff and see if she liked the facility. She further stated she had a background check started, but it had not yet been completed.</p> <p>During an interview on 10/23/14 from 11:50 a.m. - 12:45 p.m., the Program Director stated staff that have not completed a background check should not be alone with individuals.</p> <p>The facility failed to ensure staff with an incomplete background check was not left alone with an individual.</p>	MM066		
MM196	<p>16.03.11.075.10(c) Consent of Parent or Guardian</p> <p>Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.</p>	MM196	<p><b>MM196 16.03.11.075.10(c)</b></p> <p>Refer to W263</p>	
MM197	<p>16.03.11.075.10(d) Written Plans</p> <p>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.</p>	MM197	<p><b>MM197 16.03.11.075.10(d)</b></p> <p>Refer to W312</p>	

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MM212	Continued From page 4	MM212		
MM212	<p>16.03.11.075.17(a) Maximize Developmental Potential</p> <p>The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W252.</p>	MM212	<p><b>MM212 16.03.11.075.17(a)</b></p> <p>Refer to W252</p>	
MM724	<p>16.03.11.270.01(a) Assessments</p> <p>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 W225.</p>	MM724	<p><b>MM724 16.03.11.270.01(a)</b></p> <p>Refer to W225</p>	
MM755	<p>16.03.11.270.02(f)(ii)(a) Resident unable to Self-Administrate</p> <p>If the resident is not capable of self-administration of medications under staff supervision, this fact must be documented in the resident's assessment. Such residents cannot be accepted by facilities unless a licensed nurse is on duty to administer and record such medications. This Rule is not met as evidenced by: Refer to W370.</p>	MM755	<p><b>MM755 16.03.11.270.02(f)(ii)(a)</b></p> <p>Refer to W370</p>	
MM769	<p>16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio</p>	MM769	<p><b>MM769 16.03.11.270.03(c)(vi)</b></p> <p>Refer to W455</p>	

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MM769	Continued From page 5  Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		