



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 4, 2014

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 Medicaid/Licensure survey of South Bannock Group Home, 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 4, 2014  
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

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

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

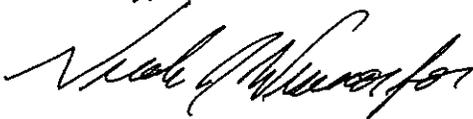
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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

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

NOV 20 2014

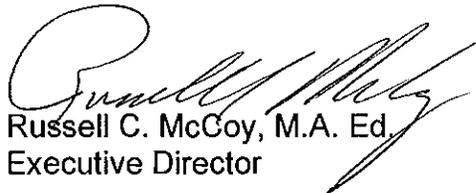
FACILITY STANDARDS

Dear Nicole:

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

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Russell C McCoy, M.A. Executive Director • russellmccoy415@gmail.com

415 So. Arthur Avenue • Pocatello, Idaho 83204-3303 • Phone (208) 233-6833 • Fax (208) 233-6842 • www.developmentaloptions.com

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>13G015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH BANNOCK GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3875 SOUTH BANNOCK HIGHWAY 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:  HRC - Human Rights Committee IM - Intramuscular IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record OCD - Obsessive Compulsive Disorder PRN - As needed QIDP - Qualified Intellectual Disabilities Professional	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 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 #1), whose vocational assessments were reviewed. This resulted in a lack of information on which to base program decisions. The findings include:  1. Individual #1's 6/3/14 IPP stated she was a 36	W 225	<b>W225 483.440(c)(3)(v)</b>  For Individual #1 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	<b>RECEIVED</b>  <b>NOV 20 2014</b>  <b>FACILITY STANDARDS</b>

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

TITLE

(X6) DATE

*Russell M. [Signature]* *Executive Director* *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	<p>Continued From page 1</p> <p>year old female whose diagnoses included moderate mental retardation, schizoaffective disorder, and OCD.</p> <p>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 "-".</p> <p>A narrative section was included at the end of the document, titled "Summary of Vocational Section."</p> <p>Individual #1's form was completed and signed by direct care staff on 5/19/14. In the Summary section of the form, staff documented Individual #1 "said she wanted to work at the dog pond [sic]."</p> <p>However, the form did not include any information related to Individual #1's present and future employment options, or information related to what needed to happen to pursue her desire to work at a dog pound.</p> <p>During an interview on 10/23/14 from 10:35 - 11:30 a.m., the Program Director/QIDP stated she trained certain direct care staff to complete</p>	W 225	<p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>		

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W 225	Continued From page 2 the basic portions of the vocational section of the Comprehensive Functional Assessment, but it was the QIDP's job to prioritize the needs identified. The program Director/QIDP stated the form would need to be revised to include information related to present and future employment options.	W 225			
W 262	The facility failed to ensure Individual #1's vocational assessment contained comprehensive information related to employment options. <b>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE</b>  The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 1 of 4 individuals (Individual #3) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include:  1. Individual #3's IPP, dated 1/7/14, documented a 65 year old male whose diagnoses included moderate mental retardation, mood disorder and OCD.  Individual #3's record included a Physician's Orders, dated 8/13/14, which documented he	W 262	<b>W262 483.440(f)(3)(i)</b>  For Individual #3, Human Rights Committee approval will be obtained for any restrictive elements found in the individual's plan. A chart review will be conducted by the Residential Program Director to ensure the other individuals in the facility have appropriate approval from the Human Rights Committee for restrictive elements. A repeat chart review will take place in six months to ensure the deficient practice does not recur.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Jamie L. Anthony, Residential Program Director		

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W 262	Continued From page 3 received Zyprexa (an antipsychotic drug) 2.5 mg twice a day, Haldol (an antipsychotic drug) 0.5 mg twice a day, and Ativan (an anxiolytic drug) 1 mg PRN for agitation.  However, Individual #3's record did not include current HRC approval for the use of Zyprexa, Haldol or Ativan.  When asked on 10/23/14 from 10:35 - 11:30 a.m., the Program Director/QIDP stated there was no approval due to an oversight.  The facility failed to ensure HRC approval was obtained prior to the use of Individual #3's restrictive medications.	W 262	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE  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.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure procedures that had the potential to violate individuals' rights were implemented only with the written informed consent of the individual's guardian for 1 of 4 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through consents for the use of psychoactive medications. The findings include:  1. Individual #3's IPP, dated 1/7/14, documented	W 263	W263 483.440(f)(3)(ii)  For Individual #3, a written consent will be sent to the guardian to obtain a signature indicating approval of restrictive elements. 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.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Jamie L. Anthony, Residential Program Director

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W 263	Continued From page 4 a 65 year old male whose diagnoses included moderate mental retardation, mood disorder, and OCD.  Individual #3's record included a Physician's Orders, dated 8/13/14, which documented he received Zyprexa (an antipsychotic drug) 2.5 mg twice a day, Haldol (an antipsychotic drug) 0.5 mg twice a day, and Ativan (an anxiolytic drug) 1 mg PRN for agitation.  However, Individual #3's record did not include current guardian consent for the use of Zyprexa, Haldol or Ativan.  When asked on 10/23/14 from 10:35 - 11:30 a.m., the Program Director/QIDP stated there was no consent due to an oversight.  The facility failed to ensure guardian consent was obtained prior to the use of Individual #3's restrictive medications.	W 263			
W 312	483.450(e)(2) DRUG USAGE  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of, and	W 312	<b>W312 483.450(e)(2)</b>  For Individual #1 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		

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W 312	<p>Continued From page 5</p> <p>eventual elimination of, the behaviors for which the drugs were employed for 2 of 3 individuals (Individuals #1 and #3) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drug usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's 6/3/14 IPP stated she was a 36 year female whose diagnoses included moderate mental retardation, schizoaffective disorder and OCD.</p> <p>Individual #1's Physician's Orders, dated 8/13/14, stated she received risperidone (an antipsychotic drug) 50 mg IM every 2 weeks, lithium (an antimanic drug) 900 mg daily, gabapentin (Neurontin - an anticonvulsant drug) 300 mg daily, and Prozac (an antidepressant drug) 60 mg daily.</p> <p>Individual #1's Medication Reduction Plan, dated 12/2/13, was reviewed and did not include sufficient information, as follows:</p> <p>a. Individual #1's Medication Reduction Plan stated risperidone and lithium were both prescribed for schizoaffective disorder and were to reduce assault, self injurious behavior and destruction of property.</p> <p>The reduction criteria for both drugs stated reduction would be considered when Individual #1 had "...1 or less Assault episodes for 6 out of 7 consecutive months OR...has 3 or less Self Injurious Behavior episodes for 6 out of 7 consecutive months OR...has 3 or less Destruction of Property episodes for 6 out of 7</p>	W 312	<p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>		

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W 312	<p>Continued From page 6 consecutive months."</p> <p>Additionally, the Medication Reduction Plan stated Neurontin was for schizoaffective disorder and was to reduce obsessive compulsive behavior, anxiety, self injurious behavior and assault.</p> <p>The reduction criteria for Neurontin stated reduction would be considered when Individual #1 had "...1 or less Assault episodes for 6 out of 7 consecutive months, OR...has 3 or less Self Injurious Behavior episodes for 6 out of 7 consecutive months..."</p> <p>As written, if Individual #1 met criteria for assault or self injurious behavior, risperidone, lithium, and Neurontin would all be targeted for reduction at the same time.</p> <p>Additionally, if Individual #1 met criteria for destruction of property, risperidone and lithium would both be targeted for reduction at the same time.</p> <p>b. Individual #1's Medication Reduction Plan stated Prozac was prescribed for OCD and was to reduce obsessive compulsive behavior and anxiety.</p> <p>The reduction criteria for Prozac stated reduction would be considered when Individual #1 had "...120 minutes or less of Obsessive Compulsive Behaviors/Anxiety for 6 out of 7 consecutive months."</p> <p>Additionally, the Medication Reduction Plan stated Neurontin was for schizoaffective disorder and was to reduce obsessive compulsive</p>	W 312			

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W 312	<p>Continued From page 7 behavior, anxiety, self injurious behavior and assault.</p> <p>One of the reduction criteria for Neurontin stated reduction would be considered when Individual #1 had "...120 minutes or less of Obsessive Compulsive Behaviors/Anxiety for 6 out of 7 consecutive months."</p> <p>As written, if Individual #1 met criteria for "Obsessive Compulsive Behaviors/Anxiety," both Prozac and Neurontin would be targeted for reduction at the same time.</p> <p>Further, the bottom of the Medication Reduction Plan stated "Many of these medications are tied to the same behaviors. The order in which medications will be decreased will be left up to [Individual #1's] physician, [name of physician] who is managing the medications."</p> <p>No additional information related to which medication would be targeted for reduction first (based on severity of potential side effects, the individual's reaction to the drug, long term effects of the drug's use, team input, etc.) could be found.</p> <p>During an interview on 10/23/14 from 10:35 - 11:30 a.m., the Program Director/QIDP stated no additional information related to the order in which Individual #1's psychotropic drugs would be targeted for reduction was present.</p> <p>The facility failed to ensure Individual #1's drugs to control maladaptive behavior were appropriately incorporated into a plan.</p> <p>2. Individual #3's IPP, dated 1/7/14, documented</p>	W 312		

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W 312	Continued From page 8 a 65 year old male whose diagnoses included moderate mental retardation, mood disorder and OCD.  Individual #3's record included a Physician's Orders, dated 8/13/14, which documented he received Ativan (an anxiolytic drug) 1 mg PRN for severe agitation.  His record also contained a Medication Reduction Plan, dated 6/30/14, that documented Ativan would be discontinued if it had not been used for 60 consecutive days.  However, Individual #3's MARs documented he had not receive Ativan during the months of May - August of 2014.  When asked on 10/23/14 from 10:35 - 11:30 a.m., the Program Director/QIDP stated they had talked about discontinuing the Ativan. However, no documentation of the conversation could be found in their meeting minutes.  The facility failed to ensure Individual #3's medication reduction plan was followed as it related to the use of Ativan.	W 312			
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING  The facility must keep all drugs and biologicals locked except when being prepared for administration.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	W 382	<b>W382 483.460(l)(2)</b>  For Individual #2 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 once every six months to ensure the proper procedure is followed.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH BANNOCK GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3875 SOUTH BANNOCK HIGHWAY 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 382	<p>Continued From page 9</p> <p>ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:</p> <p>1. An observation was conducted at the facility on 10/21/14 from 5:50 - 8:20 a.m. During that time, an individual's drugs were observed to be unlocked, as follows:</p> <p>Individual #2's 7/7/14 IPP stated he was a 26 year old male whose diagnoses included profound mental retardation. He utilized a gastrostomy tube (g-tube: a tube inserted through the abdominal wall into the stomach) for nutrition and medications.</p> <p>At 6:15 a.m., a direct care staff was observed to prepare medications for Individual #2's medication administration program. The direct care staff removed liquid medications and set them on the counter in the medication administration area. The medications included Docusate sodium (a laxative drug), milk of magnesia (a laxative drug), vitamin D (a supplemental drug) and a multivitamin (a supplemental drug).</p> <p>The direct care staff left the medication administration area to take items to Individual #2's bedroom. The liquid medications remained unlocked, sitting on the counter.</p> <p>At 6:20 a.m., the direct care staff returned to the medication administration area and retrieved the liquid medications. Once in Individual #2's</p>	W 382	<p>Corrective Action Completion Date: December 15, 2014</p> <p>Person Responsible: Christy Day, Lead LPN</p>	

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W 382	Continued From page 10 bedroom, the direct care staff completed the medication administration process utilizing Individual #2's g-tube.  At the completion of the medication administration routine, the direct care staff took items back to the medication administration area leaving the liquid medications unlocked on a shelf in Individual #2's room. The direct care staff returned to Individual #2's bedroom after approximately 2 minutes to retrieve the liquid medications and return them to the locked medication cabinet.  During an interview on 10/23/14 from 10:35 - 11:30 a.m., the LPN stated all drugs should remain locked if not under the direct supervision of staff. The LPN stated Individual #2's liquid medications should not have been left unattended and unlocked in either the medication administration area or Individual #2's bedroom.	W 382		
W 440	483.470(i)(1) EVACUATION DRILLS  The facility failed to ensure all drugs were maintained locked.  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 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals'	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	

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W 440	Continued From page 11 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/QIDP stated the drill had not been completed due to an oversight.	W 440		
W 455	483.470(l)(1) INFECTION CONTROL  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  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 7 individuals (Individual #5) residing at the facility and had the potential to impact all individuals (Individuals #1 - #7) 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:  1. An observation was conducted at the facility on 10/21/14 from 5:50 - 8:20 a.m. During that time, Individual #5 was observed to take his morning	W 455	W455 483.470(l)(1)  For Individual #5 and all other residents, the staff assigned will receive additional training in the procedure used for self-administration of medication and proper infection control during this procedure. Each person 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 procedures are followed.  Corrective Action Completion Date: December 15, 2014  Person Responsible: Christy Day, Lead LPN	

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W 455	<p>Continued From page 12 medications.</p> <p>At 6:10 a.m., Individual #5 entered the medication administration area with a direct care staff. The direct care staff assisted Individual #5 to punch pills from blister packs into a small plastic medication cup. The pills included the following:</p> <p>Gabapentin (an anticonvulsant drug) 1-600 mg tablet, Chantix (a nicotinic drug) 1-0.5 mg tablet, Sertraline HCL (an antidepressant drug) 1-100 mg tablet, GNP One Daily (a supplemental drug) 1 tablet, Tegretol (an anticonvulsant drug) 1-100 mg tablet and 2-200 mg tablets, divalproex (an anticonvulsant drug) 3-500 mg tablets.</p> <p>The direct care staff then poured the pills into her ungloved hand and counted each pill as she placed it back into the medication cup. The direct care staff then handed the pills to Individual #5 and he took the pills.</p> <p>When asked during the observation, the direct care staff stated it was okay for her to touch Individual #5's pills with her bare hands if she had used hand sanitizer before doing so.</p> <p>A second direct care staff, who was also present during the observation and noted to assist individuals with medications, was asked and stated staff were taught to never touch individuals' pills with bare hands. The second direct care staff stated effort should be made to avoid touching individuals' pills, but if they had to touch the pills a glove should be worn.</p> <p>During an interview on 10/23/14 from 10:35 - 11:30 a.m., the LPN stated staff should not touch individuals' pills with their bare hands.</p>	W 455			

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W 455	Continued From page 13  The facility failed to ensure infection control procedures were sufficiently implemented.	W 455			

Bureau of Facility Standards

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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  Common abbreviations used in this report are:	M 000		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee  Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	<b>MM194 16.03.11.075.10(a)</b>  Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian  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.	MM196	<b>MM196 16.03.11.075.10(c)</b>  Refer to W263	
MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W312.	MM197	<b>MM197 16.03.11.075.10(d)</b>  Refer to W312	

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

TITLE

(X6) DATE

*[Signature]*

*Executive Director*

11/14/2014

Bureau of Facility Standards

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MM724	Continued From page 1	MM724		
MM724	16.03.11.270.01(a) Assessments  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.	MM724	<b>MM724 16.03.11.270.01(a)</b>  Refer to W225	
MM753	16.03.11.270.02(f)(i) Locked Area  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	<b>MM753 16.03.11.270.02(f)(i)</b>  Refer to W382	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio  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	<b>MM769 16.03.11.270.03(c)(vi)</b>  Refer to W455	