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 6, 2014

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

RE: Bitterroot Home, Provider #13G022

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure survey of Bitterroot Home, which was conducted on October 24, 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

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 19, 2014,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

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

This request must be received by November 19, 2014. If a request for informal dispute resolution is received after November 19, 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,

ASHLEY HENSCHEID
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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	W 000		
	The following deficiencies were cited during the annual recertification survey conducted from 10/20/14 to 10/24/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: CFA - Comprehensive Functional Assessment DCS - Direct Care Staff HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 4 of 6 individuals (Individuals #2 - #5) residing in the facility. This resulted in implementation of blanket	W 125	RECEIVED NOV 19 2014 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Stephens | TITLE: Administrator | (X6) DATE: 11/19/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 125	Continued From page 1 restrictions to personal possessions, not based on individual need, and without assuring due process protections. The findings include: 1. During an observation conducted on 10/21/14 from 6:20 - 8:10 a.m., the following was noted: - At 6:56 a.m., the cook/housekeeper obtained Individual #5's backpack from a locked closet in the office area and assisted Individual #5 to put the backpack on. When asked, the cook/housekeeper stated, "The closet was locked." - At 6:58 a.m., when requested by the surveyor, DCS A unlocked the office closet and said that backpacks and extra supplies (disposable gloves, shampoo, etc) were stored in the closet. DCS A then closed and locked the closet door. Individual #2 - #5's records were reviewed. No documentation related to locking individuals' backpacks in the office closet could be found. When asked during an interview on 10/21/14 at 11:52 a.m., the Facility Manager said the backpacks for Individuals #2, #3, #4, and #5 were locked in the office closet when the individuals came home for the day. The Facility Manager also said no programming, consents or approvals were in place for for locking the backpacks in the office closet. The facility failed to ensure individuals' rights to personal possessions was ensured.	W 125	**W125** The individuals no longer have restriction of personal possessions. Collecting backpacks had originally started temporarily to find out where one individual was getting depends, but eventually had become a routine for housekeeping when the residents arrived home from day program. They currently store their items in their own rooms, and have total access at any time. Any restrictive measures will be approved and consented by family/guardian, HRC, and treatment team. Review of this rule and regulation has taken place during treatment team with all Facility Managers, Leadworkers, QIDP, Facility Nurse, and Administrator to ensure an understanding of how to teach clients to advocate for their rights to have access to personal property. This was addressed at our treatment team meeting and house meetings for the entire agency. If anything that warrants a restriction needs to be in place, it will be discussed at the face to face monthly Q review meetings to address corresponding assessment, consents and programming. Date of Correction: 11-07-2014 Responsible: QIDP, Facility Manager	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS	W 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 137	Continued From page 2 The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure individuals had access to their personal possessions for 4 of 6 individuals (Individuals #2 - #5) residing in the facility. This resulted in individuals not being able to freely access their personal backpacks. The findings include: 1. During an observation conducted on 10/21/14 from 6:20 - 8:10 a.m., the following was noted: - At 6:56 a.m., the cook/housekeeper obtained Individual #5's backpack from a locked closet in the office area and assisted Individual #5 to put the backpack on. When asked, the cook/housekeeper stated, "The closet was locked." - At 6:58 a.m., when requested by the surveyor, DCS A unlocked the office closet and said that backpacks and extra supplies (disposable gloves, shampoo, etc) were stored in the closet. DCS A then closed and locked the closet door. When asked during an interview on 10/21/14 at 11:52 a.m., the Facility Manager said the backpacks for Individuals #2, #3, #4, and #5 were locked in the office closet when the individuals came home for the day. The decision to lock the backpacks in the closet was made due to Individual #6 rummaging through and taking items from individuals' backpacks when staff	W 137	**W137** The individuals no longer have restriction of personal possessions. Collecting backpacks had originally occurred as a temporary measure to find out where one individual was getting depends, but eventually had become a routine for housekeeping when the residents arrived home from day program. They currently store their items in their own rooms, and have total access at any time. Any restrictive measures will be approved and consented by family/guardian, HRC, and treatment team. Review of this rule and regulation will take place during treatment team with all Facility Managers, Leadworkers, QIDP, Facility Nurse, and Administrator to ensure an understanding of access to personal property. This was addressed at our treatment team meeting and house meetings for the entire agency. If anything that warrants a restriction needs to be in place, it will be discussed at the face to face monthly Q review meetings to address corresponding assessment, consents and programming. Date of Correction: 11-07-2014 Responsible: QIDP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 137	Continued From page 3 were not watching. The facility failed to ensure Individual #2, #3, #4, and #5 were able to freely access their personal backpacks.	W 137		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure the HRC reviewed and approved facility practices that restricted individuals' free access to personal items for 4 of 5 individuals (Individuals #2 - #5) residing in the facility. This resulted in access to personal possessions being restricted without cause. The findings include: 1. During an observation conducted on 10/21/14 from 6:20 - 8:10 a.m., the following was noted: - At 6:56 a.m., the cook/housekeeper obtained Individual #5's backpack from a locked closet in the office area and assisted Individual #5 to put the backpack on. When asked, the cook/housekeeper stated, "The closet was locked."	W 264	**W264** The individuals no longer have restriction of personal possessions. Collecting backpacks had originally occurred as a temporary measure long ago to find out where one individual was getting depends, but somehow it had become a routine for housekeeping when the residents arrived home from day program. This was never supposed to be an ongoing practice. Residents currently store their items in their rooms and have access at any time. Any restrictive measures will be approved and consented by family/guardian, HRC, and treatment team. It has been our practice to first present and justify all restrictive measures to the HRC committee for review. Any items that may be deemed to be potentially harmful or dangerous to others will be addressed through the CFA and programming will be established first as a lesser restrictive procedure. Since items are back in the possession of the residents HRC consent is not necessary at this time. This issue was discussed at our monthly house meeting on 11/07/14. Date of Correction: 11-07-2014 Responsible: Facility Manager, QIDP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 264	Continued From page 4	W 264		
	- At 6:58 a.m., when requested by the surveyor, DCS A unlocked the office closet and said that backpacks and extra supplies (disposable gloves, shampoo, etc) were stored in the closet. DCS A then closed and locked the closet door. When asked during an interview on 10/21/14 at 11:52 a.m., the Facility Manager said the backpacks for Individuals #2, #3, #4, and #5 were locked in the office closet when the individuals came home for the day. The Facility Manager also said informed consents were not in place for locking the backpacks in the office closet. Individual #2 - #5's consents were reviewed. The documents did not include documentation the HRC reviewed and approved locking individuals' backpacks in the office closet. During a follow-up interview on 10/23/14 from 8:00 - 9:45 a.m., the Administrator and the Facility Manager confirmed the HRC was not involved in the practice of locking individuals' backpacks in the office closet. The facility failed to ensure all practices resulting in potential rights violations were reviewed and approved by the HRC.			
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.	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 312	Continued From page 5 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 an individual's IPP that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #3) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs without the implementation of a plan related to how the drugs may be changed in relation to progress or regression. The findings include: 1. Individual #3's IPP, dated 12/1/13, documented he was a 32 year old male whose diagnoses included severe mental retardation and autism. Individual #3's Physician Orders, dated 8/14/14, documented he received risperidone (an antipsychotic drug) 3.5 mg daily for "symptoms associated with autism." Individual #3's Informed Consent for risperidone, dated 11/17/13, documented as risks involved with the medication, "Continued symptoms and increased symptoms of Autism associated with: yelling, screaming, hair pulling, and clinging to staff or family." However, Individual #3's Medication Reduction Plan, dated 11/2013, documented he took risperidone for "Autism Spectrum Disorder" and "Screaming (see program: Loud Vocalizations)." The Reduction Plan stated the medication would be reduced when Individual #3 had demonstrated a reduction of loud vocalizations to less than 5	W 312	**W312** The resident's disruptive behaviors have not only been limited to yelling and screaming. Now the Med Reduction documentation more thoroughly and accurately includes the self-injurious and aggressive behaviors. Current symptoms of Risperdal use have been reassessed each year and written into the WICs, Medication Reduction Plan, CFA, and the IPP. Formal programming has long been established to address SIB and aggressive behaviors associated with autism spectrum disorder. QIDP, Facility Manager, and Facility Nurse will review files at least annually to ensure that the behaviors are identified and appropriate medications are administered to decrease targeted behaviors on CFA, WICs, and Medication Reduction Plan. Corresponding behaviors are systematically assessed on the CFA and are transferred to the Med Reduction Plan at least annually for all individuals living at this facility and the entire agency. Date of Correction: 11-30-2014 Responsible: QIDP, Facility Manager, and Facility Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 312	Continued From page 6 times per month of six consecutive months with an 80% success rate. The Reduction plan did not include reduction criteria for aggressive behavior as indicated in his Informed Consent. When asked about the purpose of the medication during an interview on 10/23/14 from 2:00 - 4:50 p.m., the LPN stated the medication was initiated because Individual #3 engaged in biting, pulling hair and other aggressive behavior in addition to his yelling. The facility failed to ensure Individual #3's medication reduction plan was sufficiently developed.	W 312		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews were completed on a quarterly basis for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: 1. Individual #1 - #3's medical records were reviewed. Individual #1 - #3's records included	W 336		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 336	Continued From page 7 nursing reviews that were completed on 9/26/13, 12/31/13, 3/21/14, and 7/28/14. The medical records did not include a completed review for the second quarter (April, May, June) of 2014. During an interview on 10/23/14 from 2:00 - 4:50 p.m., the LPN said the quarterly nursing reviews for the second quarter of 2014 were rescheduled and completed on 7/28/14. The facility failed to ensure nursing reviews were completed on a quarterly basis.	W 336	**W336** Quarterly nursing reviews have been updated to ensure that that they are met within the established time frames, specifically, within each quarter. A file review during survey noted that the quarterly review had been delayed by 30 days, missing one quarter even though the corresponding schedule of assessments established actually included 4 total reviews for the year. LPN and RN have scheduled corresponding assessments to align within the correct time frames for the regulatory guidelines. Any adjustments will be noted by LPN and RN and dates will be established from that point forward to keep the reviews within the quarter as required. Reminders have been set for the beginning of the last month in each quarter, March, June, September, and December. If a scheduled review must be changed there is still adequate time in that month to be sure it happens in a timely manner. Date of Correction: 11-30-2014 Responsible: LPN, RN	
W 463	483.480(a)(4) FOOD AND NUTRITION SERVICES The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the physician prescribed each individual's modified diet for 1 of 3 individuals (Individual #1) whose nutritional records were reviewed. This resulted in a lack of clear direction to staff regarding an individual's food texture. The findings include: 1. Individual #1's IPP, dated 6/10/14, documented he was a 26 yr old male whose diagnoses included mild mental retardation, down syndrome, and malformed jaw. During an observation on 10/20/14 from 5:50 - 7:15 p.m., the evening meal was observed. The menu consisted of slow cooker turkey or chicken	W 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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 463	Continued From page 8 chili, corn bread, fruit salad and skim milk. Only one meal, of regular texture, was observed to be prepared for all individuals in the facility. After assisting with meal preparation, at 6:20 p.m., Individual #1 was observed to serve himself a bowl of chili and walk to a table outside. Individual #1 was noted to eat outside with Individual #4 and a direct care staff. His CFA, dated 6/6/14, stated his therapeutic diet was mechanical soft. His IPP and PIP, also dated 6/10/14, both stated he would independently cut his food into pea-sized pieces before eating. Individual #1's Speech-Language Pathology Evaluation, dated 4/28/14, included the recommendation to cut his food into bite-size pieces. The RD's Nutrition Consultation Follow-Up reports, dated 12/30/13, 3/20/14, and 6/30/14, all stated his current diet order was "regular." Individual #1's physician order sheets documented the following: - 12/27/13, diet was "regular." - 3/27/14 and 9/29/14, diet was "mechanical soft" due to his jaw. Additionally, Individual #1's record did not contain a physician's order changing his diet from regular to mechanical soft. During an interview on 10/22/14 at 2:23 p.m., the LPN stated she made the change to mechanical soft on the 3/27/14 physician's order sheet	W 463	**W463** The decision was made by the treatment team to obtain a physician order for specific diet. Any resident in need of a specific diet other than a regular diet will have a physician order obtained to determine dietary needs. The dietitian has agreed to request whether there is a doctor's order if she has not previously noted that in her records or if she has any question. The dietitian will continue with her routine assessments and documentation of dietary needs which includes specific recommendations for residents based on their medical and nutritional status. The QIDP, Facility Manager, and Facility Nurse will review dietary assessments and recommendations to ensure that specific dietary needs are being met, that physician orders in place if necessary, and they will clearly convey instructions to staff for modified diets. Date of Correction: 11-14-2014 Responsible: QIDP, LPN, Dietitian, Facility Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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)	(X6) COMPLETION DATE
W 463	Continued From page 9 because she entered the regular texture on the 12/27/13 physician order sheet by mistake. The diet should have been mechanical soft. The Facility Manager stated cutting Individual #1's food into pea-sized pieces was determined to be the best size for him to eat. The Manager also said his food was not ground up like food normally was for a mechanical soft diet. When asked during a follow-up interview on 10/23/14 from 2:00 - 4:50 p.m., the LPN stated the physician did not prescribe the mechanical soft diet for Individual #1. The QIDP of a sister facility, stated during Individual #2's initial IPP meeting and due to Individual #1's malformed jaw, the decision was made for a mechanical soft diet. When asked, the QIDP also stated the physician and the RD were not part of the discussion process when the decision was made for Individual #1's diet to be mechanical soft. The facility failed to ensure Individual #5's mechanical soft diet texture was appropriately prescribed by the IDT including the RD and the physician.	W 463		

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
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BITTERROOT HOME	1806 BITTERROOT DRIVE TWIN FALLS, ID 83301

(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) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 10/20/14 to 10/24/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000		
MM167	16.03.11.075.07 Exercise of Rights Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. This Rule is not met as evidenced by: Refer to W125.	MM167	MM167 – see W125	
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 W264.	MM194	MM194 – see W264	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and	MM197	MM197 – see W312	

RECEIVED
NOV 19 2014
FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jane Stephens — Administrator — 11/19/14

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
	13G022		10/24/2014

NAME OF PROVIDER OR SUPPLIER: BITTERROOT HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 1806 BITTERROOT DRIVE, TWIN FALLS, ID 83301

(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) COMPLETE DATE
MM197	Continued From page 1 This Rule is not met as evidenced by: Refer to W312.	MM197		
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	MM209 – see W137	
MM649	16.03.11.250.02 Physician's Duties All diets must be ordered by the attending physician. This Rule is not met as evidenced by: Refer to W463.	MM649	MM649 – see W463	
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336.	MM766	MM766 – see W336	