



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 25, 2013

Russell McCoy, Administrator
Rulon House
415 South Arthur
Pocatello, ID 83204

RE: Rulon House, Provider #13G020

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of Rulon House, which was conducted on November 21, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Russell McCoy, Administrator
November 25, 2013
Page 2 of 2

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **December 9, 2013**, and keep a copy for your records.

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

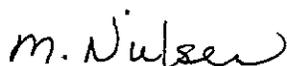
www.icfmr.dhw.idaho.gov

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

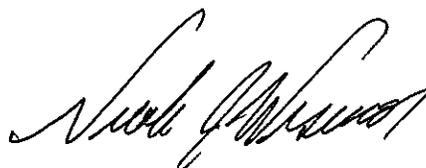
This request must be received by December 8, 2013. If a request for informal dispute resolution is received after December 8, 2013, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

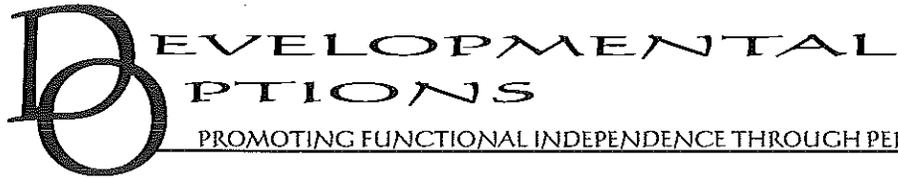


MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/pmt
Enclosures



December 04, 2013

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

RECEIVED

DEC - 9 2013

FACILITY STANDARDS

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the survey completed November 21, 2013. On the Statement of Deficiencies / Plan of Correction, State Form, 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 below.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Russell C. McCoy', is written over a printed name and title.

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

Enclosures

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

PRINTED: 11/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
NAME OF PROVIDER OR SUPPLIER RULON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey conducted from 11/18/13 - 11/21/13.</p> <p>The survey was conducted by: Monica Nielsen, QIDP, Team Leader Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are: IBI - Intensive Behavioral Intervention IPP - Individual Program Plan Mandt - a physical restraint system PTSD - Post Traumatic Stress Disorder QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure outside services met the needs for 1 of 1 individual (Individual #1) who attended a local high school. This resulted in an individual being placed in a time-out room where constant visual supervision could not be maintained, the individual was not protected from hazardous conditions within the room, and a lack of data being kept in relation to time-out procedures. The findings include:</p> <p>1. Individual #1's IPP, dated 2/26/13, documented an 18 year old male diagnosed with mild</p>	W 120	<p>W120 483.410(d)(3)</p> <p>For Individual #1, the facility will work with School District 25 to either (1) eliminate the use of the time out room entirely from the IBI response with Individual #1 or (2) ensure the proper documentation and room requirements are used for a time out room.</p> <p>Corrective Action Completion Date: January 15, 2014</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>	<p>RECEIVED</p> <p>DEC - 9 2013</p> <p>FACILITY STANDARDS</p>

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

TITLE

(X6) DATE

Sumell Mc G *Executive Director* *12/24/2013*

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

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W 120	<p>Continued From page 1</p> <p>intellectual disability, autism, mood disorder, and seizure disorder.</p> <p>Individual #1 attended a local high school, Monday through Friday, from 8:30 a.m. to 2:30 p.m.</p> <p>An observation was conducted at Individual #1's school on 11/19/13 from 9:55 - 10:48 a.m. During that time Individual #1's IBI worker stated Individual #1 used a calming room when he became agitated and showed the room to the survey team. The IBI worker stated if Individual #1 became aggressive when he was in the calming room, the IBI worker simply stepped outside of the room and held the door shut with his foot. The IBI worker stated that happened only 1 time this year. When asked about a report related to the incident, the IBI worker stated he did not document it because he felt it was more of a safety issue.</p> <p>The door to the room was metal with a 12 inch by 6 inch window. The room was large with high ceilings. There were multiple uncovered electrical outlets present and a large table was bolted to the wall. There was no padding on the corners of the table. The IBI worker was asked to lay in front of the door and a surveyor stood by the table inside the room. A second surveyor stepped out of the room, closed the door, and looked through the window. Neither the IBI worker nor the surveyor in the room could be seen by the surveyor outside of the room.</p> <p>When asked about the school's calming room, the QIDP stated during an interview on 11/20/13 from 2:40 - 4:00 p.m., Individual #1 used the room when he was agitated. When asked about</p>	W 120			

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W 120	Continued From page 2 holding the door shut from the outside the room, the QIDP stated she was not aware that was occurring.	W 120		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior assessments contained comprehensive information for 1 of 3 individuals (Individual #2) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's IPP, dated 10/7/13, documented a 23 year old male diagnosed with moderate intellectual disability, autism, mood disorder, PTSD, sleep disorder, and depression. Individual #2's Behavior Management Assessment, dated 5/3/13, documented he engaged in non-compliance, insomnia, assault, destruction of property, targeted aggression and refusing to come out of his room. The assessment documented Individual #2 was "most	W 214	W214 483.440(c)(3)(iii) For Individual #2, the behavior assessment will be updated to include information related to his depressive symptoms and other pertinent information. The behavior assessments for the other individuals in the facility will be reviewed for accuracy and modified as needed. This review will be conducted on a quarterly basis by the QIDP. The behavior assessments will also be updated within thirty days of significant changes (i.e. additional diagnosis, changes or discontinuation of behaviors). Corrective Action Completion Date: January 15, 2014 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 214	Continued From page 3 active in the home when the majority of the residents and staff are out of the facility." A New Medication Review, dated 11/6/13, documented Individual #2 was prescribed Cymbalta (an antidepressant drug) on 4/24/13. The review documented the Cymbalta was for anxiety related to PTSD and depression. The Review stated "the behaviors associated with this impedes [Individual #2's] ability to function as he remains isolated in his bedroom." When asked about the isolation, the QIDP stated during an interview on 11/20/13 from 2:40 - 4:00 p.m., Individual #2 had refused to come out of his room to avoid noise in the home since admission. The QIDP stated Cymbalta was added when Individual #2 refused to come out of his room even if other residents and staff were gone and the physician attributed the behavior to depression. However, Individual #2's Behavior Management Assessment did not include information related to Individual #2's depressive signs or symptoms. When asked, the QIDP stated during the interview noted above that no information related to Individual #2's depressive symptoms was included in the assessment and the assessment needed to be revised. The facility failed to ensure Individual #2's depression was comprehensively assessed and included in his Behavior Management Assessment.	W 214			
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 289			

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W 289	Continued From page 4 The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include: 1. Individual #1's IPP, dated 2/26/13, documented an 18 year old male diagnosed with mild intellectual disability, autism, mood disorder, and seizure disorder. Individual #1's Behavior Management Program, dated 3/5/13, stated he engaged in assaults (defined as hitting, kicking, throwing objects, biting, hair pulling, pushing, and pinching), destruction of property (defined as breaking items by throwing, kicking, or hitting them, putting holes in walls, and slamming doors which break) and self-injurious behavior (defined as biting self, pinching self, and hitting his head, legs and arms). The program stated if Individual #1's behavior escalated, staff were to use a one-arm one-person standing restraint for no more than 3 minutes.	W 289	W289 483.450(b)(4) For Individual #1, his behavior assessment will be reevaluated for the possible need of a two person restraint as well as include the definition of "calm" to better guide staff on when to release the restraint. There are no other individuals in the facility with the use of restraints. Corrective Action Completion Date: January 15, 2014 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 289	Continued From page 5 On 11/18/13 at 4:05 p.m., a direct care staff was asked about Individual #1's restraints. The direct care staff stated she was almost always involved in restraining Individual #1. The staff stated Individual #1's behavior plan allowed for a one-arm one-person restraint. The staff stated Individual #1 was able to use his free arm to reach around and grab the staff person's hair and face. The staff person reported two staff were used and the second staff person performed a side body hug to control Individual #1's free arm during restraints. When asked about restraints, the QIDP stated during an interview on 11/20/13 from 2:40 - 4:00 p.m., she was not aware 2 staff were being used to restrain Individual #1. When asked about the 3 minute time frame, the QIDP stated it was Mandt policy and Individual #1 usually calmed within 30 seconds. When asked about the definition of calm, the QIDP stated calm was not included in Individual #1's program.	W 289			
W 303	The facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into Individual #1's behavior program. 483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a record of restraint was maintained for 1 of 1 individuals (Individual #1) for whom restraint was	W 303	W303 483.450(d)(4) For Individual #1, his behavior assessment will be reevaluated for the possible need of a two person restraint as well as include the definition of "calm" to better guide staff on when to release the restraint. Appropriate HRC and Guardian approval will be obtain should the restrictive elements change in his behavior management program. There are no other individuals in the facility with the use of restraints.		

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W 303	<p>Continued From page 6</p> <p>used. Failure to keep a comprehensive record of restraint usage impeded the ability of the IDT, the facility's HRC, and an individual's guardians to make informed decisions and/or recommendations regarding the use of restraint. The findings include:</p> <p>1. Individual #1's IPP, dated 2/26/13, documented an 18 year old male diagnosed with mild intellectual disability, autism, mood disorder, and seizure disorder.</p> <p>Individual #1's Behavior Management Program, dated 3/5/13, stated he engaged in assaults which were defined as hitting, kicking, throwing objects, biting, hair pulling, pushing, and pinching. The program stated if Individual #1's behavior escalated, staff were to use a one-arm one-person standing restraint for no more than 3 minutes.</p> <p>Individual #1's incident reports were reviewed and documented a one-arm one-person restraint was used with him on 9/18/13, 10/19/13, 10/22/13, and 11/11/13 due to his assaultive behavior.</p> <p>However, on 11/18/13 at 4:05 p.m., a direct care staff was asked about Individual #1's restraints. The direct care staff stated she was almost always involved in restraining Individual #1. The staff stated Individual #1's behavior plan allowed for a one-arm one-person restraint. The staff stated Individual #1 was able to use his free arm to reach around and grab the staff person's hair and face. The staff person reported two staff were used and the second staff person performed a side body hug to control Individual #1's free arm during restraints.</p>	W 303	<p>Corrective Action Completion Date: January 15, 2014</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>	

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W 303	Continued From page 7 When asked about restraints, the QIDP stated during an interview on 11/20/13 from 2:40 - 4:00 p.m., she was not aware 2 staff were being used to restrain Individual #1.	W 303		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility failed to ensure an accurate record of restraint was maintained for Individual #1. The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure an individual was provided with adaptive equipment for 1 of 2 individuals (Individual #3) who required adaptive eating equipment. This resulted in an individual not being provided with adaptive equipment to take his medications. The findings include: 1. Individual #3's IPP, dated 12/4/12, documented a 31 year old male whose diagnoses included severe intellectual disability, cerebral palsy, and seizure disorder. His record contained an Eating Skills program, dated 6/24/12, that documented Individual #3 was to use a weighted spoon and a scoop plate when eating.	W 436	W436 483.470 (g)(2) For Individual #2, his self-administration of medication program will be re-assessed for the need of using his adaptive equipment during a medication pass. This self-administration of medication program will be revised accordingly. The other individuals in the facility will receive additional assessment for the use of adaptive equipment in other areas such as self-administration of medication. These needs will be reviewed at each individual's annual IPP meeting. Corrective Action Completion Date: January 15, 2014 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 436	<p>Continued From page 8</p> <p>During observations on 11/18/13 from 5:15 - 6:30 p.m. and 11/19/13 from 6:35 - 9:10 a.m., Individual #3 was noted to use a weighted spoon and a scoop dish during meals.</p> <p>However, during a medication pass observation on 11/19/13 from 8:56 - 9:01 a.m., a direct care staff was noted to put Individual #3's medications in a medicine cup and mix it with applesauce. Individual #3 was then given a regular spoon and the direct care staff assisted him to eat the mixture.</p> <p>Use of a weighted spoon or scoop plate was not observed.</p> <p>During an interview on 11/20/13 from 2:40 - 4:00 p.m., the QIDP stated Individual #3's adaptive eating equipment should have been used during the medication pass.</p> <p>The facility failed to ensure Individual #3's adaptive eating equipment was used during his medication pass.</p>	W 436		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 11/18/13 - 11/21/13. The survey was conducted by: Monica Nielsen, QIDP, Team Leader Jim Troutfetter, QIDP	M 000		
MM182	16.03.11.075.09 (a)(iv) Resident placed in Restraints The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and This Rule is not met as evidenced by: Refer to W303.	MM182	MM182 16.03.11.075.09(a)(iv) Refer to W303	
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 W289.	MM197	MM197 16.03.11.075.10(d) Refer to W289	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally	MM380	MM380 16.03.11.120.03(a) All environmental concerns cited in the report will be fixed to be in good repair. The Active Treatment Specialist will evaluate the condition of the home noting any areas that require extra attention for	

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12/04/2013
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER RULON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201
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(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
MM380	<p>Continued From page 1</p> <p>washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean and sanitary for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the environment not being kept clean. The findings include:</p> <p>1. During an environmental review conducted on 11/19/13 from 11:00 - 11:30 a.m., the following was noted:</p> <ul style="list-style-type: none"> - There were three toilets in the facility. All three toilets were missing bolt covers. - There were cob webs and dust build-up on the wall vent in Individual #3's bedroom. - There were food splatters on the top interior of the microwave. - There was dried urine on the toilet seat in the bathroom attached to Individual #3's bedroom. - There was a brown build up around the baseboard behind the toilet in the bathroom attached to Individual #3's bedroom. - There was black molded areas on the calking of the bathtub in the bathroom that was attached to Individual #3's bedroom. <p>The facility failed to ensure the facility was kept clean and sanitary.</p>	MM380	<p>cleaning or repair. This will be completed on a monthly basis and reviewed by the Residential Program Director.</p> <p>Corrective Action Completion Date: December 1, 2013</p> <p>Person Responsible: Jesse Atwell, Physical Facilities Manager</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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MM429	Continued From page 2	MM429		
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	MM429 16.03.11.120.11 Refer to W436	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 16.03.11.270.01(d)(i) Refer to W214	
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859	MM859 16.03.11.270.08(f)(i) Refer to W120	