



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 208-364-1886

December 9, 2014

Merinda Halladay, Administrator
Belmont Care Center Crestview
4806 Hawthorne Road
Chubbuck, ID 83202

RE: Belmont Care Center Crestview, Provider #13G050

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure survey of Belmont Care Center Crestview, which was conducted on December 3, 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

Merinda Halladay, Administrator
December 9, 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 **December 22, 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:

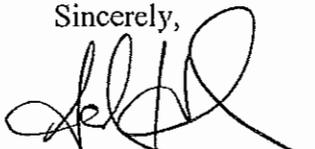
www.icfmr.dhw.idaho.gov

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 December 22, 2014. If a request for informal dispute resolution is received after December 22, 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, option 4.

Sincerely,


ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures



Aspire Human Services, LLC
Belmont Management
4806 Hawthorne Road
Chubbuck, Idaho 83202

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DEC 19 2014

FACILITY STANDARDS

December 16, 2014

Nicole Wisenor, Supervisor Non-Long Term Care
Facility Standards Division of Medicaid
3232 Elder Street
Boise, Idaho 83705-4711

Dear Ms. Wisenor:

Attached is the original copy of the CMS-2567 for Crestview Care Center Survey concluded on 12/3/14. Please call if you or your team has any questions or concerns. I would like to continue to express my gratitude for how professional and helpful Ashley was during this survey. We appreciate the support from you and your team. Ashley has our sincere respect and represented your office in an outstanding manner. Please extend our teams appreciation to her.

Sincerely,

Merinda Halladay
Belmont Mgt. Administrator

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

PRINTED: 12/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER CRESTVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 4024 MOUNTAIN LOOP POCATELLO, ID 83204	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 12/1/14 to 12/3/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Common abbreviations used in this report are: IPP - Individual Program Plan	W 000		
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 the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without the development and implementation of comprehensive plans that identified the drugs' usage and how they may change in relation to progress or regression. The findings include:	W 312		

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DEC 19 2014
FACILITY STANDARDS

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

TITLE

(X6) DATE

M. Halladay *City Director* *12/15/14*

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.

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W 312	<p>Continued From page 1</p> <p>1. Individual #1's IPP, dated 3/26/14, documented a 66 year old male whose diagnoses included moderate mental retardation and major depression, recurrent.</p> <p>a. Individual #1's Medication Reduction Plan, undated, documented he received 100 mg of Zoloft (an antidepressant drug) and 5 mg of Abilify (an antipsychotic drug) daily for major depression and the associated symptoms, including, but not limited to, feeling sad, appearing tearful and decreased interest in activities.</p> <p>Individual #1's Written Informed Consent for Abilify, dated 10/7/14, documented he "would benefit from taking the Abilify to help stabilize his mood...as evidenced by a decrease in [Individual #1's] inappropriate social behavior and a decrease in his depressive type symptoms."</p> <p>However, the Medication Reduction Plan for Abilify did not include increase or reduction criteria for the drug as it related to its effects on inappropriate social behavior.</p> <p>When asked, the Assistant Behavior Specialist stated during an interview on 12/3/14 from 2:00 - 3:00 p.m., both Zoloft and Abilify were used for depressive symptoms as well as inappropriate social behavior and the Medication Management Plan would be updated.</p> <p>b. Individual #1's Medication Reduction Plan documented Individual #1 received melatonin (a supplemental drug) 3 mg to aid with sleep. The Criteria for Reduction stated Individual #1 "needs to sleep for 8 consistent hours without disruption (with the exception of getting up to use the</p>	W 312	<p>POC W312 483.450(e)(2) DRUG USAGE</p> <p>Crestview will ensure that medications used to control inappropriate behavior will only be used as an integral part of the individual program plan that is directed specifically to the reduction of an eventual elimination of the behaviors for which the medications are employed.</p> <p>The medication reduction plan for Individual 1 was reviewed and revisions made to ensure a comprehensive medication plan is in place. In addition, a review of all medication plans will be completed to ensure each individual's medication reduction plans are comprehensive and implemented accordingly.</p> <p>Person Responsible: Assistant Behavior Specialist/BS, RN, LPN, QMRP(s) and City Director.</p> <p>Monitor: These Reduction plans will be monitored through monthly behavioral summaries, during monthly behavioral meetings, and quarterly with the psychiatrist. In addition, the Assistant Behavior Specialist/ BS, QMRP(s), RN, LPN, and City Director will review monthly the status of the consumer and the criteria for reduction or change. The Facility acknowledgement form will include the measurable and specific criteria for reduction, as well as the diagnosis or reasoning for the medication to ensure that all are aware and monitoring the progression or regression of the individual.</p>	2/3/15
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W 312	Continued From page 2 restroom during sleeping hours which he is not awake for more than 15 minutes) for 90% of the time for 3 consecutive months." Individual #1's Behavior Summaries from 4/2014 - 10/2014 were reviewed. The summaries documented Individual #1 met his sleep objective at 100% for each of the 7 months. When asked, during an interview on 12/3/14 from 2:00 - 3:00 p.m., the Assistant Behavior Specialist stated she could not locate documentation related to melatonin reduction. She stated a possible reduction of melatonin should have been discussed when Individual #1 met his sleep objective criteria. The facility failed to ensure comprehensive medication reduction plans were developed and implemented for each of Individual #1's behavior modifying drugs.	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 and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:	W 382		

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W 382	Continued From page 3 1. An observation was conducted at the facility on 12/2/14 from 9:00 - 9:45 a.m. At approximately 9:20 a.m., the direct care staff assigned to medication administration for the shift was noted to assist Individual #4 into the medication room via his gait belt. An environmental review was conducted at the facility on 12/2/14 from 9:45 - 10:35 a.m. At 10:12 a.m., the medication cart was noted to be unlocked with no one present in the medication room. When asked, on 12/2/14 at approximately 10:35 a.m., the direct care staff stated Individual #4 was the last individual to receive medications. Upon reaching the unlocked medication cart, the City Director, present during the environmental review, stated the cart of medications should have been locked. The facility failed to ensure all drugs were locked when not being administered.	W 382	POC W382 483.460(I)(2) DRUG STORAGE AND RECORDKEEPING Crestview will ensure all drugs and biologicals are locked except when being prepared for administration. Staff will ensure the medication cabinet is locked when medications are not being administer. A sign will be posted above the medication cabinet reminding staff to lock it upon completion of medication preparation or administration. Responsible Parties: DSP, Lead DSP, and Home Supervisor. Monitor: Checks will be completed by the Lead DSP following the medication preparation and administration. If the Lead DSP is the medication passer, they will assign a DSP staff to check the medication cabinet. The Home Supervisor will complete random checks while in the home to ensure the cabinet is locked.	<i>2/3/15</i>	

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 12/1/14 to 12/3/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead	M 000		
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	POC MM197 16.03.11.075.10(d) Written Plans Refer to W312	2/3/15
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 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. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 12/2/14 from 9:45 - 10:35 a.m. During	MM380	POC MM380 16.03.11.120.03(a) Building and Equipment Crestview will ensure the building and all equipment is in good repair. Crestview will also ensure the walls and floors are in such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms will have smooth enameled or equally washable surfaces. The building will be kept clean and sanitary, and every reasonable precaution will be taken to prevent the entrance of insects and rodents. 1. Individual #3;s bed drawers will be repaired or replaced.	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

M. Halladay

TITLE

City Director

(X6) DATE

12/15/14

Bureau of Facility Standards

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MM380	<p>Continued From page 1</p> <p>that time, the following was noted:</p> <ul style="list-style-type: none"> - Individual #3's bed frame contained four drawers, three of which were off track and missing stops on the backs to prevent them from falling out. - The footboard of Individual #4's bed was comprised of two wooden panels. One of the panels was pushed through the footboard and laying under his bed. - Both drawers in the second row down of Individual #5's dresser were off track and missing stops on the backs to prevent them from falling out. - In the largest bathroom, the toilet paper roll was connected to an approximately 4 foot by 2 foot panel. The panel had no less than four holes, approximately 1/2 inch in diameter. - There were various stains on the carpet in the common areas; including no less than 10 stains, up to approximately one foot in diameter, in both the common area near individuals' bedrooms and the living room. - In the medication/laundry room, the third drawer under the medication counter was off track and missing stops on the back to prevent it from falling out. - The facility had two ovens, both of which contained food spills and burnt on debris. <p>The facility failed to ensure the environment was kept clean and repairs were completed and maintained.</p>	MM380	<ol style="list-style-type: none"> 3. The footboard panel on Individual #4's bed will be replaced or repaired. 4. The drawers in Individual #5's dresser will be repaired or replaced. 5. The large bathroom panel will be replaced. 6. The carpet in the common areas outside the individuals rooms and in the living area will be cleaned or replaced. 7. The drawer in the laundry room will be repaired or replaced. 8. The ovens have been cleaned. <p>Responsible Parties: Housekeeping Supervisor, Dietary Manager, Home Supervisor, and City Director.</p> <p>Monitor: Bi-monthly the Housekeeping Supervisor will complete a home audit. Monthly the Home Supervisor will complete a monthly audit. Results or repairs will be sent to the City Director. The City Director will work with both Supervisors to ensure repairs or replacements occur within a timely manner.</p>	2/3/15

Bureau of Facility Standards

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MM753	Continued From page 2	MM753		
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	POC MM753 16.03.11.270.02(f)(i) Locked Area Refer to W382	2/3/15