



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

December 30, 2014

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 December 18, 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
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **January 12, 2015**, 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 January 12, 2015. If a request for informal dispute resolution is received after January 12, 2015, 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,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures



January 09, 2015

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

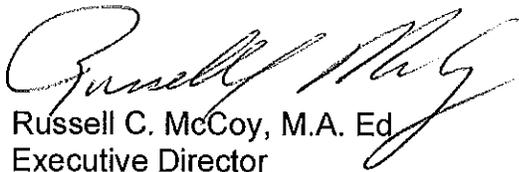
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FACILITY STANDARDS

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the survey completed December 18, 2014. 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,


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

Enclosures

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

PRINTED: 12/29/2014
FORM APPROVED
OMB NO. 0938-0391

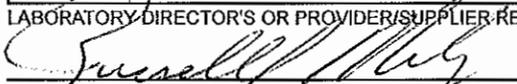
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER RULON HOUSE	STREET 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) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 12/15/14 to 12/18/14.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Lead Ashley Henscheid, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADHD - Attention Deficit Hyperactivity Disorder HRC - Human Rights Committee IEP - Individual Educational Plan IBI - Intensive Behavioral Intervention IPP - Individual Person/Program Plan LPN - Licensed Practical Nurse RD - Registered Dietitian RPD - Residential Program Director</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 and outside service interviews, it was determined the facility failed to ensure outside services met the needs for 1 of 2 individuals (Individual #1) who attended a local school. This resulted in an individual being placed in a time-out room without adequate protection from potentially hazardous conditions within the room. The findings include:</p> <p>1. Individual #1's 2/25/14 IPP stated he was a 19</p>	W 120	<p>W120 483.410(d)(3)</p> <p>For Individual #1 and any other individuals in the facility who receive services through School District #25, the Qualified Intellectual Disabilities Professional will meet with the appropriate personnel to ensure (1) the behavior intervention plan is updated to provide clear and concise instructions for aggressive behaviors and (2) use of the calm room will meet safety requirements. Monthly interviews and observations with the IBI worker will be conducted throughout the school year to ensure the revised practices are being implemented.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 01/15/2015
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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>year old male diagnosed with mild intellectual disability, autism, mood disorder, and seizure disorder.</p> <p>Individual #1 attended a local school, Monday through Friday, from 9:00 a.m. to 3:00 p.m.</p> <p>An observation was conducted at Individual #1's school on 12/16/14 from 10:20 - 11:00 a.m. During that time Individual #1's IBI worker stated the school used a calming room when Individual #1 became agitated and showed the room to the survey team. The IBI worker stated if Individual #1 became aggressive he was directed into the calming room and the IBI worker stepped outside of the room, closed the door, and watched him through the window in the door. If Individual #1 went into an area of the room not visible through the window in the door, he would open the door to keep Individual #1 in his line-of-sight. If Individual #1 was still aggressive and came towards him, he would step outside the room, close the door, and continue to observe him through the window in the door. The IBI worker stated Individual #1 had been placed in the room only 1 time this current school year.</p> <p>During a follow-up interview on 12/16/14 at 12:45 p.m., Individual #1's teacher stated the door to the calming room could be open or closed depending on what was the safest for Individual #1, for the school staff, and other students should Individual #1 become aggressive. The teacher stated Individual #1 was aggressive 1 time this current semester and required a total of 4 individuals (himself, the IBI worker, and two others) to redirect him into the calming room. The door was then closed while he (the teacher) and the IBI worker stood outside the door. They</p>	W 120	<p>Corrective Action Completion Date: February 15, 2015</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>	
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W 120	<p>Continued From page 2</p> <p>watched Individual #1 through the window in the door and if he moved out-of-sight, they opened the door and stood in the doorway. However, when Individual #1 came towards them and was still aggressive, they closed the door and continued to observe him through the window until he calmed.</p> <p>The teacher also provided documentation he received from the IBI worker, dated 11/12/14 at 11:00 a.m., that stated, "...After a short 2-3 minutes in the hall we were able to get [Individual #1] into the room where he can calm down. Due to the fact that I did not observe any behavior leading me to believe that he was getting escalated I did not clear the room. Since the room was not cleared [Individual #1] was able to get an old chair and throw it at the door several times resulting in the chair being broken. As soon as there was an opening I removed the chair out of the room...This event lasted about 30 minutes start to finish."</p> <p>During the observation on 12/16/14 from 10:20 - 11:00 a.m. the room was observed. 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.</p> <p>Individual #1's 3/13/14 IEP included a Behavior Intervention Plan which stated if Individual #1 engaged in aggressive behavior, he would be directed to the calm room, the calm room would be cleared of all things and everyone will exit the room. The plan did not include information regarding how Individual #1 was to be protected from the potentially hazardous conditions within</p>	W 120		

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W 120	Continued From page 3 the room (e.g. uncovered electrical outlets and table corners). During an interview on 12/16/14 from 11:35 a.m. - 12:30 p.m., the RPD stated on 11/11/14 she met with the head of the school district's special education program, Individual #1's teacher, and the IBI worker. The RPD stated the school staff told her Individual #1 would not be left alone in the room as either his teacher or the IBI worker would be with him. However, Behavior Intervention Plan included on Individual #1's 3/13/14 IEP was not updated to include instructions to staff which directed them to remain in the calm room with Individual #1. The facility failed to ensure coordination with the school was sufficient to ensure Individual #1's IEP was updated to reflect the interventions discussed at his 11/11/14 coordination meeting.	W 120			
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure IPPs were revised to reflect and respond to an individual's current needs and functional changes for 1 of 3 individuals (Individual #1) whose IPPs were reviewed. This resulted in an IPP which was not reflective of the individual's current status and needs. The findings include:	W 260	W 260 483.440(f)(2) for individual #1 and all other residents in the facility, the individual Program Plan will be updated to reflect the current nutritional status through use of an addendum to the plan. The Qualified Intellectual Disabilities Professional will obtain clarification from the Registered Dietician on information that may no longer be pertinent to the current plan. Corrective Action Completion Date: February 15, 2015 Person Responsible: Jamie L. Anthony, Residential Program Director		

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W 260	<p>Continued From page 4</p> <p>1. Individual #1's 2/25/14 IPP stated he was a 19 year old male diagnosed with mild intellectual disability and autism. His IPP was reviewed and documented recommended dietary supplements, as follows:</p> <ul style="list-style-type: none"> - DMG (Dimethylglycine, an amino acid) start with 125 mg per day with breakfast and after a few days increase to 250 - 1000 mg - Vitamin B6 (water soluble vitamin and cofactor in amino acid, lipid, and glucose metabolism) 500-100 mg - Magnesium (a mineral involved in more than 300 chemical reactions in the body) 400 mg - Vitamin C (an anti-oxidant) 1000-1500 mg <p>Individual #1's 6/4/12 Diet Note documented the RD attended a Nutrition and Autism presentation and discussed with the presenter Individual #1's dietary supplements as identified above. The facility's RD recommended to "hold off on the proposed dietary treatments until the results of...clinical research are available..." The entry was signed by the facility's RD.</p> <p>During an interview on 12/17/14 at 11:34 a.m., the RD stated in 2012 she recommended to hold off on the proposed dietary supplements until the results of clinical research for effectiveness of the supplements was made available to the public.</p> <p>When asked during an interview on 12/18/14 from 9:08 - 10:38 a.m., both the RPD and the LPN stated in 2012 the RD attended a Nutrition and Autism presentation and discussed the</p>	W 260			

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W 260	Continued From page 5 presentation with the facility. At that time, it was decided to not implement the above identified dietary supplements and Individual #1's IPP should have been updated.	W 260			
W 262	The facility failed to revise and update Individual #1's IPP related to his nutritional status. 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE 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 observation, record review, staff interview and environmental review, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 1 of 3 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #2's 8/5/14 IPP stated he was a 13 year old male whose diagnoses included autism and moderate mental retardation. Individual #2's record was reviewed and documented the use of restrictive interventions without HRC approval, as follows: a. Individual #2's Physician's Orders Progress Record, dated 11/13/14, documented Individual	W 262	W262 483.440(f)(3)(i) For Individual #2, 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: February 15, 2015 Person Responsible: Jamie L. Anthony, Residential Program Director		

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W 262	<p>Continued From page 6</p> <p>#2 received diphenhydramine (an antihistamine drug) 50 mg daily.</p> <p>Individual #2's Medication Profile, reviewed 11/2014, documented diphenhydramine was originally prescribed on 8/13/14 for 25 mg daily as a sleep aid. The profile documented the medication was increased to 50 mg daily on 8/20/14.</p> <p>However, Individual #2's record did not include HRC approval for the use of either dose of diphenhydramine.</p> <p>b. Individual #2's Consent to Treat, dated 7/7/14, documented Individual #2 had a one-on-one staff from 7:00 a.m. - 9:00 p.m. The consent documented "This is due to his history of aggression and elopement, which can be a danger to him and others."</p> <p>During observations of Individual #2 conducted on 12/15/14 and 12/16/14 for a cumulative 2 hours, Individual #2 was consistently observed to work with a staff member one-on-one.</p> <p>However, Individual #2's record did not include HRC approval for the use of one-on-one staffing.</p> <p>c. During observations conducted in the facility on 12/15/14 and 12/16/14 for a cumulative 6 hours and 20 minutes, video cameras were noted to be mounted near the ceiling in the common areas of the facility.</p> <p>During an environmental review on 12/17/14 from 2:35 - 3:00 p.m., a camera monitor was observed and included multiple windows providing live feed from the video cameras.</p>	W 262		
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W 262	Continued From page 7 However, Individual #2's record did not include HRC approval for the use of video surveillance. d. Individual #2's IPP documented Individual #2 "has a frequent tendency to run away or attempt to elope from the home...His mother stated that he would probably use the window in his bedroom as an escape route. Since he does not have a roommate at this time, it was decided to add an alarm on his window to prevent him from using this as an escape route without staff knowledge." During an environmental review on 12/17/14 from 2:35 - 3:00 p.m., Individual #2's bedroom window was noted to have an alarm attached which sounded upon opening the window. However, Individual #2's record did not include HRC approval for the use of a window alarm. e. During an environmental review on 12/17/14 from 2:35 - 3:00 p.m., the door leading outside from the downstairs common area was noted to have an alarm attached which sounded upon opening the door. However, Individual #2's record did not include HRC approval for the use of a door alarm. During an interview on 12/18/14 from 9:08 - 10:38 a.m., the RPD stated HRC approval for the interventions had been missed. The facility failed to ensure HRC approval was received prior to the implementation of Individual #2's restrictive interventions.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING &	W 263	W263 483.440(f)(3)(ii)	

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W 263	<p>Continued From page 8 CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, staff interview and environmental review, it was determined the facility failed to ensure written guardian consent was obtained prior to the implementation of restrictive interventions for 1 of 3 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior consent of restrictive interventions. The findings include:</p> <p>1. Individual #2's 8/5/14 IPP stated he was a 13 year old male whose diagnoses included autism and moderate mental retardation. Individual #2's record was reviewed and documented the use of restrictive interventions without guardian consent, as follows:</p> <p>a. Individual #2's Physician's Orders Progress Record, dated 11/13/14, documented Individual #2 received diphenhydramine (an antihistamine drug) 50 mg daily.</p> <p>Individual #2's Medication Profile, reviewed 11/2014, documented diphenhydramine was originally prescribed on 8/13/14 for 25 mg daily as a sleep aid. The profile documented the medication was increased to 50 mg on 8/20/14.</p> <p>However, Individual #2's record did not include</p>	W 263	<p>For Individual #2, 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.</p> <p>Corrective Action Completion Date: February 15, 2015</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>		

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W 263	<p>Continued From page 9</p> <p>written guardian consent for the use of either dose of diphenhydramine.</p> <p>b. Individual #2's IPP documented Individual #2 "has a frequent tendency to run away or attempt to elope from the home...His mother stated that he would probably use the window in his bedroom as an escape route. Since he does not have a roommate at this time, it was decided to add an alarm on his window to prevent him from using this as an escape route without staff knowledge."</p> <p>During an environmental review on 12/17/14 from 2:35 - 3:00 p.m., Individual #2's bedroom window was noted to have an alarm attached which sounded upon opening the window.</p> <p>However, Individual #2's record did not include written guardian consent for the use of a window alarm.</p> <p>c. During an environmental review on 12/17/14 from 2:35 - 3:00 p.m., the door leading outside from the downstairs common area was noted to have an alarm attached which sounded upon opening the door.</p> <p>However, Individual #2's record did not include written guardian consent for the use of a door alarm.</p> <p>During an interview on 12/18/14 from 9:08 - 10:38 a.m., the RPD stated both the window and door alarms had been discussed with Individual #2's guardian at Individual #2's IPP meeting. The RPD stated Individual #2's guardian started the idea for the alarms, but she could not locate written guardian consent.</p>	W 263			

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

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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 12/18/2014	
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W 263	Continued From page 10 The LPN, also present during the interview, stated she thought she had guardian consent for Individual #2's medication and would look for it. As of 12/22/14 at 8:00 a.m., no consent was submitted.	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 eventual elimination of, the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #2) whose medication reduction plans were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified the drug's usage and how it may change in relation to progress or regress. The findings include: 1. Individual #2's 8/5/14 IPP stated he was a 13 year old male whose diagnoses included autism, ADHD and moderate mental retardation.	W 312	W312 483.450(e)(2) For Individual #2 as well as the other individuals in the facility, the medication reduction plans will be revised to include all prescribed psychotropic medications. 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: February 15, 2015 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 312	Continued From page 11 Individual #2's Physician's Orders Progress Record, dated 11/13/14, documented he received Risperdal (an antipsychotic drug) 4 mg daily. Individual #2's Consent for Treatment for Risperdal, dated 7/22/14, documented Risperdal was prescribed so Individual #2 "will have decreased numbers of aggression, self injurious behaviors and destruction of property. Will be less aggitated [sic] which often leads to attempted elopment [sic]." However, Individual #2's Medication Reduction Plan, dated 7/7/14, did not include a plan related to the use, and eventual reduction, of Risperdal. During an interview on 12/18/14 from 9:08 - 10:38 a.m., the RPD stated she did not add Risperdal to Individual #2's reduction plan. The facility failed to ensure Individual #2's Risperdal was appropriately incorporated into a plan.	W 312			
W 440	483.470(i)(1) EVACUATION DRILLS 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 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals'	W 440	W440 483.470(i)(1) 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 18, 2014 Person Responsible: Jamie L. Anthony, Residential Program Director		

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W 440	<p>Continued From page 12 responses to emergencies or identify problem areas. The findings include:</p> <p>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.</p> <p>During an interview on 12/16/14 at 12:21 p.m., the RPD stated the drill had not been completed due to an oversight.</p> <p>The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.</p>	W 440			

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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the annual licensing survey conducted from 12/15/14 to 12/18/14.</p> <p>The survey was conducted by:</p> <p>Karen Marshall, MS, RD, LD, Team Lead Ashley Henscheid, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ATS - Active Treatment Specialist</p>	M 000		
MM194	<p>16.03.11.075.10(a) Approval of Human Rights Committee</p> <p>Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.</p>	MM194	<p>MM194 16.03.11.075.10(a)</p> <p>Refer to W262</p>	
MM196	<p>16.03.11.075.10(c) Consent of Parent or Guardian</p> <p>Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.</p>	MM196	<p>MM196 16.03.11.075.10(c)</p> <p>Refer to W263</p>	
MM197	<p>16.03.11.075.10(d) Written Plans</p> <p>Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.</p>	MM197	<p>MM197 16.03.11.075.10(d)</p> <p>Refer to W312</p>	

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MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. On 12/17/14 from 2:35 - 3:00 p.m., an environmental review was conducted with the ATS. During that time, the following was noted:</p> <ul style="list-style-type: none"> - There were multiple stains of various size on the carpet in the sensory room. - The upper, right drawer of Individual #1's dresser was off track and missing a stop on the back to prevent it from falling out. - Individual #2's bedroom had a strong, urine-like odor. - There were multiple stains on the carpet in Individual #2's bedroom, including multiple small, circular, black stains and a red stain no less than 5 inches in diameter. - The second and third drawer of Individual #2's dresser were off track and missing stops on the 	MM380	<p>MM380 16.03.11.120(a)</p> <ul style="list-style-type: none"> - The carpet in the sensory room will be cleaned by a professional carpet cleaner - Individual #1's dresser will be fixed. - Individual #2 room will be thoroughly cleaned to eliminate any foul odors - The carpet in Individual #2 room will be cleaned by a professional carpet cleaner - Individual #2's dresser will be fixed - Individual #3's dresser will be fixed - Individual #5's dresser will be fixed - The downstairs bathroom will be thoroughly cleaned to eliminate any stains. - The dining room chairs will be thoroughly cleaned to eliminate the stains <p>The items will be assessed on a quarterly basis to prevent any further issues from arising.</p> <p>Corrective Action Completion Date: February 15, 2015</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director</p>	
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MM380	Continued From page 2 backs to prevent them from falling out. - The second, third and fifth drawer of Individual #3's dresser were off track and missing stops on the backs to prevent them from falling out. - All five drawers of Individual #5's dresser were off track and missing stops on the backs to prevent them from falling out. - There was a brown substance on the floor around the base of the toilet pedestal located in the downstairs common area bathroom. - There were multiple stains on the seats and backs of 3 of 5 upholstered dining chairs. The ATS was interviewed and stated the 3 upholstered chairs were in need of cleaning. The facility failed to ensure the environment was kept clean and repairs were completed and maintained.	MM380		
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	
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by:	MM861	MM861 16.03.11.270.08(f)(iii) Refer to W260	

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MM861	Continued From page 3 Refer to W260.	MM861		