

Statement of Deficiencies

Residential Habilitation Agency

Inclusion South, Inc.
RHA-270

1122 Eastland Dr N Ste 1
Twin Falls, ID 83301-
(208) 888-1758

Survey Type: Investigation

Entrance Date: 6/12/2014

Exit Date: 6/13/2014

Initial Comments: Surveyors assigned to investigate: Pam Loveland-Schmidt, Medical Program Specialist, Licensing & Certification; and Kerrie Ann Hull, Medical Program Specialist, Licensing & Certification.
140822-Mailed/emailed SOD, POC letter and list. Cert# 7012 3050 0001 2128 2767

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
<p>16.04.17.203.03</p> <p>203. STAFF RESIDENTIAL HABILITATION PROVIDER TRAINING. Training must include orientation and ongoing training at a minimum as required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 700 through 706. Training is to be a part of the orientation training and is required initially prior to accepting participants. All required training must be completed within six (6) months of employment with a residential habilitation agency and documented in the employee residential habilitation provider record. The agency must ensure that all employees and contractors receive orientation training in the following areas: (3-29-12) 03. Understanding of Participants' Needs. A basic understanding of the needs, desires, goals and objectives of participants served. (3-20-04)</p>	<p>Three of four employee record review lacked documentation prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include training specific to the needs of the participant.</p> <p>For example: The agency had a training summary sheet, but did not address training specific to Participant 1 and 2's needs. Discussed with the Program Manager and she stated they do not have that documentation. Participant has a dual diagnosis and has specific medical needs, but no documentation/evidence training occurred. Participant 2 requires reminding/prompting to utilize medical equipment at night, but no documentation/evidence training occurred. In addition, the same staff lack documentation they have received ongoing training specific to</p>	<p>1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. The agency has developed participant information sheets that are trained to staff as part of orientation. But, the core information will be in the PIPs.</p> <p>2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All staff will be retrained on the information sheets despite having received it previously.</p> <p>3. Who will be responsible for implementing each corrective action? Administrator or designee</p>	<p>10/1/14</p>

	<p>the needs of the participant as needed and training on a basic understanding of the needs, desires, goals and objectives of participants served. For example: No documentation the staff has been trained on the participant's goals and objectives for participant 1 and 2.</p> <p>Also see IDAPA 16.03.10.705.01.c.ix; and 16.03.10.705.01.e</p>	<p>4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored ongoing, upon hire, and quarterly as part of the QA program.</p>	
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Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
<p>16.04.17.302.03 302. SERVICE PROVISION PROCEDURES. 03. Periodic Review. Review of services and participant satisfaction must be conducted at least quarterly or more often if required by the participant's condition or program. (3-20-04)</p>	<p>Two of two participant record reviews lack documentation. A review of services and participant satisfaction must be conducted at least quarterly or more often if required by the participant's condition or program. For example: There is no documentation of periodic review of services (quarterly) to address the participant's condition or program. After multiple requests received the provider status review's (PSR) for both individuals. The PSR's state to continue running objectives that have met the goal. For example: Participant 2's PSR for objective "Eats Nutritious Meals at a regular time each day with 3 direct verbal cues with 55% proficiency averaged monthly for three consecutive months by 01/02/15." Data documents he met the goal requirement for three months (01/14-57%; 02/14-56%; 03/14-57%) with no changes. Participant 1 no documentation submitted for quarterly review of his condition or programs</p>	<p>1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Training of compliance expectations will be provided to professionals. Changes to services will also be made and reflected in the provider status reviews. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All professionals will be retrained and all objectives will be reviewed to determine if changes are necessary. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored monthly when outcomes for provider status reviews are generated.</p>	<p>10/10/14</p>

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
<p>16.04.17.302.04</p> <p>302. SERVICE PROVISION PROCEDURES.</p> <p>04. Medication Standards. The agency must maintain a policy describing the program's system for handling participant medications which is in compliance with the IDAPA 23.01.01, "Rules of the Board of Nursing." (3-20-04)</p>	<p>Two of two participant record review lacked evidence the agency staff comply with the agency policy describing the program's system for handling participant medications which is in compliance with the IDAPA 23.01.01, "Rules of the Board of Nursing."</p> <p>For example: Participant 2 's 8pm medications were removed from the bubble pack but not taken and left in the medication box; 8pm medications for 06/01/14,06/04/14, 06/05/14, 06/08/14, 06/10/14,06/12/14, 06/14/14, 06/17/14-06/22/14 and 06/23/14 were removed from the bubble pack but no documentation on the bubble pack the medication was given it was left blank-no initials. Some medication bubble packs indicated participant refused medication(s); some medications were left blank on the medication log with no signature or initial, unknown if the medication was given. Discussed the medication process with day staff and participant. The participant stated the staff is to get his medications out, the participant is to pop the medication out of the bubble pack and take while staff watches him take the medication, then the staff documents the medication was taken. The</p>	<p>1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Retraining of the assistance with medication standards will be rendered to the staff, including documenting the agency's assistance.</p> <p>2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All staff will be retrained</p> <p>3. Who will be responsible for implementing each corrective action? Administrator or designee</p> <p>4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This ill be monitored ongoing and quarterly as part of the QA program</p>	<p>10/1/14</p>

	<p>staff marks 'refused' if he does not take the medications at 8:00pm; he wants to take them at 9:00pm. The day staff stated he has an hour either way from the scheduled time which 9:00pm is within that time line. Unable to determine what protocol or process the agency was following regarding the one hour timeline. No evidence this was part of the medication policy/procedure or part of the medication instructions.</p> <p>Per agency policy the staff is required to complete the medication shift count sheet. The shift count sheet for Participant 2 were missing information on medication shift count sheet for some medications.</p> <p>In addition the controlled drug records were missing signature of staff completing the count/record.</p> <p>Also, Participant 2 is to wear oxygen at night and the documentation listed on the medication log states he refused 06/17/14-06/20/14.</p>		
Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
<p>16.04.17.400.01</p> <p>400. PARTICIPANT RECORDS.</p> <p>01. Participant Records. Each agency must have and maintain a written policy outlining the required content of participant records, criteria for completeness, and methodology to be used to ensure current and accurate records. An individual record must be maintained for each participant and retained for a period of three (3) years following the participant's termination of services. All entries made into a participant record must be dated and signed in ink. (3-20-04)</p>	<p>Two of two participant record review lack documentation the agency assures staff comply with the agency written policy outlining the required content of participant records, criteria for completeness, and methodology to be used to ensure current and accurate records. An individual record must be maintained for each participant and retained for a period of three (3) years following the participant's termination of services. All entries made into a participant record must be dated and signed in ink.</p> <p>For example: The data sheet for participant 1 has no data documented for services provided on 6/23/14 (7am-3pm shift). Participant 2 has no documentation within the logs from 6/22/14</p>	<p>1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report.</p> <p>All staff will be retrained on data collection procedures for formal services and those who fail to comply will be terminated. The agency documents supports that may/may not have data collected, but is evidence of services rendered.</p> <p>2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken?</p> <p>All staff will be trained on the data collections expectations.</p>	<p>10/1/14</p>

(7am) until 6/23/14 at (11pm).

3. Who will be responsible for implementing each corrective action?

Administrator or designee

4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur?

This will be monitored ongoing, monthly, and quarterly as part of the QA program.

Administrator/Provider Signature:

Date:

9/16/14

Department POC Approval Signature:

Date:

9/22/14

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.