COPY

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 208-334-6628
FAX 208-364-1888

CERTIFIED MAIL: 70070710000279790802

August 13, 2010

Russell McCoy, Administrator
Church Hill Downs
415 South Arthur
Pocatello, ID 83204

RE: Church Hill Downs, Provider #13G043

Dear Mr. McCoy:

Based on the Medicaid survey completed at Church Hill Downs on July 30, 2010, we have determined that Church Hill Downs is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of **Participation on Client Protections (42 CFR 483.420) and Client Behavior and Facility Practices (42CRF 483.450)**. To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Church Hill Downs to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **September 12, 2010**. **To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than September 2, 2010**.

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Church Hill Downs is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective July 30, 2010, through November 27, 2010. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **September 10, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of

the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 Informational Letter #2007-02. State Informational Letter #2007-02 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/ICFMR/tabid/431/Default.aspx

This request must be received by August 26, 2010. If a request for informal dispute resolution is received after August 26, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

M. Nielsen

MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/srp
Enclosures

DEVELOPMENTAL OPTIONS
PROMOTING FUNCTIONAL INDEPENDENCE THROUGH PERSON-CENTERED SERVICES

August 26, 2010

RECEIVED
AUG 31 2010
FACILITY STANDARDS

Ms. Nicole Wisenor, Co-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

Dear Ms. Wisenor:

The staff of Developmental Options has worked diligently for the past few weeks doing corrective action based on the *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Church Hill Downs Group Home for the survey completed July 30, 2010. We have made substantial changes in the operation of this home that we believe provide the necessary corrections to assure compliance with the Condition of Participation on Client Protections (42 CFR 483.420) and Client Behavior and Facility Practices (42 CFR 483.450). In that respect, we would like to invite the Survey Team to revisit the facility and verify that the corrections have been made.

In summary, we have completed the following activities that we believe contribute to meeting these Conditions of Participation:

Condition of Participation – Client Protections:

1) The facility has identified a resident representative for Individual #2 and has submitted an application to the Bannock County Board of Community Guardians for full guardianship. Once the proper paperwork is completed for the resident representative, the appropriate consents will be obtained. For all residents, we are in the process of encouraging family members to become legal guardians and we will ensure that each resident has a resident representative involved with their treatment plan until a guardian is identified.
2) The Suicide Prevention Procedure has been revised to address all of the concerns listed in the survey report from July 30, 2010. Church Hill Downs staff members were trained on the new procedure during their staff meeting on August 25, 2010. They were each given their own copy of the procedure for further review and reference.

Condition of Participation – Behavior and Facility Practices

1) The Behavior Management Programs have been reviewed by the QMRP for appropriate replacement behaviors and interventions to promote safety. Revisions will be implemented once appropriate consents are obtained by guardian/resident representative and Human Rights Committee (if necessary). Revisions will include clear instructions for staff members to promote the safety of the individuals and staff will be thoroughly trained to implement these programs.
2) The Behavior Management Policy was reviewed and revised by the Treatment team. This included reviewing classification of levels of restriction, definitions and techniques in the policy.
3) The medication reduction plans were written (for any that were missing) and others were reviewed for accuracy. Revisions were made where errors were found.

Russell C. McCoy, Executive Director • rmccoy@ida.net
415 South Arthur • Pocatello, Idaho 83204 • Phone (208) 233-6833 • Fax (208) 233-6842 • doptions@ida.net • www.developmentaloptions.com

There have been many other adjustments and changes made that are reflected in the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION,* however, the above are the critical elements. If there is any additional information you require or clarifications you may need, please contact me or Jamie Anthony, Residential Program Director, at the address or telephone number listed.

Sincerely,

Russell C. McCoy, MA Ed.
Executive Director

Enclosures

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

PRINTED: 08/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: ATS - Active Treatment Specialist BMP - Behavior Management Program EMT - Emergency Medical Technician GERD - Gastroesophageal Reflux Disease HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse NOS - Not Otherwise Specified PICA - Ingestion of non-edible items QMRP - Qualified Mental Retardation Professional SIR - Significant Incident Report	W 000	RECEIVED AUG 31 2010 FACILITY STANDARDS	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, review of the facility's policies and procedures, significant incident reports, record review, and individual and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals' health, safety and rights. These failures resulted in a lack of effective systems to ensure	W 122	**W 122 483.420** Refer to W 124 Refer to W 125 Refer to W 137 Refer to W 149	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 08/26/10

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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 122	Continued From page 1 individuals were safe and their rights were upheld. The findings include: 1. Refer to W124 as it relates to the facility's failure to ensure individuals who were their own guardians were able to give informed consent for restrictive interventions. 2. Refer to W125 as it relates to the facility's failure to ensure individuals were taught and encouraged to exercise their rights and that guardianship was actively pursued for individuals who were not able to give informed consent for restrictive interventions. 3. Refer to W137 as it relates to the facility's failure to ensure an individual's right to retain and use personal possessions was upheld. 4. Refer to W149 as it relates to the facility's failure to ensure the facility's policy and procedures to prevent suicide were adequately developed and implemented. The cumulative effect of these negative facility practices significantly impeded the ability of the facility to provide services necessary to ensure individuals health, safety and rights were protected.	W 122		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124	**W 124 483.420(a)(2)** For individual #2, the facility will approach various agencies and potential volunteers to assist her with making informed consent. Individual #2 has no family members to approach. Once an appropriate advocate has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 124	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual who was her own guardian was able to consent to restrictive interventions for 1 of 2 individuals (Individual #2) who were their own legal guardians. This resulted in an individual consenting to restrictive interventions without the ability to do so. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. Individual #2's Physician's Orders, dated 5/13/10, showed she received the following behavior modify drugs: Tegretol (an anticonvulsant drug) 200 mg three times a day, Geodon (an antipsychotic drug) 160 mg daily, Celexa (an antidepressant drug) 40 mg each day, and Clonazepam (an anticonvulsant drug) 1 mg daily, as needed, for severe agitation. Individual #2's record contained a consent, dated 1/28/10, related to her behavior modifying drugs. The consent included definitions of her maladaptive behaviors and listed her behavior modify drugs and their benefits, side effects, risks, and alternatives. The consent stated Individual #2's behavior program did not contain any restrictive elements and her current behavior plan was the first behavior program since her admission on 3/7/07. Further, under the section titled "Other" within the above noted consent, it	W 124	identified and in place, informed consent will be obtained. The Qualified Mental Retardation Profession will review the other individual's charts to ensure that a guardian or family members is assisting with informed consent. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 124	Continued From page 3 stated "[Individual #2] has a schedule program in which she can earn free time. Her gameboy/tomagachi pets and other electronics are kept locked up and used as a reinforce [sic] for staying on task." The consent contained Individual #2's signature as well as various signatures from the facility's HRC. However, Individual #2's Human Rights Assessment, dated 10/6/09, showed she did not understand what was meant by a "right" unless it was explained to her, she did not understand her right to be free from unnecessary restraints, and she thought it was okay if the facility made her do work for the facility. Further, the Assessment showed she did not understand due process even after it was explained to her. Individual #2's record also contained an untitled document, dated 2/24/10, which stated she did not understand the risks and benefits of her current treatment and that there were alternative treatments available. The document stated she was not able to express a decision and then provide a rationale for making that decision. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 was not able to give informed consent. Without the knowledge and ability to understand the information, Individual #2 could not give informed consent for the use of her behavior modifying drugs and the restriction of her personal possessions. The facility failed to ensure Individual #2's rights were protected by obtaining informed consent	W 124		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 124	Continued From page 4 prior to restrictive interventions being used.	W 124		
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 record review and staff interview, it was determined the facility failed to ensure each individual's need for rights education and/or guardianship was addressed for 1 of 2 individuals (Individual #2) who were their own legal guardians. Failure to provide education or obtain guardianship did not ensure the individual's rights were protected. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. Individual #2's Physician's Orders, dated 5/13/10, showed she received the following behavior modify drugs: Tegretol (an anticonvulsant drug) 200 mg three times a day, Geodon (an antipsychotic drug) 160 mg daily, Celexa (an antidepressant drug) 40 mg each day, and Clonazepam (an anticonvulsant drug) 1 mg daily, as needed, for severe agitation. Individual #2's record contained a consent, dated	W 125	**W 125 483.420(a)(3)** **For individual #2, the facility will submit an application to the Bannock County Board of Community Guardians. The Qualified Mental Retardation Profession will review the other individual's charts to ensure that a guardian is present. If a guardian is not present, measures will be taken to encourage a family member to become a guardian.** **Corrective Action Completion Date: September 1, 2010** **Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 125	Continued From page 5 1/28/10, related to her behavior modifying drugs. The consent included definitions of her maladaptive behaviors and listed her behavior modify drugs and their benefits, side effects, risks, and alternatives. The consent stated Individual #2's behavior program did not contain any restrictive elements and her current behavior plan was the first behavior program since her admission on 3/7/07. Further, under the section titled "Other" within the above noted consent, it stated "[Individual #2] has a schedule program in which she can earn free time. Her gameboy/tomagachi pets and other electronics are kept locked up and used as a reinforce [sic] for staying on task." The consent contained Individual #2's signature as well as various signatures from the facility's HRC. However, Individual #2's Human Rights Assessment, dated 10/6/09, showed she did not understand what was meant by a "right" unless it was explained to her, she did not understand her right to be free from unnecessary restraints, and she thought it was okay if the facility made her do work for the facility. Further, the Assessment showed she did not understand due process even after it was explained to her. Individual #2's record also contained an untitled document, dated 2/24/10, which stated she did not understand the risks and benefits of her current treatment and that there were alternative treatments available. The document stated she was not able to express a decision and then provide a rationale for making that decision. Individual #2's record documented she did not have the knowledge and ability to give informed consent. However, no other documentation of	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 125	Continued From page 6 rights education or outside advocacy (i.e. an appointed guardian or representative) was present in her record. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 was not able to give informed consent and nothing had been done within the last year to pursue a guardian for Individual #2. The facility failed to ensure Individual #2's rights were protected by ensuring her ability to give informed consent or by assisting her to obtain a guardian to advocate on her behalf prior to restrictive interventions being used.	W 125		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS 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 individual and staff interviews, it was determined the facility failed to ensure sufficient systems had been developed and implemented to ensure individuals' rights to retain personal possessions was upheld for 1 of 1 individual (Individual #2) whose daily schedule was reviewed. This resulted in an individual's possessions being restricted. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and	W 137	**W 137 483.420(a)(12)** **For individual #2, the facility will provide her with a locking container so that she can lock up her own possessions if the suicide protocol is required because of individual #1. She will be given a key for her own use during the time this protocol is implemented. The suicide prevention policy will be revised addressing the topic of personal possessions. Individual #2 did not have a personal television. For individual #2, the facility will approach various agencies and potential volunteers to assist her with making informed consent regarding the removal of her gameboy/tomagachi toys (if the challenge of this restrictive element does not work). Individual #2 has no family members to approach.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 137	Continued From page 7 personality disorder NOS. Her record showed she was her own guardian. During an observation on 7/26/10 from 3:10 - 4:00 p.m., it was noted that a cardboard box was sitting on the floor of the office (which was also used for medication administration). The box contained various items including personal grooming products, books, and trinkets. A plastic milk crate was sitting opposite the box and contained a similar variety of personal grooming items. When asked, present staff stated the box of items belonged to Individual #1 and the crate belonged to Individual #2. Staff stated the items were removed from Individual #1 and #2's bedroom the evening of 7/24/10, per LPN orders, due to Individual #1 ingesting hand sanitizer in the office that same evening. Individual #1 and #2 agreed to be interviewed during the observation. Both stated they did not know when their personal items would be returned to them. When asked about the removal of Individual #2's possessions when Individual #1 threatened suicide, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., that Individual #2 said it was okay. However, no documentation (informed consents, assessment information, program interventions, etc.) related to the removal of Individual #2's personal possessions as a result of Individual #1 threatening suicide could be found in Individual #2's records. During an observation on 7/27/10 from 6:37 - 9:08 a.m., Individual #2's gameboy and tomagachi electronic pets were noted to be locked in the medication cabinet. Further, during an observation on 7/27/10 from 2:05 - 3:05 p.m.,	W 137	**Corrective Action Completion Date: September 1, 2010** **Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 137	Continued From page 8 Individual #2 reported to the survey team her television had been taken away from her and stored in the garage. Individual #2's record contained a consent, dated 1/28/10. Under the section titled "Other" within the consent, it stated "[Individual #2] has a schedule program in which she can earn free time. Her gameboy/tomagachi pets and other electronics are kept locked up and used as a reinforce [sic] for staying on task." The consent contained Individual #2's signature as well as various signatures from the facility's HRC. However, Individual #2's Human Rights Assessment, dated 10/6/09, showed she did not understand what was meant by a "right" unless it was explained to her, she did not understand her right to be free from unnecessary restraints, and she thought it was okay if the facility made her do work for the facility. Further, the Assessment showed she did not understand due process even after it was explained to her. Individual #2's record also contained an untitled document, dated 2/24/10, which stated she did not understand the risks and benefits of her current treatment and that there were alternative treatments available. The document stated she was not able to express a decision and then provide a rationale for making that decision. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 was not able to give informed consent. Without the knowledge and ability to understand the information, Individual #2 could not give	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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 137	Continued From page 9 informed consent for the restriction of her personal possessions when Individual #1 threatened suicide or when she failed to follow her schedule. The facility failed to ensure Individual #2's right to retain and use personal possessions was upheld.	W 137		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, review of significant incident reports and the facility's suicide policy, record review, and individual and staff interviews, it was determined the facility failed to adequately develop policies necessary to provide sufficient assessment and monitoring of individuals with suicidal ideation and mental health issues. This directly affected 1 of 1 individual reviewed who engaged in suicidal ideation (Individual #1), and had the potential to affect all individuals (Individuals #1 - #8) residing at the facility. This resulted in a lack of understanding, assessment, and monitoring to keep an individual safe. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. Individual #1's records	W 149	**W 149 483.420(d)(1)** **The facility has revised the Suicide Prevention Policy that will affect individual #1 and all current and future clients of the facility. All current direct care and management staff have been trained in the new procedures and these will be reviewed quarterly in staff meetings. Additionally, all new staff at this home will be trained in this procedure as part of their orientation.** **Corrective Action Completion Date: September 1, 2010** **Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 10 from her previous placement showed borderline personality disorder was secondary to her general medical condition including traumatic brain injury. Her medical reports showed she had an extensive medical history including hypothyroidism, high blood pressure, GERD, chronic renal failure type II, chronic pain issues, history of obstructive sleep apnea, history of congestive heart failure, chronic bilateral lower extremity pedal edema, and seizure disorder. Individual #1's records from her previous placement were reviewed and showed the following history: Individual #1's Functional Assessment, compiled from 12/5/08 through 7/27/09, from her previous placement stated the reason for her admission included "an extensive history of behaviors that were dangerous to herself (e.g. suicide attempts, self-injurious behaviors, etc.) or to others (e.g. verbal and physical assaults) and she was unable to be safely managed in a less restrictive placement (e.g. incarcerated from 11/11/08 until admission to [a psychiatric facility] on 11/21/08)." The Assessment stated she had an extensive history of combative, aggressive and self-injurious behaviors and had "significant problems with impulsive behavior, low frustration tolerance, emotional instability especially depression, aggression as evidenced by physical assaults and self injury (i.e. insertion, PICA, burning, biting, cutting) and suicide ideation (i.e. threats, attempts). These continue to be ongoing issues for [Individual #1]." The assessment stated Individual #1 had a	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 11 complicated psychiatric history that included multiple psychiatric admissions and "The behaviors that [Individual #1] exhibits are significant and present a danger to her and others and significantly affect her overall quality of life." The Assessment included a "Suicide Assessment Review" which stated Individual #1 made suicide threats or was placed on suicide precautions up to 26 times within the year. "There are several themes within the content of discussions in the assessments. They include 1) [Individual #1] reports she wanted attention, 2) [Individual #1] states she is in pain, 3) peer conflicts are upsetting [Individual #1], 4) [Individual #1] saying she is hearing voices that say to harm self, and 5) [Individual #1] indicates she wants to die or hurt self as she feels depressed. It is noted that [Individual #1] may fluctuate between more than one theme during and/or following assessments. The majority of the suicide assessment results in [Individual #1] being place on enhanced supervision for a period of time, turning in items she can hurt herself with or a combination of both. [Individual #1] refused to talk with the assessor on a few occasions indicating to [sic] angry to talk. At these times precautions remained in place until assessment could involve [Individual #1]. [Individual #1] indicates suicide ideation in several ways. The most common is making a statement such as 'I'm going to kill myself.' At other times she states she will drink/eat something or on the converse refuse to eat/drink. [Individual #1] will also state she is going to stab or shoot herself." Individual #1 continued to express suicidal ideation and acts after she was admitted to the facility on 5/17/10. However, the facility's suicide	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 12 policy was not sufficiently developed and implemented necessary to ensure her safety as follows: The facility's Policy on Suicide Precautions, dated 5/25/10, included the following definitions: historical significant injuries from self injury, attempts to take an overdose of medication, gesturing acts of self injury (e.g. pointing to a knife then gesturing towards one's neck), self destructive behavior resulting in injury, verbal threats indicating they are going to kill themselves, and ingestion of toxic substances. Under the section of the policy titled Procedures, it stated if a resident engaged in self mutilating behavior, had an injury, or ingested a toxic substance, staff were to immediately call 911. The policy stated if a resident was threatening suicide including verbal or gestured threats, staff were to first ensure the resident was safe. Safe was defined as "Removal of any harmful implement or substance within the vicinity of that individual within the home (example: sharp objects, toxins, cords, shoe laces, belts, etc.). Block further attempts or any attempts of self abuse." The policy stated a second staff was to call the Administrator and the Administrator was to call the "emergency cell" for additional staff support and call the resident's parent or guardian. The facility's policy stated staff were to then call the local hospital's behavioral health services office "to consult with mental health professionals about the state and condition of the individual who is suicidal." The policy stated staff "will obtain and implement the recommendation of the Mental Health Program Professional...and...will ask the...professional to determine what level of care	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 13 the resident will require: Retention in the group home with increased staffing and surveillance...transportation to [the local hospital's emergency room] via staff...ambulance...or...police." The facility's policy stated if the recommendation was to remain in the home environment, staff were to conduct visual observations of the resident no less than every fifteen (15) minutes and up to continual observation as instructed by the Mental Health Program Professional. The policy stated staff were to conduct visual observations of the environment every fifteen (15) minutes. The policy stated the resident was not allowed to be out of visual contact even for toilet use and if the environment had potential un-movable hazards, staff were to conduct continual observation. The policy stated if restraint was necessary, staff were to follow existing behavior management policies and if the resident became combative, staff were to call 911 for assistance. An SIR, dated 5/25/10 at 12:10 a.m., stated Individual #1 informed staff that she cut herself and that it was an accident. Individual #1 showed staff her wrist which contained "light cut marks across her wrist." Individual #1 stated she was trying to cut yarn then stated "she was not trying to do suicide." The SIR stated staff called the LPN, removed all sharp objects from her room, and completed 5 minute bed checks. The SIR did not include information as to why sharp objects were removed and 5 minute bed checks were implemented if it was not a suicide attempt and the SIR did not include documentation that additional potentially harmful	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 14 objects were removed from Individual #1 if it was considered a suicide attempt. A second SIR, dated 5/25/10 at 12:50 a.m., stated Individual #1 told staff she was going to kill herself and she wanted to pack her belongings and leave. As she started towards the door, staff redirected her to the kitchen while a second staff called the LPN. The SIR did not include documentation that all harmful objects or substances were removed as defined in policy (any harmful implement or substance within the vicinity of that individual within the home such as sharp objects, toxins, cords, shoe laces, belts, etc.). The SIR showed the Administrator was not contacted until 7:07 a.m. on 5/25/10, and it was not documented that additional staff support and Individual #1's guardian was called in accordance with facility policy. The facility failed to ensure the policy was implemented. The ATS was interviewed on 7/29/10 at 1:00 p.m. When asked what items were to be removed from Individual #1's room, the ATS stated they removed sharp pointed objects and ingestible items. When asked about cords, the ATS stated it was not clear if they were to be removed. The ATS stated items should include what the person has a history of using as well. When asked, the ATS stated they did not perform a room search; they did not inventory and secure the removed items, and they did not perform any kind of a body search. The facility failed to ensure the policy was	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 15 sufficiently developed to include the discovery and removal of all potentially harmful objects and substances, necessary to keep Individual #1 safe. The SIR stated staff called the LPN and was told to "talk to resident kept on 5 min bed check [sic]." The SIR did not document staff's call to the local hospital's behavioral health services office "to consult with mental health professionals about the state and condition of the individual who is suicidal" in accordance with the facility's policy. The facility failed to ensure the policy was implemented. The SIR further stated Individual #1 was transported to the hospital. The corresponding hospital report stated Individual #1 was transported to the hospital by ambulance and that she cut her left wrist, superficially, in anger about her current living situation. The report stated she was not suicidal, had a low frustration tolerance, and was experiencing increased anxiety secondary to recent changes in her life. Counseling and possible medication for anxiety and sleep were recommended. Individual #1 was discharged back to the facility. No other recommendations related to continued heightened supervision, continued restrictions of potentially harmful objects and substances, etc. were included in Individual #1's record. The facility's policy did not include instructions to staff regarding what to do in the absence of instructions by the Mental Health Program Professional. The facility failed to ensure the policy was	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 16 sufficiently developed. Additionally, during an observation on 7/26/10 from 3:10 - 4:00 p.m., it was noted that a cardboard box was sitting on the floor of the office (which was also used for medication administration). The box contained various items including personal grooming products, books, and trinkets. A plastic milk crate was sitting opposite the box and contained a similar variety of personal grooming items. When asked, present staff stated the box of items belonged to Individual #1 and the crate belonged to Individual #2. Staff stated the items were removed from Individual #1 and #2's bedroom the evening of 7/24/10, per LPN orders, due to Individual #1 ingesting hand sanitizer in the office that same evening. When asked, staff stated since that evening, Individual #1 was not allowed to be in the office unattended. Individual #1 and #2 agreed to be interviewed during the observation. Both individuals stated they did not know when their personal items would be returned to them. The ATS was interviewed on 7/29/10 at 1:00 p.m. When asked about returning items to Individual #1 and Individual #2, the ATS stated he believed Individual #1's counselor was suppose to assess Individual #1 and make a determination as to whether it was safe to return the items. When asked, the ATS stated Individual #1 saw her counselor on 7/28/10, but it was not clear if they could be returned and the process was not clear. The facility's suicide policy was not sufficiently developed to address how it was to be determined an individual was no longer suicidal and when personal possessions could be returned to them.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 17 During an observation on 7/27/10 from 2:05 - 3:05 p.m., present staff was asked about Individual #1's current status and level of supervision. The staff stated they were required to stay with Individual #1 because the evening of 7/24/10, Individual #1 drank about ¼ cup of hand sanitizer when she was in the office. Staff stated they called the LPN who called the doctor. The staff reported the LPN called the facility and told staff Individual #1 should drink some water. The staff reported that Individual #1 refused to drink water and Individual #1 proceeded to call 911. The staff stated the EMTs arrived and stayed with Individual #1 until she consumed some water. The staff reported the EMTs left the facility. The staff reported that Individual #1 was not calming down by 10:00 p.m., so she was taken to the hospital for a psychiatric evaluation. When asked about the items removed from her room the evening of 7/24/10 versus cords, glass, yarn, and other potentially harmful items still in her room, the staff stated she was not sure. A second staff was asked the same question. That staff replied they were told by the LPN to just remove ingestible items, not all harmful objects. When asked, the staff stated she had not worked with "suicidal folks" before. The facility's policy did not address re-assessment of individuals to ensure they were no longer suicidal when they returned to the facility and did not address whether or not continued supervision was deemed necessary upon their return. Additionally, the facility's suicide policy was not implemented as staff called the LPN and all harmful objects were not removed from Individual #1's environment.	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 18 When asked about an SIR related to the 7/24/10 incident, the QMRP stated on 7/29/10 at 11:10 a.m., no incident report was completed. The LPN proceeded to hand the survey team a Progress Note, dated 7/24/10, which contained three un-timed entries. The first entry stated she (the LPN) received a call from staff who reported that Individual #1 reported to staff that she (Individual #1) swallowed hand sanitizer. The Note stated it was a small amount as staff had previously used it and only a small amount was missing. The Note stated the LPN instructed the staff to have Individual #1 drink 2 to 3 glasses of water. The Note stated the LPN then called the doctor and the doctor said the sanitizer would not harm Individual #1 if it was only a small amount, and to have her drink water. The Note stated the LPN called the facility with instructions. The ATS was interviewed on 7/29/10 at 1:00 p.m. When asked about the process staff were to follow when an individual threatened suicide, the ATS stated they had to call 911. The facility failed to ensure the policy was implemented as the LPN was called instead of 911 and no immediate additional staff support was sought. The second entry stated the LPN received a call from staff stating Individual #1 called 911 and informed them that she drank hand sanitizer and was suicidal. The Note stated the LPN called Individual #1's guardian who stated she (the guardian) would go to the facility. The same entry stated the LPN received a call from staff who reported Individual #1's guardian talked with her (Individual #1) and then left and that the ambulance was gone as well. Staff reported	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 19 Individual #1 was still in the facility. The entry stated the guardian called the LPN and stated Individual #1 "was in a really bad mood" and asked if she (Individual #1) could be evaluated. The entry stated the guardian was informed Individual #1 would have to be sent to the emergency room of the local hospital at which point the guardian "told me (the LPN) to do it." The entry showed the Administrator and QMRP were notified as well as Individual #1's doctor. The facility failed to ensure the policy was implemented in that staff did not call 911, the LPN notified the guardian rather than the Administrator, and no additional support staff was called into the facility. The third entry stated Individual #1 returned to the facility and staff were instructed to follow suicide precautions and remove dangerous items from Individual #1's room and that "...[Individual #1] was not to be in the office alone due to hazards in the office and other items." It should be noted that during an environmental review on 7/29/10 at 1:55 p.m., Individual #1's bottom dresser drawer contained a black zipper bag. Inside the bag were two bottles of shampoo and a bottle of hair conditioner. The facility failed to ensure the policy was implemented in that all dangerous items were not removed from Individual #1's room. The corresponding hospital report for the 7/24/10 incident stated Individual #1 appeared depressed with flat affect and admits to suicidal ideation without a plan. The report stated "Patient is sad that her niece decided today that she couldn't be her guardian. She is also frustrated about her	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 20 living circumstances...Patient stated she just needed a break from stress...I asked her if we could give her a little more time here to get a break - if she's feel ok to go home and get a good night's sleep...She agreed...Patient no longer suicidal. Not homicidal. Agreed to return home...Patient discharged to home." The facility's policy did not include instructions to staff on how or if they were to continue monitoring individuals for safety following assessment at the hospital. Additionally, the policy did not include instruction regarding returning personal possessions previously removed. The facility's policy was not sufficiently developed. The ATS was interviewed on 7/29/10 at 1:00 p.m. The ATS stated when Individual #1 came home, they had to "keep watch" of her until deemed by her counselor that she was not a serious threat. When asked about Individual #1's level of supervision, the ATS stated Individual #1 was not staffed one-to-one; she was "visual." However, "visual" was not defined in the facility's suicide policy. The policy stated staff were to conduct visual observations of the resident no less than every fifteen (15) minutes and up to continual observation as instructed by the Mental Health Program Professional. The policy stated staff were to conduct visual observations of the environment every fifteen (15) minutes. The policy stated the resident was not allowed to be out of visual contact even for toilet use and if the environment had potential un-movable hazards, staff were to conduct continual observation. It was not clear how actively suicidal individuals were to remain safe with visual monitoring only once every 15 minutes or how the environment	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 149	Continued From page 21 was to be assessed to determine whether or not "continual" monitoring was warranted. In sum, the facility's suicide policy was not sufficiently developed and implemented to ensure Individual #1's safety. The policy did not define or contain sufficient directions related to enhanced supervision of Individual #1 when she threatened or attempted suicide. The policy did not contain clear directions to ensure all potentially harmful items were removed from Individual #1's environment, completing an inventory of removed items, and ensuring those items were secured. The policy did not address conducting a body search to ensure Individual #1 did not have potentially harmful items concealed on her person. The policy did not address re-assessing Individual #1 when she returned to the facility to ensure she was no longer suicidal, what level of supervision was required upon her return, and when her personal possessions could be returned to her. The facility failed to ensure the Policy on Suicide Precautions was sufficiently and adequately developed and implemented to ensure Individual #1's safety.	W 149		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, review of the facility's policies and procedures, significant incident reports, record review, and individual and staff	W 159	**W 159 483.430(a)** Refer to W 124 Refer to W 125 Refer to W 137 Refer to W 210 Refer to W 214 Refer to W 225 Refer to W 239 Refer to W 250	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 159	Continued From page 22 interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination which directly affected 4 of 8 individuals (Individuals #1 - #4) reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. That failure resulted in individuals not receiving the necessary assessments, objectives, and training required to meet their behavioral needs. The findings include: 1. Refer to W124 as it relates to the facility's failure to ensure the QMRP ensured individuals who were their own guardians were able to give informed consent for restrictive interventions. 2. Refer to W125 as it relates to the facility's failure to ensure the QMRP ensured individuals were taught and encouraged to exercise their rights and that guardianship was actively pursued for individuals who were not able to give informed consent for restrictive interventions. 3. Refer to W137 as it relates to the facility's failure to ensure the QMRP ensured an individual's right to retain and use personal possessions was upheld. 4. Refer to W210 as it relates to the facility's failure to ensure the QMRP ensured a vocational assessment was conducted for an individual within 30 days of admission. 5. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 6. Refer to W225 as it relates to the facility's	W 159	Refer to W 262 Refer to W 263 Refer to W 278 Refer to W 285 Refer to W 289 Refer to W 303 Refer to W 312 Refer to W 436	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 159	Continued From page 23 failure to ensure the QMRP ensured vocational assessments were current, comprehensive, and accurately identified individuals' vocational needs. 7. Refer to W239 as it relates to the facility's failure to ensure the QMRP ensured the replacement plans for individuals' maladaptive behavior was appropriate to meet their behavioral needs. 8. Refer to W250 as it relates to the facility's failure to ensure the QMRP ensured an active treatment schedule was developed that allowed for flexibility and was adjusted to the needs and preferences of an individual. 9. Refer to W262 as it relates to the facility's failure to ensure the QMRP ensured restrictive interventions were implemented only with approval from the facility's Human Rights Committee. 10. Refer to W263 as it relates to the facility's failure to ensure the QMRP ensured restrictive interventions were implemented only with the written informed consent of appropriately authorized individuals. 11. Refer to W278 as it relates to the facility's failure to ensure the QMRP ensured less restrictive interventions were systematically tried and proven to be ineffective prior to implementing restrictive interventions when an individual did not follow her schedule. 12. Refer to W285 as it relates to the facility's failure to ensure the QMRP ensured that techniques to manage inappropriate behavior were employed with sufficient safeguards and	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 159	Continued From page 24 supervision to ensure the safety, welfare and civil and human rights. 13. Refer to W289 as it relates to the facility's failure to ensure the QMRP ensured that techniques used to manage inappropriate behavior were incorporated into the program plans. 14. Refer to W303 as it relates to the facility's failure to ensure the QMRP ensured a record of restraint was kept for an individual who required restraint during dental examinations. 15. Refer to W312 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. 16. Refer to W436 as it relates to the facility's failure to ensure the QMRP ensured an individual had a plan in place to teach her use of eyeglasses.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure staff were provided initial and on-going training related to suicidal ideation and mental	W 189	**W 189 483.430(e)(1)** **For Individual #1 the staff will receive training on individual's history, suicidal ideation and mental health. A training curriculum will be developed that will cover different mental health topics in each staff meeting over the course of the year.** **Corrective Action Completion Date: September 30, 2010**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 189	Continued From page 25 health which enabled them to perform the job duties effectively, efficiently, and competently for 1 of 1 individual (Individual #1) reviewed, who engaged in suicidal ideation and had the potential to affect all individuals (Individuals #1 - #8) residing at the facility. This resulted in a lack of understanding, assessment, and monitoring to keep an individual safe. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. Individual #1's records from her previous placement showed borderline personality disorder was secondary to her general medical condition including traumatic brain injury. a. Individual #1's Functional Assessment from her previous placement, compiled from 12/5/08 through 7/27/09, stated she had "significant problems with impulsive behavior, low frustration tolerance, emotional instability especially depression, aggression as evidenced by physical assaults and self injury (i.e. insertion, PICA, burning, biting, cutting) and suicide ideation (i.e. threats, attempts)." The Assessment stated Individual #1 made suicide threats or was placed on suicide precautions up to 26 times within the year. Individual #1 continued to express suicidal ideation and acts after she was admitted to the facility on 5/17/10, as follows:	W 189	**Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 189	Continued From page 26 - An SIR, dated 5/25/10 at 12:10 a.m., stated Individual #1 showed staff her wrist which contained "light cut marks across her wrist." Individual #1 stated she was trying to cut yarn then stated "she was not trying to do suicide." - A second SIR, dated 5/25/10 at 12:50 a.m., stated Individual #1 told staff she was going to kill herself and she wanted to pack her belongings and leave. Additionally, during an observation on 7/26/10 from 3:10 - 4:00 p.m., it was noted that a cardboard box was sitting on the floor of the office (which was also used for medication administration). The box contained various items including personal grooming products, books, and trinkets. A plastic milk crate was sitting opposite the box and contained a similar variety of personal grooming items. When asked, present staff stated the box of items belonged to Individual #1 and the crate belonged to Individual #2. Staff stated the items were removed from Individual #1 and #2's bedroom the evening of 7/24/10, per LPN orders, due to Individual #1 ingesting hand sanitizer in the office that same evening. Further, during an observation on 7/27/10 from 2:05 - 3:05 p.m., present staff was asked about Individual #1's current status and level of supervision. The staff stated they were required to stay with Individual #1 because the evening of 7/24/10, Individual #1 drank about ¼ cup of hand sanitizer when she was in the office. Staff stated they called the LPN who called the doctor. The staff reported the LPN called the facility and told staff Individual #1 should drink some water. The staff reported that Individual #1 refused to drink	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 189	Continued From page 27 water and Individual #1 proceeded to call 911. The staff stated the EMTs arrived and stayed with Individual #1 until she consumed some water. The staff reported the EMTs left the facility. The staff reported that Individual #1 was not calming down by 10:00 p.m., so she was taken to the hospital for a psychiatric evaluation. When asked about the items removed from her room the evening of 7/24/10 versus cords, glass, yarn, and other potentially harmful items still in her room, the staff stated she was not sure. A second staff was asked the same question. That staff replied they were told by the LPN to just remove ingestible items, not all harmful objects. When asked, the staff stated she had not worked with "suicidal folks" before. The ATS was interviewed on 7/29/10 at 1:00 p.m. The ATS was asked about training related to suicidal ideation. The ATS reported the only training that he and direct care staff received was after the 5/25/10 incident, and it was on the suicide policy. The ATS reported the training occurred on 5/26/10. When asked about her own knowledge of suicidal ideation, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., she did not know a lot about it. b. Individual #1's Functional Assessment from her previous placement stated she had a complicated psychiatric history that included multiple psychiatric admissions and "The behaviors that [Individual #1] exhibits are significant and present a danger to her and others and significantly affect her overall quality of life." The ATS was interviewed on 7/29/10 at 1:00 p.m.	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 189	Continued From page 28 When asked about training related to borderline personality disorder, the ATS asked "Is that where someone has multiple personalities?" When asked about impulse control disorder and schizophrenia, the ATS reported he had "no idea" about impulse control disorder and no one in the facility had schizophrenia. When asked about training provided to direct care staff related to mental health issues, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., staff were trained on general topics like autism. The facility failed to provide staff with initial and on-going training related to Individual #1's history, suicidal ideation, and mental health.	W 189		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were conducted within 30 days of admission for 1 of 1 individual (Individual #1) admitted to the facility within the last 3 months. This resulted in a lack of information being available on which to base vocational program decisions. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental	W 210	**W 210 483.440(c)(3)** For Individual #1, an application has been submitted to the Idaho Division of Vocational Rehabilitation and she has an appointment for an assessment on September 1, 2010. The Vocational Assessment will be added to the admission assessments packet for completion within the first thirty days. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 210	Continued From page 29 retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Her record from her previous placement showed she participated in shredding and laundry for work. She was admitted to the facility on 5/17/10. However, Individual #1's record did not include a vocational evaluation. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., she had not scheduled an evaluation yet. The facility failed to ensure a vocational assessment was conducted within the first 30 days of Individual #1's admission.	W 210		
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 behavioral assessments were completed and contained comprehensive information for 4 of 4 individuals (Individuals #1 - #4) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on	W 214	**W 214 483.440(c)(3)(iii)** For Individual #1-4, the Functional Analysis of Behavior will be re-done addressing the concerns written in the citation documentation. The facility will revise the forms used for Functional Analysis of Behavior in order to obtain more accurate information. The new forms will be used in the future when an individual requires an assessment update. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 30 5/17/10 with a history of impulse control disorder and major depression. Her records showed borderline personality disorder was secondary to her general medical condition including traumatic brain injury. a. Individual #1's Functional Analysis of Behavior, dated 7/22/10, consisted of a series of questions with hand-written answers. According to the Analysis, Individual #1's problem behaviors included yelling, cussing, assault, name calling, elopement, attempting to elope, threatening, and spitting. However, Individual #1's Functional Assessment, compiled from 12/5/08 through 7/27/09 from her previous placement, stated she had an extensive history of combative, aggressive and self-injurious behaviors and had "significant problems with impulsive behavior, low frustration tolerance, emotional instability especially depression, aggression as evidenced by physical assaults and self injury (i.e. insertion, PICA, burning, biting, cutting) and suicide ideation (i.e. threats, attempts)." The Assessment stated Individual #1 made suicide threats or was placed on suicide precautions up to 26 times within the year. b. The 7/22/10 Analysis included the following questions: 1) What medical complications could effect behavior? "Estrogen patch" 2) What psychiatric conditions does the person experience? "Depression, possible rape, (and) fear of tall people or men." 3) What medications does the person take and how could these effect behavior? "Insulin." 4) When are behaviors most likely to occur? "Morning."	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 31 5) Are there particular situations that 'set-off' behaviors? "None listed." However, Individual #1's medical reports showed she had an extensive medical history including hypothyroidism, high blood pressure, GERD, chronic renal failure type II, chronic pain issues, history of obstructive sleep apnea, history of congestive heart failure, chronic bilateral lower extremity pedal edema, and seizure disorder. Further, historical assessment stated Individual #1 had a complicated psychiatric history that included multiple psychiatric admissions and "a complicated and quite extensive medication history." c. Under "What Consequences Maintain the Behaviors" of the 7/22/10 Analysis, it stated name calling was for attention, refusing tasks was to agitate staff, and elopement was for attention. However, the historical assessment stated "[Individual #1's] past history suggests that it will be very important to balance her medical and mental health needs to maintain her optimal quality of life." Further, the historical assessment stated there were several reasons for her suicidal ideation including " 1) [Individual #1] reports she wanted attention, 2) [Individual #1] states she is in pain, 3) peer conflicts are upsetting [Individual #1], 4) [Individual #1] saying she is hearing voices that say to harm self, and 5) [Individual #1] indicates she wants to die or hurt self as she feels depressed. It is noted that [Individual #1] may fluctuate between more than one theme during and/or following assessments."	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 32 The ATS was interviewed on 7/29/10 at 1:00 p.m. When asked about the Analysis, the ATS stated the form was given to him and he gave it to the staff person who he thought knew the individual the best. The staff person was to read and complete the form and if they had questions, they were to call the QMRP. The direct care staff who completed Individual #1's Analysis, and was present in the facility, was asked if she received training on how to complete the Analysis. She stated she read the form and answered the questions. When asked, the staff person stated she worked only day shifts. Additionally, Individual #1's record also included a Motivation Assessment Scale (undated). On the second page it showed it was used to identify "Variables Maintaining Self Injurious Behavior." When asked how the Assessment Scale was used, the QMRP stated she did not use it; she stated she found it on the Internet. Further, her BMP included target behaviors for crying/emotionally upset, suicide threats and attempts, and refusing to take medications or participate in medical procedures that were not included in the Analysis. In sum, Individual #1's Functional Analysis of Behavior assessment was not comprehensive in nature. The Analysis did not identify or consider her history, health status, nutritional status, medications, psychiatric conditions, sleep data, cognitive development, social support, vocational and environmental issues, financial status, and effective reinforcement. When asked about Individual #1's Functional	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 33 Analysis of Behavior, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., it was not adequate. 2. Individual #3's IPP, dated 7/7/10, documented a 39 year old female diagnosed with severe mental retardation and cerebral palsy. She used a wheelchair for mobility purposes. Individual #3's record showed that on 7/25/10, she started receiving Paxil (an antidepressant drug) 20 mg each morning for depression which presented itself as assaults and tantrums. Her BMP, dated 7/31/07, described assaults as hitting or kicking another individual. Tantrums was described as attempting to bite, flailing her arms, crying, yelling, rocking back and forth in her wheelchair, and attempting to get out of her wheelchair to come after the staff person. According to an IPP Addendum, dated 7/7/10, a meeting was called to discuss the increase in Individual #3's maladaptive behaviors and her mother's request to start an anti-anxiety medication. Behavior data, attached to the Addendum, showed her behaviors started to increase in 3/10, as follows: - Tantrums: 1/10 = 10 2/10 = 23 3/10 = 77 4/10 = 55 5/10 = 48 6/10 = 31 - Assault: 1/10 = 0	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 34 2/10 = 5 3/10 = 37 4/10 = 17 5/10 = 12 6/10 = 7 - Biting: 1/10 = 3 2/10 = 0 3/10 = 15 4/10 = 20 5/10 = 13 6/10 = 5 Individual #3's record did not contain an assessment related to her maladaptive behaviors. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #3 was not re-assessed since the behavioral increase and the original assessment had been misplaced. 3. Individual #4's IPP, dated 11/10/09, documented a 22 year old female diagnosed with severe mental retardation and cerebral hypotonia (a form of cerebral palsy characterized by low muscle tone). Individual #4's record contained an Assessment of Maladaptive Behavior, dated 4/21/08, which stated she engaged in self-injurious behavior, crying, and destruction of property. Self-injurious behavior was described as hitting her head, crying was described as being emotionally upset to the point of emitting tears, and destruction of property was described as using toilet tissue inappropriately by tearing it up. Individual #4's record also contained a Functional	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 35 Analysis of Behavior, dated 8/14/09, which stated the problem behavior was assault which was described as pulling hair and hitting with an open hand. According to the Analysis, Individual #4 was able to gain attention and avoid a task by displaying assaultive behavior. However, Individual #4's record contained a Psychiatric Evaluation, dated 1/27/10, which stated she "Hits herself in the head often and cries frequently, much more since finishing high school a year ago. [LPN] thinks she misses her school friends and also she doesn't see (her) parents as much. Sometimes just inconsolable and will cry, scream, and hit herself." According to her record, she started receiving Remeron (an antidepressant drug)15 mg daily for depression and sleep issues on 2/24/10. Further, descriptions of maladaptive behaviors were compared with Individual #4's BMP, dated 2/7/10, and showed the following changes: self-injurious behavior was described as biting her hand (usually the left hand) and hitting her head, crying was to the point of emitting tears, and destruction of property was tearing apart books, taking things apart in her room, and picking apart clothing. No assessment related to Individual #4's hand biting, screaming, increase in crying, or change in destruction of property behavior could be found in her record. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., there were no updates to the aforementioned assessments. 4. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 36 retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Individual #2's Physician's Orders, dated 5/13/10, showed she received the following behavior modify drugs: Tegretol (an anticonvulsant drug) 200 mg three times a day, Geodon (an antipsychotic drug) 160 mg daily, Celexa (an antidepressant drug) 40 mg each day, and Clonazepam (an anticonvulsant drug) 1 mg daily, as needed, for severe agitation. Individual #2's Medication Reduction Plan, dated 4/16/09, showed she received the behavior modifying drugs for agitation, assault, non-compliance, refusing programmatic tasks, and refusing meals. Individual #2's BMP, dated 6/29/10, included the following maladaptive behaviors: - Assault which was defined as hitting others which included kicking, using arms/hands to hit an individual, or using an object to hit an individual. - Agitation was defined as screaming, cursing at others, name calling and being very argumentative. - Refusing Meals was defined as refusing to eat at least 50% of a meal. - Refusing Programmatic Tasks was defined as refusing to participate in scheduled activities and not wanting to take a bath, floss her teeth, and clean her room. Individual #2's record did not contain an assessment related to her maladaptive behaviors. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., she did not know if one was completed.	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 214	Continued From page 37 The facility failed to ensure comprehensive behavior assessments were completed for Individuals #1 - #4.	W 214		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure comprehensive vocational assessments were completed for 2 of 4 individuals (Individuals #2 and #4) who were of age to be involved in vocational training. Without comprehensive assessments, the facility would be unable to assist individuals with vocational training needs through the development of objectives designed to optimize their abilities. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Individual #2's record contained a job placement evaluation, dated 4/21/08, which recommended working with supervision in a controlled environment. According to her IPP, Individual #2 obtained a part-time housekeeping job which ended on 9/2/08 after calling a co-worker's mother racist and engaging in inappropriate behavior with the co-worker. However, Individual #2's record did not contain a previous or updated vocational evaluation. When asked, the QMRP stated during an interview on	W 225	**W 225 483.440(c)(3)(v)** **For Individuals #2 and #4 a vocational assessment will be completed and recommendations will be implemented. The Qualified Mental Retardation Professional will review the other client's charts to ensure adequate, and complete vocational assessments are present.** **Corrective Action Completion Date: October 15, 2010** **Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 225	Continued From page 38 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 did not have an evaluation. 2. Individual #4's IPP, dated 11/10/09, documented a 22 year old female diagnosed with severe mental retardation and cerebral hypotonia (a form of cerebral palsy characterized by low muscle tone). Her record contained a Vocational Assessment that was dated 8/14/09. The Assessment contained a list of questions that were to be completed by direct care staff, the ATS, and the QMRP. Individual #4's Assessment showed several areas were not completed including vocational abilities, vocational barriers, potential present and future employment options, and recommendations. Additionally, some areas of the Assessment did not contain comprehensive information. For example, one section showed staff were to indicate Individual #4's abilities in the following areas: Verbal (vocabulary, reading comprehension, spelling), Numerical (counting, reading numbers, adding, subtracting), and Achievement (reading, writing, perceptual abilities, follows directions). The answers given were "sign some words, letters and numbers." The Assessment did not identify what words, letters, or numbers Individual #4 could sign. Individual #4's Assessment was not comprehensive. It did not include comprehensive information related to her strengths, needs, abilities, limitations, work interests, work skills, present and future employment options, and possible adaptations that could be helpful to her in being more independent.	W 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 225	Continued From page 39 Further, under the section titled Vocational Skills in Individual #4's IPP, it stated "She has two Completion of Task programs ...She will often time [sic] throw stuff on the floor but not want to pick them up. This [sic] focus of this program is to increase her willingness to use her hands. The second one is focused on her Vacuuming [sic]." However, her vocational assessment did not contain information showing use of hands and vacuuming were assessed and identified as needs. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #4's assessment was not complete. The facility failed to ensure comprehensive vocational assessments were completed for Individuals #2 and #4.	W 225		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior management plans for 2 of 4 individuals (Individuals #2 and #4) whose behavior management programs were reviewed. This	W 239	**W 239 483.440(c)(5)(vi)** For individuals #2 and #4 the replacement behaviors will be revised to reflect the function of the behavior(s). The Qualified Mental Retardation Professional will review the other individual's behavior management programs and revise any replacement behaviors that require expansion. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 239	Continued From page 40 resulted in individuals not receiving appropriate training to replace their maladaptive behaviors. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. Individual #2's BMP, dated 6/29/10, included target behaviors for assault (defined as hitting others which included kicking, using arms/hands to hit an individual, or using an object to hit an individual), agitation (screaming, cursing at others, name calling and being very argumentative), refusing meals (defined as refusing to eat at least 50% of a meal), and refusing programmatic tasks (defined as refusing to participate in scheduled activities and not wanting to take a bath, floss her teeth, and clean her room). a. Her BMP stated the function of assault and agitation was to escape a task, seek attention, and to obtain an item. The replacement behavior stated staff were to prompt her to communicate what it was she wanted. However, under the Speech and Language Development section of her IPP, it stated she was verbally assertive, very direct, able to express her opinions and preferences, and was able to communicate beyond wants and needs. It was not clear why staff were to prompt her to communicate when she was, according to her IPP, "an articulate young woman."	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 239	Continued From page 41 b. Her BMP for refusing programmatic tasks did not contain the function of the behavior. However, the replacement behavior stated "we want to teach [Individual #2] that she is living at [the facility] so she can learn to be more independent." Under the Speech and Language Development section of her IPP, it stated she was oriented to her environment, had a good memory, retained accurate information, and was able to understand her limitations and recognize when she needed help. It was not clear how teaching her where she was living was related to refusing tasks. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., she did not know. 2. Individual #4's IPP, dated 11/10/09, documented a 22 year old female diagnosed with severe mental retardation and cerebral hypotonia. Individual #4's BMP, dated 2/7/10, included target behaviors for self-injurious behavior (described as biting her hand (usually the left hand), hitting her head, or other acts that could cause injury to herself), crying (described as when she had tears), and destruction of property (described as tearing apart books, taking things apart in her room, and picking apart clothing). a. Her BMP stated the function of crying was to seek attention. The replacement behavior stated "We want to teach [Individual #4] to obtain your attention by gently grabbing onto the individual she wants attention from. Show her how to do this replacement behavior then have her demonstrate	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 239	Continued From page 42 this behavior." However, her BMP stated sometimes she cried for attention, sometimes for no apparent reason, sometimes when other individuals' families come to visit, and sometimes she would cry when she was in pain. It was not clear how teaching Individual #4 to gain attention by gently grabbing onto someone was functionally related to her sadness about other individual's families visiting or pain related issues. b. Her BMP stated the function of property destruction was to seek attention. The replacement behavior stated "We want to teach [Individual #4] to obtain your attention by gently grabbing onto the individual she wants attention from. Show her how to do this replacement behavior then have her demonstrate this behavior." However, her BMP stated she also engaged in property destruction when she was not engaged in an activity. It was not clear how teaching Individual #4 to gain attention by gently grabbing onto someone was functionally related to her lack of engagement in activities. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., replacement behaviors could be expanded. The facility failed to ensure appropriate replacement behaviors were identified and incorporated into Individuals #2 and #4's behavior management programs.	W 239		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION	W 250	**W 250 483.440(d)(2)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 250	Continued From page 43 The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews, it was determined the facility failed to develop an active treatment schedule that allowed for flexibility and was adjusted to the preferences of an individual for 1 of 1 individual (Individual #2) whose active treatment schedule was reviewed. This had the potential to impede an individual's ability to make choices and significantly limited her opportunities for self direction. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. Individual #2's record contained a Schedule program, dated 1/4/10, which stated "[Individual #2's] Game Boy & (and) Tomogachi Games will be kept locked up in the medication cabinet. Her television was removed from her bedroom. These items are highly reinforcing to [Individual #2]. She enjoys her time away to participate in these activities. [Individual #2's] staff is responsible to follow this program exactly the way it is written - DO NOT DEVIATE FROM THIS PROGRAM UNDER ANY CIRCUMSTANCES!!" The attached schedule was divided into 15	W 250	For Individual #2 her active treatment schedule will be revised to allow for flexibility and adjustment. For the other individuals in the facility, the active treatment schedules will be reviewed and revised if necessary. Corrective Action Completion Date: October 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 250	Continued From page 44 minute increments, starting at 7:00 a.m. and ending at 9:00 p.m., for each day of the week including Saturday and Sunday. An example is as follows: Monday: "7:00 am Allow [Individual #2] to sleep in. 7:15 am Allow [Individual #2] to sleep in. 7:30 am [Individual #2] gets up for the day - If she is wet, she needs to get up within 15 minutes of being prompted. 7:45 am [Individual #2] gathers her clothes & (and) items needed for a shower. 8:00 am [Individual #2] takes a shower or bath - She needs to allow staff to help her shower every other day. 8:15 am [Individual #2] takes her medications. 8:30 am [Individual #2] goes to breakfast - If she does not like what is on the menu, she chooses an equal substitute. 8:45 am Continue with breakfast. 9:00 am [Individual #2] cleans up her mess & puts her dishes away. 9:15 am [Individual #2] gets her items needed for oral care. [Individual #2] brushes & flosses her teeth. She allows staff to help. 9:30 am If [Individual #2] earned her FREE TIME, then document "FREE." If she did not, have [Individual #2] clean up any dirty laundry on her floor. 9:45 am If [Individual #2] earned her FREE TIME, then document "FREE." If not, allow her to take a break from her morning routine. She can read the paper or a book but cannot access the game boy, Tomogachi Game or TV (television) 10:00 am Options for Community Activity: Bowling, Shopping at the Mall, Zoo, Museum @ [college]. Document what activity she chose. 10:15 am Continue with above activity.	W 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 250	Continued From page 45 10:30 am Continue with above activity. 10:45 am Continue with above activity. 11:00 am Continue with above activity. 11:15 am Continue with above activity. 11:30 am Finish up with activity and head back to the home. 11:45 am Put away any items that you have from out in the community outing. Wash hands." According to the schedule, Individual #2 had three ½ hour opportunities a day to earn free time. If she did not earn free time, she had pick up dirty laundry in her room, wash a load of her clothes, vacuum her room, dust her room, or help cook dinner for everyone for the first 15 minutes and then she was allowed to read a book or newspaper the second 15 minutes but "cannot access the game boy, Tomogachi Game or TV (television)." When asked about the schedule, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., staff and Individual #2 adjusted the schedule when necessary but those changes were not documented. However, during an observation on 7/27/10 at 5:45 p.m., a staff person working with Individual #2 was asked about the schedule. Staff stated if Individual #2 refused to follow her schedule, staff were to continue to prompt her and score a "no" next to the task. Staff stated they were not allowed to deviate from the schedule. Further, Individual #2 agreed to be interviewed on 7/29/10 at 2:15 p.m. When asked about her schedule, she stated if she did not follow her schedule or was having a bad day, staff scored a "no" and "restrict my personal stuff." She	W 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 250	Continued From page 46 reported the QMRP would not let her change the schedule when she wanted it to be changed. The facility failed to ensure Individual #2's schedule allowed for flexibility and was adjustable based on her preferences and ability to make choices.	W 250		
W 262	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, and staff interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 4 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. An SIR, dated 5/25/10 at 12:10 a.m., stated Individual #1 informed staff that she cut herself	W 262	**W 262 483.440(f)(3)(i)** For individual #1, Human Rights Committee consent will be obtained for removal of personal items when the suicide prevention policy is implemented. The HRC will sign the revised document at the next meeting. For the other individuals in the facility, the Qualified Mental Retardation Professional will review the charts to ensure all restrictive elements are reflected in the Human Rights Committee documents. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 262	Continued From page 47 and that it was an accident. Individual #1 showed staff her wrist which contained "light cut marks across her wrist." Individual #1 stated she was trying to cut yarn then stated "she was not trying to do suicide." The SIR stated staff called the LPN, removed all sharp objects from her room, and completed 5 minute bed checks. During an observation on 7/26/10 from 3:10 - 4:00 p.m., it was noted that a cardboard box was sitting on the floor of the office (which was also used for medication administration). The box contained various items including personal grooming products, books, and trinkets. When asked, present staff stated the box of items belonged to Individual #1 and the items were removed from her bedroom the evening of 7/24/10, per LPN orders, due to Individual #1 ingesting hand sanitizer in the office that same evening. A corresponding Progress Note, dated 7/24/10, stated the LPN instructed staff to follow suicide precautions and remove dangerous items from Individual #1's room. Individual #1's BMP, dated 6/15/10, included a target behavior for suicide threats and attempts which were defined as acts that were an attempt to take her own life, doing gestures of self-injury, self destructive behavior resulting in an injury, verbal threats indicating she is going to kill herself, and ingestion of toxic substances. Under the section titled Staff Response for suicide threat and attempts, it stated staff were to "Ensure the resident is safe: Remove any harmful items or substances within the vicinity of that individual within the home (i.e. sharp objects,	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 262	Continued From page 48 toxins, cords, shoe laces, belts, etc.)." Individual #1's record did not contain approval from the facility's Human Rights Committee to remove her personal items. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., approval was not obtained as it was not seen as restrictive. The facility failed to ensure restrictive interventions used for Individual #1 were implemented only with the approval of the human rights committee.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE 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. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of an appropriate person for 2 of 4 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approval of a restrictive intervention. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2.	W 263	**W 263 483.440(f)(3)(ii)** For individual #1, Guardian consent will be obtained for removal of personal items when the suicide prevention policy is implemented. The guardian will sign the revised document. For the other individuals in the facility, the Qualified Mental Retardation Professional will review the charts to ensure all restrictive elements are reflected in the Consent to Treat documents. For individual #2, the facility will approach various agencies and potential volunteers to assist her with making informed consent. Individual #2 has no family members to approach. The Qualified Mental Retardation Profession will review the other individual's charts to ensure that a guardian or family members is assisting with informed consent. Corrective Action Completion Date: September 30, 2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 263	Continued From page 49 Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. An SIR, dated 5/25/10 at 12:10 a.m., stated Individual #1 informed staff that she cut herself and that it was an accident. Individual #1 showed staff her wrist which contained "light cut marks across her wrist." Individual #1 stated she was trying to cut yarn then stated "she was not trying to do suicide." The SIR stated staff called the LPN, removed all sharp objects from her room, and completed 5 minute bed checks. During an observation on 7/26/10 from 3:10 - 4:00 p.m., it was noted that a cardboard box was sitting on the floor of the office (which was also used for medication administration). The box contained various items including personal grooming products, books, and trinkets. When asked, present staff stated the box of items belonged to Individual #1 and the items were removed from her bedroom the evening of 7/24/10, per LPN orders, due to Individual #1 ingesting hand sanitizer in the office that same evening. A corresponding Progress Note, dated 7/24/10, stated the LPN instructed staff to follow suicide precautions and remove dangerous items from Individual #1's room. Individual #1's BMP, dated 6/1510, included a target behavior for suicide threats and attempts which were defined as acts that were an attempt to take her own life, doing gestures of self-injury, self destructive behavior resulting in an injury, verbal threats indicating she is going to kill herself, and ingestion of toxic substances.	W 263	**Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 263	Continued From page 50 Under the section titled Staff Response for suicide threat and attempts, it stated staff were to "Ensure the resident is safe: Remove any harmful items or substances within the vicinity of that individual within the home (i.e. sharp objects, toxins, cords, shoe laces, belts, etc.)." Individual #1's record did not contain consent from Individual #1's legal guardian to remove personal items. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., consent was not obtained as it was not seen as restrictive. The facility failed to ensure restrictive interventions were implemented only with the written informed consent of Individual #1's legal guardian. 2. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. Individual #2's Physician's Orders, dated 5/13/10, showed she received the following behavior modify drugs: Tegretol (an anticonvulsant drug) 200 mg three times a day, Geodon (an antipsychotic drug) 160 mg daily, Celexa (an antidepressant drug) 40 mg each day, and Clonazepam (an anticonvulsant drug) 1 mg daily, as needed, for severe agitation. Individual #2's record contained a consent, dated 1/28/10, related to her behavior modifying drugs. The consent included definitions of her	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 263	Continued From page 51 maladaptive behaviors and listed her behavior modify drugs and their benefits, side effects, risks, and alternatives. Further, under the section titled "Other" within the above noted consent, it stated "[Individual #2] has a schedule program in which she can earn free time. Her gameboy/tomagachi pets and other electronics are kept locked up and used as a reinforce [sic] for staying on task." The consent contained Individual #2's signature as well as various signatures from the facility's HRC. However, Individual #2's Human Rights Assessment, dated 10/6/09, showed she did not understand what was meant by a "right" unless it was explained to her, she did not understand her right to be free from unnecessary restraints, and she thought it was okay if the facility made her do work for the facility. Further, the Assessment showed she did not understand due process even after it was explained to her. Individual #2's record also contained an untitled document, dated 2/24/10, which stated she did not understand the risks and benefits of her current treatment and that there were alternative treatments available. The document stated she was not able to express a decision and then provide a rationale for making that decision. Individual #2's record documented she did not have the knowledge and ability to give informed consent. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 was not able to give informed consent. The HRC failed to ensure Individual #2 had the	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 263	Continued From page 52 ability to give informed consent prior to restrictive interventions being used.	W 263		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, review of the facility's policies and procedures, significant incident reports, record review, and individual and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 2. Refer to W239 as it relates to the facility's failure to ensure the replacement plans for individuals' inappropriate behavior was appropriate to meet their behavioral needs. 3. Refer to W276 as it relates to the facility's failure to ensure the behavior policy was adequately developed to include all restrictive behavior interventions. 4. Refer to W278 as it relates to the facility's	W 266	**W 266 483.450** Refer to W 214 Refer to W 239 Refer to W 276 Refer to W 278 Refer to W 285 Refer to W 289 Refer to 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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 266	Continued From page 53 failure to ensure less restrictive interventions were systematically tried and proven to be ineffective prior to implementing a restrictive intervention when an individual did not follow her schedule. 5. Refer to W285 as it relates to the facility's failure to ensure the QMRP ensured that techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the safety, welfare and civil and human rights. 6. Refer to W289 as it relates to the facility's failure to ensure the QMRP ensured that techniques used to manage inappropriate behavior were incorporated into the program plans. 7. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. The cumulative effect of these negative facility practices significantly impeded the ability of the facility to provide services to meet the behavioral needs of individuals residing in the facility.	W 266		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior.	W 276	**W 276 483.450(b)(1)(i)** **The facility's behavior policy will be revised to incorporate removal of personal possessions, restrictive active treatment schedules and the use of**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 276	Continued From page 54 This STANDARD is not met as evidenced by: Based on review of the facility's behavior policy, record review, and staff interview it was determined the facility failed to ensure the behavior policy included all interventions used to manage maladaptive behavior which directly impacted 3 of 4 individuals (Individuals #1, #2 and #4) whose records were reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in interventions being used that were not approved for use. The findings include: 1. The facility's Behavior Management policy, dated 4/18/03, was reviewed and did not include the following restrictive interventions that were in place for Individuals #1, #2 and #4: a. Personal possessions were removed from Individual #1's bedroom on no less than two occasions due to her attempts to commit suicide. Additionally, Individual #2's personal possessions were removed from her bedroom based upon Individual #1's behavior. Further, as of the date of this survey, Individuals #1 and #2's possessions removed from their bedrooms on 7/24/10 had not been returned to them. b. Restrictive daily schedules were in place for Individual #2 such that her personal possessions were taken away from her and locked in a medication cabinet. As per the schedule, she could earn up to three ½ hour increments a day to enjoy her personal possessions. c. A papoose board was used with Individual #4 during dental examinations on 12/5/08, 6/11/09, and 1/8/10.	W 276	papoose board. The treatment team will review all behavioral procedures and ensure they are incorporated into the policy. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 276	Continued From page 55 When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., the restrictive interventions for Individuals #1 and #4 were not incorporated in the behavior policy. The QMRP stated removing Individual #2's personal possessions as identified in her schedule was not restrictive, it was structure. The facility failed to ensure all behavioral interventions were included in the policy.	W 276		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews, it was determined the facility failed to ensure the individual's record included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 4 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in an individual being denied access to personal possessions for not following a prescribed daily schedule. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional	W 278	**W 278 483.450(b)(1)(iii)** For Individual #2, the facility will implement a two week challenge on the restrictive element of the program. If the challenge is successful, the treatment team will review and address future programming. The Qualified Mental Retardation Professional will write a report after the challenge and assessment of data for the individual's chart. The challenge will begin September 1, 2010 and the final report will be completed by October 15, 2010. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 278	Continued From page 56 defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. During an observation on 7/27/10 from 6:37 - 9:08 a.m., Individual #2's gameboy and tomagachi electronic pets were noted to be locked in the medication cabinet. Further, during an observation on 7/27/10 from 2:05 - 3:05 p.m., Individual #2 reported to the survey team her television had been taken away from her and stored in the garage. Individual #2's record contained a Schedule program, dated 1/4/10, which stated "[Individual #2's] Game Boy & (and) Tomogachi Games will be kept locked up in the medication cabinet. Her television was removed from her bedroom. These items are highly reinforcing to [Individual #2]. She enjoys her time away to participate in these activities. [Individual #2's] staff is responsible to follow this program exactly the way it is written - DO NOT DEVIATE FROM THIS PROGRAM UNDER ANY CIRCUMSTANCES!!" The attached schedule was divided into 15 minute increments, starting at 7:00 a.m. and ending at 9:00 p.m., for each day of the week including Saturday and Sunday. According to the schedule, Individual #2 had three ½ hour opportunities a day to earn free time. If she did not earn free time, she had pick up dirty laundry in her room, wash a load of her clothes, vacuum her room, dust her room, or help cook dinner for everyone for the first 15 minutes and then she was allowed to read a book or newspaper the second 15 minutes but "cannot access the game boy, Tomogachi Game or TV (television)."	W 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 278	Continued From page 57 Individual #2's record contained a consent, dated 1/28/10, related to her behavior modifying drugs. The consent contained Individual #2's signature as well as various signatures from the facility's HRC. Under the section titled "Other" within the consent, it stated "[Individual #2] has a schedule program in which she can earn free time. Her gameboy/tomagachi pets and other electronics are kept locked up and used as a reinforce [sic] for staying on task." Individual #2's record did not contain documented evidence of less restrictive techniques being systematically tried and proven to be ineffective prior to the implementation of restricting Individual #2's personal possessions based on her following the prescribed schedule. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 agreed to the schedule. The facility failed to ensure less restrictive interventions were first tried and found ineffective prior to implementing the restrictions on Individual #2's personal possessions when she did not follow her schedule.	W 278		
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by:	W 285	**W 285 483.450(b)(2)** Individual #3's Behavior management program will be revised to incorporate more appropriate interventions for when she displays behaviors that affect her physical safety. For Individual #2, the facility will provide her with a locking container so that she can lock up her own possessions if the suicide protocol	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 58 Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the safety, welfare and civil and human rights for 4 of 4 individuals (Individuals #1 - #4) whose behavior management programs were reviewed. This resulted in a lack of adequate protections related to individuals' rights and physical safety. The findings include: 1. Individual #3's IPP, dated 7/7/10, documented a 39 year old female diagnosed with severe mental retardation and cerebral palsy. She used a wheelchair for mobility purposes. Individual #3's SIRs were reviewed and showed the following injures she sustained during maladaptive behaviors: - 3/12/10 at 12:10 p.m.: "After we did the [fire] drill she was fine till [sic] it went off the second time. She jumped out of her chair numerous times in the kitchen and hallway. Then the ATS tried to have [sic] her involved and it got worse from there. We left her on the floor till [sic] it was over. She then jumped up and slammed her head on a table." The Nurse's Comments showed Individual #3 sustained "abrasions and bruising to left side of face from chin around outside of mouth to base of nose." - 5/7/10 at 11:07 a.m.: "Resident [Individual #3] flipped herself out of her chair. She was trying to bite staff, so staff lowered her to the floor and stepped out of her reach. Female resident [Individual #3] then started to flip around on the kitchen floor. She hit her head on the table, a	W 285	is required because of individual #1. The suicide prevention policy will be revised addressing the topic of personal possessions. Individual #2 did not have a personal television. For individual #2, the facility will approach various agencies and potential volunteers to assist her with making informed consent regarding the removal of her gameboy/tomagachi toys (if the challenge of this restrictive element does not work). Individual #2 has no family members to approach. Individual #2's schedule will also be revised. For Individual #1, the Suicide Prevention Policy will be revised and implemented. For individual #4 the behavior management program will be revised to incorporate more appropriate interventions for when she displays behavior that affect her physical safety. For the other individuals in the facility, the Qualified Mental Retardation Professional will review the other charts for appropriate behavioral interventions and make revisions as necessary. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 59 chair and the baker's rack. She has a bump on her forehead. Her mouth is also bleeding. She also has some red marks on her sides and stomach." The Nurse's Comments stated "Swelling on head gone within 2 hrs (hours) - left red mark. Had bitten lower lip - bleeding stopped within minutes - slight amount of swelling [sic]. Red marks on adb (abdomen) and sides gone with [sic] 2 hrs (hours)." During an observation on 7/26/10 at 4:00 p.m., staff were asked how they intervened and protected Individual #3 from injuring herself when she was engaging in maladaptive behavior. Present staff working with Individual #3 stated there were no interventions in her BMP to keep her safe. Individual #3's BMP, dated 7/31/07, included target behaviors for tantrums (described as attempting to bite, flailing her arms, crying, yelling, rocking back and forth in her wheelchair, and attempting to get out of her wheelchair to come after the staff person), assault (described as hitting or kicking another individual), and biting (described as biting staff on the neck, arms, hand or other body parts). It was noted the interventions for each maladaptive behavior, under the "Staff Response" section of her BMP, were identical and included the following five steps: 1) Ask her simple questions to determine what upset her. 2) Provide reinforcement if she responded to the questions. 3) "Step Out of Reach: When [Individual #3] is in a tantrum, it is always best to move out of her range of contact. This is case she tries to bite	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 60 you." 4) Offer her a choice to go to her room. 5) Assist her with choosing an alternative activity or task. Individual #3's BMP stated if she was attempting to throw herself out of her wheelchair, staff were to ask her if she would like assistance getting out of her wheelchair. If she said yes, staff were to assist her. If she began to fall, staff were to lower her to the ground by her gait belt. The ATS was interviewed on 7/29/10 at 1:00 p.m. When asked, the ATS stated they used to use a mat when she was on the floor but had to stop because it was not in Individual #3's BMP. The ATS stated they tried blocking to protect her as they did not want her to get hurt, but blocking was not in her BMP either. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #3's 7/31/07 BMP was the most current program and it did not include protective interventions. When asked, the QMRP stated she was not sure what staff did to protect Individual #3. The facility failed to ensure Individual #3's BMP contained sufficient protective interventions to ensure her physical safety needs were met when she engaged in maladaptive behaviors. 2. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian.	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 61 Individual #2's BMP, dated 6/29/10, included the following target behaviors: - Assault which was defined as hitting others which included kicking, using arms/hands to hit an individual, or using an object to hit an individual. Under the section titled Staff Response, it stated if Individual #2 was hitting, staff were to 1) step back out of her reach, 2) ask her simple questions to determine what upset her and assist her with obtaining the desired item if possible, 3) listen to her, and 4) "Once [Individual #2] has de-escalated, it is important to teach her how to manage her frustrations. Teach her how to get out the anger, fear, or frustration without getting herself or others hurt in the process by helping her learn new, acceptable ways of expressing their [sic] feelings (i.e., suggest going for a walk, writing a letter, drawing a picture, etc.)." The instructions under Staff Response for Assault did not contain instructions on how to intervene if Individual #2 was assaulting another individual. - Refusing Programmatic Tasks was defined as refusing to participate in scheduled activities and not wanting to take a bath, floss her teeth, and clean her room. Under the section titled Staff Response, it stated staff were to 1) discuss the natural consequences, 2) if she refused to participate in the task, staff were to inform her she had five more minutes, 3) if she still refused to complete the task, staff were to assess the situation. If it was a hygiene task, staff were to call the QMRP. If it was a task like laundry and Individual #2 wanted to do it later, staff were to "negotiate" with her and "then do an informal written contract." "Informal written contract" was	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 62 not clearly defined. However, under the section titled Staff Instructions in Individual #2's Schedule program, dated 1/4/10, it stated "[Individual #2's] Game Boy & (and) Tomogachi Games will be kept locked up in the medication cabinet. Her television was removed from her bedroom. These items are highly reinforcing to [Individual #2]. She enjoys her time away to participate in these activities. [Individual #2's] staff is responsible to follow this program exactly the way it is written - DO NOT DEVIATE FROM THIS PROGRAM UNDER ANY CIRCUMSTANCES!!" The attached schedule was divided into 15 minute increments, starting at 7:00 a.m. and ending at 9:00 p.m., for each day of the week including Saturday and Sunday. According to the schedule, Individual #2 had three ½ hour opportunities a day to earn free time. If she did not earn free time, she had pick up dirty laundry in her room, wash a load of her clothes, vacuum her room, dust her room, or help cook dinner for everyone for the first 15 minutes and then she was allowed to read a book or newspaper the second 15 minutes but "cannot access the game boy, Tomogachi Game or TV (television)." Given the instructions to staff and rigorous time frames in Individual #2's Schedule program, it would not be possible to implement her BMP, as written, when she was engaging in the target behaviors (i.e., assist her with obtaining the desired item...suggest going for a walk, writing a letter, drawing a picture...offer her a functional activity...negotiate with her). During an observation on 7/27/10 at 5:45 p.m., a	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 63 staff person working with Individual #2 was asked about her schedule. Staff stated if Individual #2 refused to follow her schedule, staff were to continue to prompt her and score a "no" next to the task. Staff stated they were not allowed to deviate from the schedule. Additionally, Individual #2 agreed to be interviewed on 7/29/10 at 2:15 p.m. When asked, she stated if she did not follow her schedule or was having a bad day, staff scored a "no" and "restrict my personal stuff." When asked how the BMP was suppose to work given the instructions in the Schedule program, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., "staff just do it; they allow for flexibility." The facility failed to ensure sufficient safeguards were in place to ensure Individual #2's personal possessions were not restricted when she did not follow her schedule and when Individual #2's personal possessions were removed from her when Individual #1 threatened suicide. 3. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. Her BMP, dated 6/15/10, included a target behavior for suicide threats and attempts. Under the section titled Staff Response, the facility's Policy on Suicide Precautions, dated 5/25/10, was	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 64 listed verbatim. The facility's suicide policy stated staff were to ensure the individual was safe (defined as removal of any harmful implement or substance within the vicinity of that individual), then call the local hospital's behavioral health services office to consult with them about the state and condition of the individual, and then obtain and implement the recommendations. The policy stated if the recommendation was to remain in the home environment, staff were to conduct visual observations of the resident and environment no less than every fifteen (15) minutes and up to continual observation as instructed by the Mental Health Program Professional. However, the facility's suicide policy did not define or contain sufficient directions related to enhanced supervision of Individual #1 when she threatened or attempted suicide. The policy did not contain clear directions to ensure all potentially harmful items were removed from Individual #1's environment, completing an inventory of removed items, and ensuring those items were secured. The policy did not address conducting a body search to ensure Individual #1 did not have potentially harmful items concealed on her person. The policy did not address re-assessing Individual #1 when she returned to the facility to ensure she was no longer suicidal, what level of supervision was required upon her return, and when her personal possessions could be returned to her. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., she thought the suicide policy was okay.	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 65 The facility failed to ensure Individual #1's BMP contained sufficient protective interventions to ensure her physical safety needs were met when she engaged in suicidal ideation and that her rights were protected when her personal possessions were removed from her based on her suicidal ideation. 4. Individual #4's IPP, dated 11/10/09, documented a 22 year old female diagnosed with severe mental retardation and cerebral hypotonia (a form of cerebral palsy characterized by low muscle tone). Individual #4's BMP, dated 2/7/10, included target behaviors for self-injurious behavior (described as biting her hand (usually the left hand), hitting her head, or other acts that could cause injury to herself), crying (described as when she had tears), and destruction of property (described as tearing apart books, taking things apart in her room, and picking apart clothing). Under the section titled Staff Response for self-injurious behavior, it stated staff were to 1) ask her simple questions to determine what upset her, 2) reinforce her for communicating, 3) offer her a quiet area, and 4) "Assist [Individual #4] with channeling her feelings into an activity. [Individual #4] does much better if her hands are occupied doing an activity." The instructions under Staff Response for Self-Injurious Behavior did not specify how to protect and intervene when Individual #4 was biting her hand or hitting her head. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m.,	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 285	Continued From page 66 Individual #4's BMP did not include protective interventions related to self-injurious behavior. The facility failed to ensure Individual #4's BMP contained sufficient protective interventions to ensure her physical safety needs were met when she engaged in self-injurious behavior.	W 285		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR 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 observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the program plans for 4 of 4 individuals (Individuals #1 - #4) whose behavior management programs were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' rights and physical safety needs were met. The findings include: 1. Individual #3's IPP, dated 7/7/10, documented a 39 year old female diagnosed with severe mental retardation and cerebral palsy. She used a wheelchair for mobility purposes. Individual #3's SIRs were reviewed and showed the following injures she sustained during maladaptive behaviors:	W 289	**W 289 483.450(b)(4)** Individual #3's Behavior management program will be revised to incorporate more appropriate interventions for when she displays behaviors that affect her physical safety. For Individual #2, the facility will provide her with a locking container so that she can lock up her own possessions if the suicide protocol is required because of individual #1. The suicide prevention policy will be revised addressing the topic of personal possessions. Individual #2 did not have a personal television. For individual #2, the facility will approach various agencies and potential volunteers to assist her with making informed consent regarding the removal of her gameboy/tomagachi toys (if the challenge of this restrictive element does not work). Individual #2 has no family members to approach. Individual #2's schedule will also be revised. For Individual #1, the Suicide Prevention Policy will be revised and implemented. For individual #4 the behavior management program will be revised to incorporate more appropriate interventions for when she displays behavior that affect her physical safety.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 67 - 3/12/10 at 12:10 p.m.: "After we did the [fire] drill she was fine till [sic] it went off the second time. She jumped out of her chair numerous times in the kitchen and hallway. Then the ATS tried to have [sic] her involved and it got worse from there. We left her on the floor till [sic] it was over. She then jumped up and slammed her head on a table." The Nurse's Comments showed Individual #3 sustained "abrasions and bruising to left side of face from chin around outside of mouth to base of nose." - 5/7/10 at 11:07 a.m.: "Resident [Individual #3] flipped herself out of her chair. She was trying to bite staff, so staff lowered her to the floor and stepped out of her reach. Female resident [Individual #3] then started to flip around on the kitchen floor. She hit her head on the table, a chair and the baker's rack. She has a bump on her forehead. Her mouth is also bleeding. She also has some red marks on her sides and stomach." The Nurse's Comments stated "Swelling on head gone within 2 hrs (hours) - left red mark. Had bitten lower lip - bleeding stopped within minutes - slight amount of swelling [sic]. Red marks on adb (abdomen) and sides gone with [sic] 2 hrs (hours)." During an observation on 7/26/10 at 4:00 p.m., staff were asked how they intervened and protected Individual #3 from injuring herself when she was engaging in maladaptive behavior. Present staff working with Individual #3 stated there were no interventions in her BMP to keep her safe. Individual #3's BMP, dated 7/31/07, included target behaviors for tantrums (described as	W 289	**For the other individuals in the facility, the Qualified Mental Retardation Professional will review the other charts for appropriate behavioral interventions and make revisions as necessary.** **Corrective Action Completion Date: September 1, 2010** **Person Responsible: Jamie L. Anthony, Residential Program Director**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 68 attempting to bite, flailing her arms, crying, yelling, rocking back and forth in her wheelchair, and attempting to get out of her wheelchair to come after the staff person), assault (described as hitting or kicking another individual), and biting (described as biting staff on the neck, arms, hand or other body parts). It was noted the interventions for each maladaptive behavior, under the "Staff Response" section of her BMP, were identical and included the following five steps: 1) Ask her simple questions to determine what upset her. 2) Provide reinforcement if she responded to the questions. 3) "Step Out of Reach: When [Individual #3] is in a tantrum, it is always best to move out of her range of contact. This is case she tries to bite you." 4) Offer her a choice to go to her room. 5) Assist her with choosing an alternative activity or task. Individual #3's BMP stated if she was attempting to throw herself out of her wheelchair, staff were to ask her if she would like assistance getting out of her wheelchair. If she said yes, staff were to assist her. If she began to fall, staff were to lower her to the ground by her gait belt. The ATS was interviewed on 7/29/10 at 1:00 p.m. When asked, the ATS stated they used to use a mat when she was on the floor but had to stop because it was not in Individual #3's BMP. The ATS stated they tried blocking to protect her as they did not want her to get hurt, but blocking was not in her BMP either.	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 69 When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #3's 7/31/07 BMP was the most current program and it did not include protective interventions. When asked, the QMRP stated she was not sure what staff did to protect Individual #3. The facility failed to ensure Individual #3's BMP was sufficiently developed and contained instructions to staff related to protective interventions during maladaptive behaviors. 2. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record showed she was her own guardian. Individual #2's BMP, dated 6/29/10, included the following target behaviors: - Assault which was defined as hitting others which included kicking, using arms/hands to hit an individual, or using an object to hit an individual. Under the section titled Staff Response, it stated if Individual #2 was hitting, staff were to 1) step back out of her reach, 2) ask her simple questions to determine what upset her and assist her with obtaining the desired item if possible, 3) listen to her, and 4) "Once [Individual #2] has de-escalated, it is important to teach her how to manage her frustrations. Teach her how to get out the anger, fear, or frustration without getting herself or others hurt in the process by helping her learn new, acceptable ways of expressing their [sic] feelings (i.e., suggest going for a walk, writing a letter, drawing a picture,	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 70 etc.)." The instructions under Staff Response for Assault did not contain instructions on how to intervene if Individual #2 was assaulting another individual. - Refusing Programmatic Tasks was defined as refusing to participate in scheduled activities and not wanting to take a bath, floss her teeth, and clean her room. Under the section titled Staff Response, it stated staff were to 1) discuss the natural consequences, 2) if she refused to participate in the task, staff were to inform her she had five more minutes, 3) if she still refused to complete the task, staff were to assess the situation. If it was a hygiene task, staff were to call the QMRP. If it was a task like laundry and Individual #2 wanted to do it later, staff were to "negotiate" with her and "then do an informal written contract." "Informal written contract" was not clearly defined. However, under the section titled Staff Instructions in Individual #2's Schedule program, dated 1/4/10, it stated "[Individual #2's] Game Boy & (and) Tomogachi Games will be kept locked up in the medication cabinet. Her television was removed from her bedroom. These items are highly reinforcing to [Individual #2]. She enjoys her time away to participate in these activities. [Individual #2's] staff is responsible to follow this program exactly the way it is written - DO NOT DEVIATE FROM THIS PROGRAM UNDER ANY CIRCUMSTANCES!!" The attached schedule was divided into 15 minute increments, starting at 7:00 a.m. and ending at 9:00 p.m., for each day of the week including Saturday and Sunday. According to the schedule, Individual #2 had three ½ hour opportunities a day to earn free	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 71 time. If she did not earn free time, she had pick up dirty laundry in her room, wash a load of her clothes, vacuum her room, dust her room, or help cook dinner for everyone for the first 15 minutes and then she was allowed to read a book or newspaper the second 15 minutes but "cannot access the game boy, Tomogachi Game or TV (television)." During an observation on 7/27/10 at 5:45 p.m., a staff person working with Individual #2 was asked about her schedule. Staff stated if Individual #2 refused to follow her schedule, staff were to continue to prompt her and score a "no" next to the task. Staff stated they were not allowed to deviate from the schedule. Additionally, Individual #2 agreed to be interviewed on 7/29/10 at 2:15 p.m. When asked, she stated if she did not follow her schedule or was having a bad day, staff scored a "no" and "restrict my personal stuff." Given the instructions to staff and rigorous time frames in Individual #2's Schedule program, it would not be possible to implement her BMP, as written, when she was engaging in the target behaviors (i.e., assist her with obtaining the desired item...suggest going for a walk, writing a letter, drawing a picture...offer her a functional activity...negotiate with her). When asked how the BMP was suppose to work given the instructions in the Schedule program, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., "staff just do it; they allow for flexibility." The facility failed to ensure Individual #2's	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 72 schedule program was compatible with her BMP. 3. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. Her BMP, dated 6/15/10, included a target behavior for suicide threats and attempts. Under the section titled Staff Response, the facility's Policy on Suicide Precautions, dated 5/25/10, was listed verbatim. The facility's suicide policy stated staff were to ensure the individual was safe (defined as removal of any harmful implement or substance within the vicinity of that individual), then call the local hospital's behavioral health services office to consult with them about the state and condition of the individual, and then obtain and implement the recommendations. The policy stated if the recommendation was to remain in the home environment, staff were to conduct visual observations of the resident and environment no less than every fifteen (15) minutes and up to continual observation as instructed by the Mental Health Program Professional. However, the facility's suicide policy did not define or contain sufficient directions related to enhanced supervision of Individual #1 when she threatened or attempted suicide. The policy did not contain clear directions to ensure all potentially harmful items were removed from Individual #1's environment, completing an	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 73 inventory of removed items, and ensuring those items were secured. The policy did not address conducting a body search to ensure Individual #1 did not have potentially harmful items concealed on her person. The policy did not address re-assessing Individual #1 when she returned to the facility to ensure she was no longer suicidal, what level of supervision was required upon her return, and when her personal possessions could be returned to her. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., she thought the suicide policy was okay. The facility failed to ensure Individual #1's BMP was sufficiently developed and contained clear instructions to staff related to suicidal ideation. 4. Individual #4's IPP, dated 11/10/09, documented a 22 year old female diagnosed with severe mental retardation and cerebral hypotonia (a form of cerebral palsy characterized by low muscle tone). Individual #4's BMP, dated 2/7/10, included target behaviors for self-injurious behavior (described as biting her hand (usually the left hand), hitting her head, or other acts that could cause injury to herself), crying (described as when she had tears), and destruction of property (described as tearing apart books, taking things apart in her room, and picking apart clothing). Under the section titled Staff Response for self-injurious behavior, it stated staff were to 1) ask her simple questions to determine what upset her, 2) reinforce her for communicating, 3) offer her a quiet area, and 4) "Assist [Individual #4]	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 289	Continued From page 74 with channeling her feelings into an activity. [Individual #4] does much better if her hands are occupied doing an activity." The instructions under Staff Response for Self-Injurious Behavior did not specify how to protect and intervene when Individual #4 was biting her hand or hitting her head. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #4's BMP did not include protective interventions related to self-injurious behavior. The facility failed to ensure Individual #4's BMP was sufficiently developed and contained instructions to staff related to protective interventions during self-injurious behavior.	W 289		
W 303	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 interviews, it was determined the facility failed to ensure an individual's record documented a clear understanding of the events before, during, and after the use of restraint for 1 of 1 individual (Individual #4) whose dental record documented the use of restraint. Failure to keep a comprehensive record of restraint usage impeded the IDT's, the facility's HRC, and an individual's guardian's ability to make informed decisions and/or recommendations regarding the use of restraint. The findings include: 1. Individual #4's IPP, dated 11/10/09,	W 303	**W 303 483.450(d)(4)** For Individual #4 and all other clients in the facility, the LPN will ensure a Significant Incident Report is completed for each incident of restraint in which it was related to medical and dental examinations. Corrective Action Completion Date: September 30, 2010 Person Responsible: Christy Day, LPN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 303	Continued From page 75 documented a 22 year old female diagnosed with severe mental retardation and cerebral hypotonia. According to Individual #4's dental record, a papoose board was used with her during dental examinations on 12/5/08, 6/11/09, and 1/8/10. When asked about records of restraint related to the papoose board, the LPN stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., there were no records. The LPN stated she did not know a record was required for restraints related to medical and dental examinations. The facility failed to ensure the use of restraint for Individual #4's dental procedures were documented to present a clear understanding of the events prior to, during, and following its use.	W 303		
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 an individual's IPP that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 4 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs	W 312	**W 312 483.450(e)(2)** For individual #1 a medical reduction plan will be written and presented to the treatment team. The Qualified Mental Retardation Professional will conduct chart reviews to ensure all of the clients have appropriate medication reduction plans in place. Corrective Action Completion Date: September 1, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 312	Continued From page 76 without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's IPP, dated 6/15/10, documented a 51 year old female diagnosed with mild mental retardation, schizophrenia paranoid type, borderline personality disorder, and insulin-dependent diabetes mellitus Type 2. Individual #1 was admitted to the facility on 5/17/10 with a history of impulse control disorder and major depression. Individual #1's Consent for Treatment, dated 5/17/10, showed was admitted to the facility with the following routine behavior modifying drugs: - Geodon (an antipsychotic drug) 240 mg daily, for schizophrenia. - Haldol (an antipsychotic drug) 5 mg daily, for schizophrenia and borderline personality disorder. - Lexapro (an antidepressant drug) 20 mg daily, for depression and anxiety. - Trazodone (an antidepressant drug) 200 mg daily, for depression. Individual #1's record did not contain a plan related to the use of the drugs. When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., there was no plan related to the use of the drugs and there were no plans related to the signs and symptoms for which the drugs were prescribed. The QMRP stated they were still trying to figure out what the drugs were for. The facility failed to develop plans related to Individual #1's use of behavior modifying drugs as well as plans related to the signs and symptoms for which the drugs were prescribed.	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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 312	Continued From page 77	W 312		
W 381	Repeat deficiency. 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and individual and staff interview, it was determined the facility failed to ensure all drugs were securely locked except when being prepared for administration for 1 of 1 individual (Individual #1) who kept medication in the refrigerator. This resulted in the potential for harm to all individuals (Individuals #1 - #8) residing in the facility in the event any individual accessed and ingested the drugs. The findings include: 1. On 7/27/10 at 7:25 a.m., Individual #1 came into the medication room to take her medications. She was carrying a plastic bag containing a bottle of Humalog (a diabetes drug) 100 U and a bottle of Lantus (a diabetes drug) 100 U. When asked where the medications came from, she stated she got them from the kitchen refrigerator. When asked if they were kept locked, she stated no. She proceeded to show the surveyor a space next to a container of sour cream on the second shelf of the inside door of the refrigerator, and stated "they are kept right there." The refrigerator was not noted to contain any kind of a locked container. When asked, the LPN, who was present during the medication pass, stated the medications needed to locked.	W 381	**W 381 483.460(l)1)** For individual #1, the facility has provided a locked box for the medications that were unlocked at time of survey. The LPN will ensure all medications are locked appropriately. Corrective Action Completion Date: August 17, 2010 Person Responsible: Christy Day, LPN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 381	Continued From page 78 The facility failed to ensure all drugs were securely locked except when being prepared for administration.	W 381		
W 436	483.470(g)(2) SPACE AND EQUIPMENT 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 record review and staff interview, it was determined the facility failed to ensure individuals were taught to wear their eyeglasses for 1 of 1 individual (Individual #2) who required eyeglasses and was known to refuse to wear them. This resulted in an individual not wearing eyeglasses. The findings include: 1. Individual #2's IPP, dated 10/6/09, documented a 21 year old female diagnosed with mild mental retardation, Fetal Alcohol syndrome, oppositional defiance disorder, Asperger's syndrome, and personality disorder NOS. Her record included a vision examination, dated 5/18/09, which stated "Care taker says she squints when she reads but don't [sic] like to wear her gls. [glasses]." An updated vision examination, dated 6/7/10, showed she had myopia and astigmatism. It stated "[LPN] says she [Individual #2] reads, but she squints to read. Doesn't wear her glasses for distance [sic]. Pt. [Patient] feels Rx [prescription]	W 436	**W 436 483.470(g)(2)** For individual #2, a program will be implemented to encourage her to wear her glasses as recommended by the Optometrist. For the other individuals in the facility, the Qualified Mental Retardation Professional will conduct chart reviews to ensure that programs are in place if any of the other individuals do not use their adaptive equipment appropriately. Corrective Action Completion Date: September 30, 2010 Person Responsible: Jamie L. Anthony, Residential Program Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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 436	Continued From page 79 is too strong." Under the section titled Patient Perception, it stated "[LPN] declined, says she won't wear them." When asked, the QMRP stated during an interview on 7/30/10 from 8:35 a.m. - 12:15 p.m., Individual #2 had glasses but did not like to wear them. When asked, the QMRP stated there was no program in place to address eyeglass wear for Individual #2. The facility failed to ensure a plan was in place to teach Individual #2 the importance of eyeglasses.	W 436		

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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	**MM164 16.03.11.075.04** Refer to W124 RECEIVED AUG 31 2010 FACILITY STANDARDS	
MM168	16.11.03.075.07(a) Rights as a Citizen Rights as a citizen refer to all the rights of citizens of this country and any particular state or locality. These include, but are not limited to, voting, marriage, divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not practice a religion. This Rule is not met as evidenced by: Refer to W125.	MM168	**MM168 16.11.03.075.07(a)** Refer to W125	
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See	MM177	**MM177 16.03.11.075.09** Refer to W122, W149, W285	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM177	Continued From page 1 also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W149, and W285.	MM177		
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	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W278.	MM191	**MM191 16.03.11.075.09(c)** Refer to W278	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's	MM194	**MM194 16.03.11.075.10(a)** Refer to W262	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G043	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/30/2010
NAME OF PROVIDER OR SUPPLIER CHURCH HILL DOWNS	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM194	Continued From page 2 human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian 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.	MM196	**MM196 16.03.11.075.10(c)** Refer to W263	
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 and W312.	MM197	**MM197 16.03.11.075.10(d)** Refer to W289 and W312	
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 16.03.11.075.15** Refer to W137	
MM212	16.03.11.075.17(a) Maximize Developmental Potential	MM212	**MM 212 16.03.11.075.17(a)** Refer to W 250 and W 266	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2010
NAME OF PROVIDER OR SUPPLIER CHURCH HILL DOWNS	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM212	Continued From page 3 The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W250 and W266.	MM212		
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 clean, sanitary, and 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: An environmental review was conducted on 7/29/10 from 1:55 - 2:15 p.m. During that time, the following was noted: - Two glass baking dishes contained dried food debris and baked-on grease. Four metal cookie sheets contained baked-on grease. - Two cloth chairs in the dining room were soiled with food. - There was a 3 inch piece of chair railing (trim)	MM380	**MM380 16.03.11.120.03(a)** **The two glass baking dishes and four metal cookie sheets will be replaced.** **The two cloth chairs in the dining room will be cleaned** **The chair railing in the laundry room will be fixed.**	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2010
NAME OF PROVIDER OR SUPPLIER CHURCH HILL DOWNS	STREET ADDRESS, CITY, STATE, ZIP CODE 1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM380	Continued From page 4 missing form the wall in the laundry room. - The window in Individual #7's bedroom was missing its handle. - The hot water handle of the sink was broken in the bathroom containing the bathtub. The caulking around the bathtub was cracked and peeling and there was black mold around the base of the bathtub. - The toilet in the bathroom containing the shower was noted to continuously run. There was black mold around the base of the shower. The door stop and the toilet paper dispenser were broken. The facility failed to ensure environmental repairs were maintained.	MM380	The window handle in individual #7's room will be replaced. The hot water handle of the sink will be fixed. The caulking around the bathtub will be fixed and replaced. The toilet in the shower bathroom will be fixed. The shower will be cleaned. The door stop and toilet paper dispenser will be fixed. Corrective Action Completion Date: September 30, 2010 Person Responsible: Sam Guyette, Facilities Manager and Jamie L. Anthony, Residential Program Director	
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	
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department.	MM520	**MM520 16.03.11.200.03(a)** Refer to W276	

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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM520	Continued From page 5 This Rule is not met as evidenced by: Refer to W276.	MM520		
MM620	16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W189.	MM620	**MM620 16.03.11.230.05(b)** Refer to W189	
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225.	MM724	**MM724 16.03.11.270.01(a)** Refer to W225	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	**MM725 16.03.11.270.01(b)** Refer to W159	

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
	13G043		07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS 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) COMPLETE DATE
MM730	Continued From page 6	MM730		
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	
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 W381.	MM753	**MM753 16.03.11.270.02(f)(i)** Refer to W381	
MM851	16.03.11.270.08(a)(ii) Appropriate Program Provide the basis for prescribing and appropriate program of training experiences for the resident. This Rule is not met as evidenced by: Refer to W210.	MM851	**MM851 16.03.11.270.08(a)(ii)** Refer to W210	