FILE 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 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

March 6, 2007

Ferren Weeks
Yellowstone Group Home #5 Burke
560 West Sunnyside
Idaho Falls, ID 83401

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure survey, which was concluded at your facility, Yellowstone Group Home #5, on February 16, 2007.

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

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

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

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

After you have completed your Plan of Correction, return the original to this office by **March 19, 2007**, and keep a copy for your records.

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

Sincerely,

NICOLE WISENOR
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

NW/mlw

Enclosures

RECEIVED
MAR 21 2007
FACILITY STANDARDS

March 19, 2007

Nicole Wisener
Health Facilitiy Surveyor
Bureau of Facility Standards

Dear Ms. Wisener

Enclosed is our plan of correction for the Burke Home survey completed February 16th 2007. I would like say "thank you" once again for the professionalism and insight that you and Ms. Jasso contributed to our visit. If you need any further details or have any questions please don't hesitate to give me a call.

Sincerely
Ferren Weeks

P.S. I circled a copy for corrections to what I faxed to you.

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

PRINTED: 03/05/2007
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
	13G067		02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #5 (BURKE)	4541 E BURKE DR AMMON, ID 83406

(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 your recertification survey. The surveyors conducting your survey were: Nicole Wisenor, QMRP, Team Leader Annette Jasso, QMRP Common abbreviations used in this report are: AD - Administrator Designee IHP - Individual Habilitation Plan LPN - Licensed Practical Nurse QMRP - Qualified Mental Retardation Professional	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain a record keeping system that contained consistent, accurate and comprehensive information for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in a lack of consistent information being available. The findings include: 1. Individual #3's 7/27/06 IHP stated he was a 22 year old male whose diagnoses included mild mental retardation and restless leg syndrome. Individual #3's record did not contain consistent and complete documentation as follows:	W 111	for the Plans of Correction for all deficiencies noted Please refer to the attached plan of Correction.	

RECEIVED
MAR 21 2007
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jason J. Webb — Regional Admin — 3/19/07

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

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W 111	Continued From page 1 a. His IHP stated he was receiving propanolol (an antianginal) for disruptiveness. However, his Medication Administration Record stated the medication was for "restless legs." When asked about the discrepancy, the QMRP and LPN stated on 2/15/07 at 3:30 p.m. the medication was for his restless leg syndrome. b. Individual #3's IHP stated Seroquel (an antipsychotic) was being used for his socially offensive behavior. However, his behavior management plan, start date 8/1/06, and his medication reduction plan, revised 8/2/06, stated Seroquel was being used for aggression. When asked about the discrepancy, the QMRP stated on 2/15/07 at 4:20 p.m., the Seroquel was used for aggression and the IHP was inaccurate. c. Individual #3's behavior management plan, start date 8/1/06, stated he was admitted to the facility (on 6/17/05) with "Psychotropic medication used for to [sic] treat aggression, depressive symptoms, and anxiety." However, objectives and plans related to Individual #3's depression and anxiety could not be found in his record. When asked, the QMRP stated on 2/16/07 at 9:20 a.m., depression and anxiety tracking had been in place since Individual #3 had been admitted. However, he had not displayed any symptoms to support the diagnoses. The QMRP stated Individual #3's diagnoses needed to be updated. d. Individual #3's physician's recap orders, dated 2/12/07, stated he was to receive Senakot 1 tablet daily. Additionally, his "Physician's Standing Medication Orders," undated, included an order which stated "MOM 30 - 60 cc PRN constipation." His record included tracking sheets	W 111		

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W 111	Continued From page 2 for his bowel movements. The form consisted of a grid which included the date, a.m., p.m., and night shifts and a comments section. Staff were to document whether or not Individual #3 had a bowel movement and all other pertinent information (i.e., size, consistency, etc.). The tracking sheets from 11/06 - 1/07 were reviewed. The tracking sheets did not contain complete documentation as follows: 11/06 - No documentation had been recorded on 3 morning shifts, 2 evening shifts, and 30 nights shifts. 12/06 - No documentation had been recorded on 12 morning shifts, 11 evening shifts, and 31 nights shifts. 1/07 - No documentation had been recorded on 12 morning shifts, 12 evening shifts, and 31 nights shifts. When asked about the documentation, the LPN stated on 2/15/07 at 2:10 p.m., she saw the individuals daily Monday through Friday, but she did not always see them on the weekends. She stated she knew the individuals were not experiencing constipation problems based on those daily visits. However, the bowel movement documentation was not adequate and she had addressed the issue with the staff. e. Individual #3's QMRP tracking forms included data summary information for following cooking directions. However, a corresponding objective could not be found in Individual #3's IHP. When asked about the data, the QMRP stated on 1/15/07 at 5:25 p.m., that Individual #3 had started working at the facility's deli in 11/06 and his IHP needed to be updated to include the objective.	W 111		

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W 111	Continued From page 3 2. Individual #1's 12/2/06 IHP stated he was a 23 year old male diagnosed with mild mental retardation, Diabetes, Bipolar Disorder, and Morbid Obesity. He was admitted to the facility on 12/2/06. Individual #1's record did not contain consistent and complete documentation as follows: a. Individual #1's IHP stated "Nursing recommends blood, constipation, and weight monitoring." Additionally, his "Physician's Standing Medication Orders," undated, included an order which stated "MOM 30 - 60 cc PRN constipation." His record included tracking sheets for his bowel movements. The form consisted of a grid which included the date, a.m., p.m., and night shifts and a comments section. Staff were to document whether or not Individual #1 had a bowel movement and all other pertinent information (i.e., size, consistency, etc.). The tracking sheets from 12/06 - 1/07 were reviewed. The tracking sheets did not contain complete documentation as follows: 12/06 - No documentation had been recorded on 13 morning shifts, 8 evening shifts, and 31 nights shifts. 1/07 - No documentation had been recorded on 11 morning shifts, 14 evening shifts, and 31 nights shifts. When asked about the documentation, the LPN stated on 2/15/07 at 2:10 p.m., she saw the individuals daily Monday through Friday, but she did not always see them on the weekends. She stated she knew the individuals were not experiencing constipation problems based on those daily visits. However, the bowel movement	W 111		

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W 111	Continued From page 4 documentation was not adequate and she had addressed the issue with the staff. b. Individual #1's physician's recap orders, dated 2/7/07, stated he received an 1800 calorie diet. However, his Dietary Assessment, dated 12/06 stated he was to receive a regular, reduced concentrated sweets diet, with larger protein and vegetables, no seconds and low calorie snacks. When asked about Individual #1's diet, the LPN stated on 2/15/07 at 2:25 p.m., Individual #1 was not receiving a restricted calorie (1800 calories) diet and his recap orders were not accurate. 3. Individual #2's 7/27/06 IHP stated he was a 54 year old male. He was diagnosed with severe mental retardation, seizure disorder, and left hemiparesis. Individual #2's record did not contain complete documentation as follows: a. Individual #2's physician's recap orders, dated 2/7/07, stated he was to receive Fiber Con 2 tabs each morning and Senakot 2 tabs daily. His "Physician's Standing Medication Orders," undated, included an order which stated "MOM 30 - 60 cc PRN constipation." His record included tracking sheets for his bowel movements. The form consisted of a grid which included the date, a.m., p.m., and night shifts and a comments section. Staff were to document whether or not Individual #2 had a bowel movement and all other pertinent information (i.e., size, consistency, etc.). The tracking sheets from 5/06 - 1/07 were reviewed. The tracking sheets did not contain complete documentation as follows: 5/06 - No documentation had been recorded on 3	W 111		

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W 111	Continued From page 5 morning shifts, 3 evening shifts, and 31 nights shifts. 6/06 - No documentation had been recorded on 3 morning shifts, 8 evening shifts, and 30 nights shifts. 7/06 - No documentation had been recorded on 4 morning shifts, 2 evening shifts, and 31 nights shifts. 8/06 - No documentation had been recorded on 6 morning shifts, 6 evening shifts, and 31 nights shifts. 9/06 - No documentation had been recorded on 6 morning shifts, 4 evening shifts, and 30 nights shifts. 10/06 - No documentation had been recorded on 9 morning shifts, 3 evening shifts, and 31 nights shifts. 11/06 - No documentation had been recorded on 28 morning shifts, 11 evening shifts, and 30 nights shifts. 12/06 - No documentation had been recorded on 5 morning shifts, 7 evening shifts, and 31 nights shifts. 1/07 - No documentation had been recorded on 17 morning shifts, 8 evening shifts, and 31 nights shifts. When asked about the documentation, the LPN stated on 2/15/07 at 2:10 p.m., she saw the individuals daily Monday through Friday, but she did not always see them on the weekends. She stated she knew the individuals were not experiencing constipation problems based on those daily visits. However, the bowel movement documentation was not adequate and she had addressed the issue with the staff. The facility failed to ensure the individuals' records contained consistent, accurate and	W 111		

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W 111	Continued From page 6 comprehensive information.	W 111		
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 staff interview and record review, it was determined the facility failed to ensure developmental assessments contained specific developmental strengths and needs described in functional terms for 3 of 3 individuals (Individuals #1 - #3) whose assessments were reviewed. This resulted in a lack of specific information on which to base program recommendations and decisions. Findings include: 1. The assessments for Individuals #1 - #3 were reviewed and included the following. Their records included "Academic Assessment (Group Home)," and "Vocational/Day treatment" assessments. The assessments consisted of a grid which contained multiple domains. Various developmental skills were listed in rows under each domain on the left hand column of the grid. For some domains, the grid included columns titled "Has skills," "Emerging Skills," and "No Skills," and a column for "Comments." Other domains included columns titled "Always," "Usually," "Sometimes," "Rarely," "Never" and a column for "Comment." Additional domains included columns titled "Knows and uses in public," "Identifies by naming when asked," "Finds upon request from a field of 4," "No skills," and a column for "Comments." The assessments did not include specific functional terms related to the individuals developmental strengths and needs.	W 214		

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W 214	Continued From page 7 Examples include but are not limited to the following: a. Individual #1's"Vocational/Day Treatment Assessment," dated 12/4/06, consisted of a grid which contained multiple domains (i.e. personal information and time management, shapes, colors, discrimination, math/numbers, reading skills, etc.). Various skills were listed in rows under each domain on the left hand column of the grid. The grid also included columns titled "Has skills," "Emerging Skills," and "No Skills," and a column for "Comments." The assessor was to place a mark in the appropriate box to indicate whether the individual had skills, had emerging skills, or had no skills for the assessed item. The assessment did not include specific functional terms related to Individual #1's developmental strengths and needs. Examples include but are not limited to the following: - The "Personal Information and Time Management" domain of the assessment included items for "Can spell common words" and "Can print/write notes/message." A checkmark was placed in the "Emerging Skills" column next to the items. No additional specific information was included as to how the skill was emerging. - The "Math/Numbers" domain of the assessment included items for "Multiplication" and "Division." A checkmark was placed in the "Emerging Skills" column next to the items. No additional specific information was included as to how the skill was emerging. - The "Math/Numbers" domain of the assessment included items for "Rote Counts 1 - " and "Identifies written numbers 1 - ." A checkmark	W 214		

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W 214	Continued From page 8 was placed in the "Has Skills" column next to the items. However, no additional specific information related to which numbers he could route count and identify was included in the assessment. Individual #1's assessment also included an "Academic Assessment (Group Home)," dated 12/3/06. The assessment also consisted of a grid which contained multiple domains (i.e. mobility and travel, cognitive skills, receptive language, community safety, etc.). Various skills were listed in rows under each domain on the left hand column of the grid. The grid also included columns titled "Always," "Usually," "Sometimes," "Rarely," "Never," and a column for "Comment." The assessor was to place a mark in the appropriate box to indicate the individual's skill level. The assessment did not include specific functional terms related to Individual #1's developmental strengths and needs. Examples include but are not limited to the following: - The "Mobility and Travel" domain of the assessment included items for "Travels route to home/day activity," "Walks up/down stairs," and "Walks on busy sidewalk without bumping into people." A checkmark was placed in the "Usually" column next to the items. No additional specific information was included on the assessment. - The "Cognitive Skills" domain of the assessment included items for "Resumes an activity after being disrupted" and "Is interested in manipulables [sic]." A checkmark was placed in the "Usually" column next to the items. No additional specific information was included on the assessment.	W 214		

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W 214	Continued From page 9 b. Individual #2's academic assessment, dated 6/29/06, included domains such as mobility and travel, cognitive skills, and community safety. - The "Mobility and Travel" domain of the assessment included items for "Practices pedestrian safety skills" and "Walks on busy sidewalk without bumping into people." An "X" was placed in the "Sometimes" column next to the items. No additional specific information was included on the assessment. - The "Cognitive Skills" domain of the assessment included items for "Resumes an activity after being disrupted" and "Is interested in manipulables [sic]." An "X" was placed in the "Sometimes" column next to the items. No additional specific information was included on the assessment. - The "Community Safety" domain of the assessment included items "responds to fire drill with a verbal cue" and "Independently responds to fire drill." An "X" was placed in the "Usually" column next to the items. No additional specific information was included on the assessment. c. Individual #3's academic assessment, dated 6/29/06, included domains such as cognitive skills and money management and shopping. - The "Cognitive Skills" domain of the assessment included an item which stated "Tolerates training situations." An "X" was placed in the "Usually" column next to the item. No additional specific information was included on the assessment. - The "Money Management and Shopping"	W 214		

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W 214	Continued From page 10 domain of the assessment included items which stated "Prepares a list of needed items before going shopping" and "Saves money in a bank account for future purchases." An "X" was placed in the "Emerging Skills" column next to the items. No additional specific information was included on the assessment. When asked about the individuals' assessments, the QMRP stated on 2/16/07 at 9:05 a.m., the assessments did not include specific information. The facility failed to ensure the individuals' assessments contained specific developmental strengths and needs described in functional terms.	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 the comprehensive functional assessment included an assessment of vocational skills which provided specified information related to the individuals' work interests and potential present and future employment options for 3 of 3 individuals (Individuals #1 - #3) who were of working age and for whom such assessments were required. Without a comprehensive assessment, the facility would be unable to assist the individuals with their vocational training needs through development of objectives designed to optimize their abilities. The findings include: 1. Individual #1's 12/2/06 IHP stated he was a 23	W 225		

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W 225	Continued From page 11 year old male diagnosed with mild mental retardation, Diabetes, Bipolar Disorder, and Morbid Obesity. He was admitted to the facility on 12/2/06. His IHP stated "vocational training is not a realistic option for [Individual #1], primarily due to behavioral difficulties...We will continue to work on prerequisite skills in a vocational setting..." His Vocational Assessment, dated 12/4/06, consisted of a list of work skills and columns labeled "Never of rarely - even if asked," "Does but not well - about 1/4 time - may need to be asked," "Does fairly well - about 3/4 time - may need to be asked," and "Does very well - always or almost always - without being asked." The assessor was to place a mark in the appropriate line to indicate how well Individual #1 preformed the various work related skills. The assessments did not include specific functional terms related to the individuals developmental strengths and needs. Examples include but are not limited to the following: - The "Present And Future Job Options" section of the assessment included items which stated "Preforms work tasks for at least 5 minutes without stopping" and "Continues working when there are distractions in the work setting." An "X" was placed in the "Does fairly well - about 3/4 time - may need to be asked," column next to the items. No additional specific information was included on the assessment. - The "Present And Future Job Options" section of the assessment included items which stated "Tries to improve work performance when told that his/her work is not good" and Talks with other workers only when it does not interrupt work." An	W 225		

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YELLOWSTONE GROUP HOME #5 (BURKE)	4541 E BURKE DR AMMON, ID 83406

(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 12 "X" was placed in the "Does but not well - about 1/4 time - may need to be asked," column next to the items. No additional specific information was included on the assessment. When asked about the individuals' assessments, the QMRP stated on 2/16/07 at 9:05 a.m., the assessments did not include specific information. 2. Individual #2's 7/27/06 IHP stated he was a 54 year old male. He was diagnosed with severe mental retardation, seizure disorder, and left hemiparesis. His IHP stated "At this time off site vocational training is not a realistic option for [Individual #2]. Before this is considered, his limitations (listed in detail later in this document), will need to be greatly reduced. Among those limitations are self abuse, aggression, self stimulatory behavior, severely limited verbal skills, limited use of his left hand, poor vision, and poor attending skills. We will continue to work on prerequisite skills in a vocational setting so that [Individual #2] can work towards his long term goal of working in a coffee shop, a field which he has demonstrated some aptitude, and significant interest towards." His Vocational Assessment, dated 6/23/06, consisted of a list of work skills and columns labeled "Never of rarely - even if asked," "Does but not well - about 1/4 time - may need to be asked," "Does fairly well - about 3/4 time - may need to be asked," and "Does very well - always or almost always - without being asked." The assessor was to place a mark in the appropriate line to indicate how well Individual #2 preformed the various work related skills. The assessments did not include specific functional terms related to	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
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W 225	Continued From page 13 the individuals developmental strengths and needs. Examples include but are not limited to the following: - The "Present And Future Job Options" section of the assessment included items which stated "Preforms work tasks for at least 5 minutes without stopping" and "Selects one object from a group of different objects on request." An "X" was placed in the "Does but not well - about 1/4 time - may need to be asked" column next to the items. No additional specific information was included on the assessment. - The "Present And Future Job Options" section of the assessment included items which stated "Indicates when a chore or assigned task is finished," and "Picks up small objects with hand." An "X" was placed in the "Does fairly well - about 3/4 time - may need to be asked" column next to the items. No additional specific information was included on the assessment. - The "Present And Future Job Options" section of the assessment included items which stated "Continues working when there are distractions in the work setting," and "Accepts criticism of a job without showing anger." An "X" was placed in the "Never of rarely - even if asked" column next to the items. No additional specific information was included on the assessment. When asked about the individuals' assessments, the QMRP stated on 2/16/07 at 9:05 a.m., the assessments did not include specific information. 3. Individual #3's 7/27/06 IHP stated he was a 22 year old male whose diagnoses included mild mental retardation and restless leg syndrome.	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
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W 225	Continued From page 14 His IHP stated "[Individual #3] has been making tremendous vocational progress working with staff doing various maintenance/lawn care projects. [Individual #3's] biggest limitation to independent employment is the abundance of inappropriate behavior. This is being addressed via counseling in work settings and behavior modeling." His Pre-Vocational/Day Treatment Assessment, dated 6/12/06, consisted of a list of work skills and columns labeled "Never of rarely - even if asked," "Does but not well - about 1/4 time - may need to be asked," "Does fairly well - about 3/4 time - may need to be asked," and "Does very well - always or almost always - without being asked." The assessor was to place a mark in the appropriate line to indicate how well Individual #3 preformed the various work related skills. The assessments did not include specific functional terms related to the individuals developmental strengths and needs. Examples include but are not limited to the following: - The "Present And Future Job Options" section of the assessment included items which stated "Talks with other workers only when it does not interrupt work," and "Waits at least 2 minutes for turn in a group activity." An "X" was placed in the " Does but not well - about 1/4 time - may need to be asked" column next to the items. No additional specific information was included on the assessment. - The "Present And Future Job Options" section of the assessment included items which stated "Works at a steady pace on a job for at least 30 minutes," and "Follows simple spoken directions."	W 225		

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W 225	Continued From page 15 An "X" was placed in the "Does fairly well - about 3/4 time - may need to be asked," column next to the items. No additional specific information was included on the assessment. When asked about the individuals' assessments, the QMRP stated on 2/16/07 at 9:05 a.m., the assessments did not include specific information. The facility failed to ensure the individuals' vocational assessments provided sufficient information on which to base program decisions.	W 225		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure written training programs provided clear and sufficient directions to staff on how to implement behavior programs for 3 of 3 individuals (Individual #1 - #3) whose behavior management plans were reviewed. This resulted in the potential for inconsistent application of techniques being utilized. The findings include: 1. The behavior management plans for Individuals #1 - #3 were reviewed and stated the following: a. Individual #1's 12/2/06 IHP stated he was a 23 year old male diagnosed with mild mental retardation, Diabetes, Bipolar Disorder, and Morbid Obesity. He was admitted to the facility on 12/2/06. His Behavior Management Plan, revised 1/1/07, stated he engaged in aggression,	W 234		

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W 234	Continued From page 16 socially offensive behavior (defined as inappropriately touching others, pouting, whining, and yelling), disruptive behavior (defined as interrupting, pacing, and perseverating thoughts), and destruction of property. b. Individual #2's 7/27/06 IHP stated he was a 54 year old male. He was diagnosed with severe mental retardation, seizure disorder, and left hemiparesis. His Behavior Management Plan, revised 8/1/06, stated he engaged in aggression (defined as hitting, kicking, and biting others), property destruction (defined as throwing and breaking objects, hitting walls, tearing objects off the walls and "messing up" his room), self abuse (defined as hitting himself on the head, biting, and pinching himself), and socially offensive behaviors (defined as whining, inappropriate touching of himself and others, and swearing). c. Individual #3's 7/27/06 IHP stated he was a 22 year old male whose diagnoses included mild mental retardation and restless leg syndrome. His behavior management plan, start date 8/1/06, stated he engaged in aggression (defined as hitting, kicking, pushing, and biting others), socially offensive behavior (defined as inappropriately touching others and pouting), disruptive behavior (defined as interrupting), property destruction, and uncooperative behavior. All three of the individuals' behavior management plans stated the individuals were to engage in "appropriate replacement behaviors such as coping skills (ask [Individual's name] if he needs some quiet time in his room when he is upset) utilize relaxation (watch TV, exercise) and feelings awareness (talk about what is bothering him...)."	W 234		

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W 234	Continued From page 17 The plans did not include specific individualized information or instructions to staff regarding how to implement the replacement behavior component of the plan. When asked about the individuals' plans, the QMRP stated on 2/16/07 at 8:57 a.m., the plans were not individualized and needed to be revised.	W 234		
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 record review and staff interviews, it was determined the facility failed to ensure evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 3 of 3 individuals (Individual #1 - #3) whose restrictive interventions were reviewed. This resulted in the potential for individuals to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #2's 7/27/06 IHP stated he was a 54 year old male. He was diagnosed with severe mental retardation, seizure disorder, and left hemiparesis. His Psychiatric notes, dated 3/1/06, documented he had been experiencing sleep problems. He was prescribed Zyprexa (an antipsychotic) 5 mg each evening. However,	W 278		

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W 278	Continued From page 18 Individual #3's record did not include evidence of less restrictive interventions being tried and found to be ineffective prior to the use of the medication. Additionally, there was no evidence that a medication with fewer potential adverse side effects had been tried prior to the use of the antipsychotic medication. When asked about less restrictive interventions, the QMRP stated on 2/16/07 at 9:30 a.m., that less restrictive interventions had not been used. 2. Individual #1's 12/2/06 IHP stated he was a 23 year old male diagnosed with mild mental retardation, Diabetes, Bipolar Disorder, and Morbid Obesity. He was admitted to the facility on 12/2/06. His Behavior Management plan, revised 1/1/07, included the use of a "Privilege Hierarchy." The plan stated the following: "In order to attach some relevance to [Individual #1's] actions and the consequences of said actions to [Individual #1], the [facility] action team has decided to place [Individual #1] on a privilege hierarchy in which he is able to directly able to ascertain [sic] that certain actions result in the loss of certain privileges. Under no circumstances are any rights to be restricted as a result of this hierarchy. We have decided that although the biggest number of behaviors are those associated with socially inappropriate behavior and disruptiveness, we will focus this behavior modification technique only on those behaviors that can't be addressed via removal or extinction. We will limit the utilization to Aggression, Socially Offensive Behavior, and Property Destruction. There are 5 levels of privileges with application to both day treatment and the home in a uniform manner. The	W 278		

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W 278	Continued From page 19 privileges range from level 1(minimal) [sic] to level 5 (maximum use of personal freedom, trust, and facility resources (laptops/tv's/videogame consoles/entertainment content)). Using input from trainers and other staff, either the AD, the Administrator, or the Day Treatment supervisor can immediately raise or lower [Individual #1's] current privilege level. [Individual #1's] privilege level will be clearly stated to the oncoming shift in communications and the Day treatment log." "Level 1 (lowest) [Individual #1] has all rights, but minimal privileges. [sic] Heavily Supervised. He can attend Day Treatment and participate in activities at the home. No community activities." "Level 2 [Individual #1] can use the laptop for work and journal (esteem). He can participate in community activities. No individual community activities." "Level 3 [Individual #1] can use laptop for personal entertainment, videogames are allowed to be played on the console in his room, and individual community activities are encouraged." "Level 4 He earns the opportunity to go to the library or [store name], and to plan an off menu meal once a week of his own choosing, paying heed to the nutritional requirements of the other residents, and the dietary guidelines." "Level 5 He earns the opportunity to cash his check independently in a bank, and to shop in a	W 278		

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W 278	Continued From page 20 convenience store independently once a week, and to go to a movie of his choice (content appropriate)." "He will earn his way up levels progressively dependent upon accumulated good behavior. Such decisions will be made by the AD, the administrator, and/or the Day treatment supervisor. A week of consecutive good behavior will merit a move to a higher level." Documentation of the use of less restrictive interventions which were attempted and found to be ineffective prior to the restriction of his community activities rights and other privileges for each level of the privilege hierarchy could not be found in Individual #1's record. When asked, the QMRP stated on 2/16/07 at 9:30 a.m., Individual #1's record did not include evidence of less restrictive interventions. 3. Individual #3's 7/27/06 IHP stated he was a 22 year old male whose diagnoses included mild mental retardation and restless leg syndrome. His Behavior Management plan, start dated 8/1/06, included the use of a "Privilege Hierarchy." The plan stated the following: "In order to attach some relevance to [Individual #3's] actions and the consequences of said actions to [Individual #3], the [facility] action team has decided to place [Individual #3] on a privilege hierarchy in which he is able to directly able to ascertain [sic] that certain actions result in the loss of certain privileges. Under no circumstances are any rights to be restricted as a result of this hierarchy. We have decided that although the biggest number of behaviors are those associated with socially inappropriate	W 278		

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W 278	Continued From page 21 behavior and disruptiveness, we will focus this behavior modification technique only on those behaviors that can't be addressed via removal or extinction. We will limit the utilization to Aggression, Self Abuse, and Property Destruction. There are 5 levels of privileges with application to both day treatment and the home in a uniform manner. The privileges range from level 1(minimal) [sic] to level 5 (maximum use of personal freedom, trust, and facility resources (laptops/tv's/videogame consoles/entertainment content)). Using input from trainers and other staff, either the AD, the Administrator, or the Day Treatment supervisor can immediately raise or lower [Individual #3's] current privilege level. [Individual #3's] privilege level will be clearly stated to the oncoming shift in communications and the Day treatment log." "Level 1 (lowest) [Individual #3] has all rights, but minimal privileges. [sic] Heavily Supervised. He can attend Day Treatment and participate in activities at the home. No community activities. The company provided TV in his room is removed." "Level 2 [Individual #3] can use the laptop for work and journal. He can participate in community activities. No individual community activities. Company provided tv [sic] in room returned." "Level 3 [Individual #3] can use laptop for personal entertainment, videogames are allowed to be played on the console in his room, and individual community activities are encouraged." "Level 4	W 278		

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W 278	Continued From page 22 He earns the opportunity to work with [name of staff] in maintenance, and to plan an off menu meal once a week of his own choosing, paying heed to the nutritional requirements of the other residents, and the dietary guidelines." "Level 5 He earns the opportunity to cash his check independently in a bank, to earn a trac [sic] phone ([sic] the first 40 minutes of which will be provided by [facility]) and to shop in a convenience store independently o [sic] a week." "He will earn his way up levels progressively dependent upon accumulated good behavior. Such decisions will be made by the AD, the administrator, and/or the Day treatment supervisor. A week of consecutive good behavior will merit a move to a higher level." Documentation of the use of less restrictive interventions which were attempted and found to be ineffective prior to the restriction of his community activities rights and other privileges for each level of the privilege hierarchy could not be found in Individual #3's record. When asked, the QMRP stated on 2/16/07 at 9:30 a.m., Individual #3's record did not include evidence of less restrictive interventions. The facility failed to ensure less restrictive interventions were attempted and found to be ineffective prior to the use of more restrictive intervention being implemented for Individuals #1 - #3.	W 278		
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	W 312		

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W 312	Continued From page 23 client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IHPs that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs were employed for 2 of 3 individuals (Individuals #1 - #2) reviewed, who received behavior modifying drugs. This resulted in individuals receiving behavior modifying drugs without plans that identified drug usage and how it may change in relation to progress or regression. The findings include: 1. Individual #1's 12/2/06 IHP stated he was a 23 year old male diagnosed with mild mental retardation, Diabetes, Bipolar Disorder, and Morbid Obesity. He was admitted to the facility on 12/2/06. His Behavior Management Plan, revised 1/1/07 stated he received Klonopin (an anticonvulsant) 1 mg each evening to decrease his anxiety symptoms and Geodone (an antipsychotic) 40 mg each morning and 80 mg each evening for aggression. The plan further stated he received Prozac (an antidepressant) 30 mg daily for depression and Trazodone (an antidepressant) 100 mg for sleep. Individual #1's record included an objective, plan, and tracking for aggression. Objectives and	W 312		

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W 312	Continued From page 24 tracking were also included for Depression, Anxiety, and sleep. However, plans designed to reduce, ameliorate, compensate or eliminate Individual #1's psychiatric symptoms (related to his Depression and Anxiety) were not in place. Additionally, his record did not include a plan to address Individual #1's sleep disturbances. When asked about the plans, the QMRP stated on 2/16/07 at 9:57 a.m., Individual #1 did not have plans in place to address his Depression and Anxiety symptoms or his sleep disturbances. 2. Individual #2's 7/27/06 IHP stated he was a 54 year old male. He was diagnosed with severe mental retardation, seizure disorder, and left hemiparesis. His Behavior Management Plan, revised 8/1/06, stated he was to receive Seroquel (an antipsychotic) for sleep. His record did not include a plan to address his sleep disturbances. When asked about a plan, the QMRP stated 2/17/06 at 9:25 a.m., Individual #3 did not have such a plan. The facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IHPs.	W 312		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on environmental review and interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below	W 426		

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W 426	Continued From page 25 110 degrees Fahrenheit for 1 of 1 individual (Individual #2) known to be unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include: 1. Hot water temperatures were obtained at the facility during an environmental review on 2/14/07 at 9:10 a.m. and were recorded as follows: Kitchen sink- 118.8 Bathroom #1 sink - 118.0 Bathtub - 115.7 Bathroom #2 sink - 124.1 When asked about the temperatures, on 6/6/05 at 9:57 a.m., the Supervisor stated Individual #2 could not self regulate the water temperatures. The Supervisor was immediately notified of the high temperatures and turned the thermostat of the hot water heater down. The water temperatures were again tested on 2/14/07 at 5:00 p.m. and were found to be within the acceptable range.	W 426		
W 463	483.480(a)(4) FOOD AND NUTRITION SERVICES The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure the physician prescribed the diet orders for 1 of 3 individuals (Individual #1) whose diet orders were reviewed. This resulted in the potential for an individual to receive an	W 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G067		02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #5 (BURKE)	4541 E BURKE DR AMMON, ID 83406

(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 463	Continued From page 26 inappropriate amount of food. Findings include: 1. Individual #1's 12/2/06 IHP stated he was a 23 year old male diagnosed with mild mental retardation, Diabetes, Bipolar Disorder, and Morbid Obesity. He was admitted to the facility on 12/2/06. Individual #1's physician's recap orders, dated 2/7/07, stated he received an 1800 calorie diet. However, his Dietary Assessment, dated 12/06 stated he was to receive a regular, reduced concentrated sweets diet, with larger protein and vegetables, no seconds and low calorie snacks. When asked about Individual #1's diet, the LPN stated on 2/15/07 at 2:25 p.m., Individual #1 was not receiving a restricted calorie (1800 calories) diet and his recap orders were not accurate.	W 463		

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
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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		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all toxic chemicals were properly labeled for 6 of 6 individuals (Individuals #1 - 6) residing in the facility. The findings include: An environmental review was conducted on 2/14/07 at 9:15 a.m. During the review it was noted that there was an unlabeled spray bottle containing a yellowish liquid in the chemical storage closet.	MM271	RECEIVED MAR 21 2007 FACILITY STANDARDS	

Bureau of Facility Standards

Aaron J. Weeks
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Regional Admin

(X6) DATE: 3/19/07

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
	13G067		02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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MM271	Continued From page 1 The House Supervisor was notified at that time and stated it needed to be labeled.	MM271		
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 building and all equipment was maintained in a sanitary manner and kept in good repair for 6 of 6 individuals (Individuals #1 - 6) residing in the facility. The findings include: An environmental review was conducted on 2/14/07 at 9:15 a.m. The following concerns were noted: a. The door frames and casings in the bathrooms, bedrooms, and hallways were visibly patched and in need of painting. b. All the vents throughout the home had an accumulation of dirt and debris. c. The floor vent in the dining area was rusted and the vent slates were bent. d. Individual #1 and #5's bedroom window track contained mold/mildew and debris. e. Individual #6's dresser drawers sat unevenly in	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G067	A. BUILDING B. WING	02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #5 (BURKE)	4541 E BURKE DR AMMON, ID 83406

(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 2 the drawer slots. The dresser drawer tracks were not working which prevented the drawers from opening. f. Individual #3's dresser drawer had broken handles, which exposed sharp edges. g. Individual #1 and #5's bathroom had exposed particle board under the bathroom sink, creating an uncleanable surface.	MM380		
MM428	16.03.11.120.10(c) Tempeature of hot water The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Refer to W426.	MM428		
MM537	16.03.11.210.01(b) Documentary Evidence Documentary evidence of the resident's progress and of his response to his habilitation program; This Rule is not met as evidenced by: Refer to W111.	MM537		
MM666	16.03.11.250.06(a) Diet Orders Diet orders must be kept on file in the facility and modified diets must be reviewed routinely by the attending physician along with other treatment. This Rule is not met as evidenced by: Refer to W463.	MM666		
MM696	16.03.11.250.09(d)(i) Refrigerator and Freezer	MM696		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/16/2007
NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #5 (BURKE)	STREET ADDRESS, CITY, STATE, ZIP CODE 4541 E BURKE DR AMMON, ID 83406		

(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
MM696	Continued From page 3 Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all refrigerators and freezers were equipped with a reliable, easily read thermometer for 6 of 6 individuals (Individuals #1 - 6) residing in the facility. The findings include: An environmental review was conducted on 2/14/07 at 9:15 a.m. The following concerns were noted: a. The freezer in the kitchen was missing the thermometer. b. The freezer side of the combination refrigerator/freezer in the garage was missing the thermometer.	MM696		
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 W214 and W225.	MM724		
MM855	16.03.11.270.08(c) Training and Habilitation Record	MM855		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	13G067		02/16/2007

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MM855	Continued From page 4 There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855		

Burke Home (#5) Plan of Correction for the survey dated February 16, 2007.

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MAR 21 2007
FACILITY STANDARDS

W 111:

1. Individual #3
a.- The QMRP and the LPN have **corrected** all records concerning this medication.
b.- The QMRP **revised** the IHP, which was in error at the time of the survey. It has been updated by Nick Schmitt, QMRP.
c.- The QMRP will provide the appropriate documentation to this individual's record to reflect the current diagnosis and what objectives are being tracked and why. The necessary revisions to the programs will also be made if needed. This will be completed by April 15, 2007 by Nick Schmitt.
d.- The bowel movement tracking sheet was **revised** prior to March 1, 2007 to provide more guidance to staff on filling out form accurately. Staff training regarding accurate completion of new bowel movement tracking sheet **was held** prior to March 1, 2007. We have also added training on this form to our orientation for **all** new employees. The new tracking sheet **has been** implemented for individual #3 and all individuals being tracked since March 1, 2007. Nursing will address this in their monthly summary notes if constipation was an issue and will be addressed accordingly. Barbara Arehart, LPN is the responsible party.
e.- Individual #3- the team has reviewed this is objective and is no longer being addressed. It was felt that it would benefit the individual more to be addressing customer service duties in the Deli rather than the cooking. The objective **has been** written and included on the individual's IHP.

2.- Individual #1
a. - The bowel movement tracking sheet was **revised** prior to March 1, 2007 to provide more guidance to staff on filling out form accurately. Staff training regarding accurate completion of new bowel movement tracking sheet **was held** prior to March 1, 2007. We have also added training on this form to our orientation for **all** new employees. The new tracking sheet **has been** implemented for individual #1 and all individuals being tracked since March 1, 2007. Nursing will address this in their monthly summary notes if constipation was an issue and will be addressed accordingly. Barbara Arehart, LPN is the responsible party.

b.- As noted in this deficiency the Physicians recap orders hadn't been revised according to the dietician's assessment. The LPN has corrected this and notified the medical director. The facilities regional administrator will discuss this concern with the RN with respect to quarterly assurance checks so that such errors can be better identified and corrected. Ferren Weeks Regional administrator will be responsible for ensuring that this is completed by April 1 of 2007.

3. - Individual #2
a- The bowel movement tracking sheet was **revised** prior to March 1, 2007 to provide more guidance to staff on filling out form accurately. Staff training regarding accurate completion of new bowel movement tracking sheet **was held** prior to March 1, 2007. We have also added training on this form to our orientation for **all** new employees. The new tracking sheet **has been** implemented for individual #3 and all individuals being tracked since March 1, 2007. Nursing will address this in their monthly summary notes if constipation was an issue and will be addressed accordingly. Barbara Arehart, LPN is the responsible party.

In conclusion the deficiencies listed in this tag will be addressed by the QMRP on the dates stated. To ensure future compliance Ferren Weeks Regional Administrator / QMRP will provide further training and discussion with Nick Schmitt regarding the listed deficiencies.
In addition to our current format of home administrators reviewing each other's files for quality assurance, Mr. Weeks will personally address the Burke home central files. The Q A form that applies to these records will be revised to be more specific and in place by May 6 2007.
The other items have been noted to be taken care of by the LPN, Barb Arehart on the dates specified.

W 214:
Ferren Weeks, Regional Administrator, will be implementing a new corporate wide computerized comprehensive functional assessment for all areas. It has been in the developmental stage within Westcare management the past few months. Ferren discussed this with the other Westcare regional administrators, along with Tony Decker, at the regional administrator meeting in Boise on March 8, 2007. We have received a more comprehensive assessment in hard copy from the group. We are reviewing

and revising it to include all the components listed in this citation. It includes a more appropriate way to determine the individual's level of skill and needs. Functional terms, emerging skills, and more specific information will be included in the assessment form and procedure.
The revisions will be completed to the hard copy by April 15, 2007. The residents identified will be re-assessed with the new format by June 6, 2007. Ferren weeks will provide an inservice to train the administrative staff on the new format by April 14th, 2007. We are asking for an additional 30 days beyond the customary 60 days for correcting deficiencies. We are making the request considering that W.214 & W. 225 will require much more detailed assessments being completed.

W 225:
Ferren Weeks discussed this issue with Tony Decker and the other regional administrators of Westcare management at a meeting held on March 8, 2007. We reviewed a more comprehensive vocational assessment based upon previous Yellowstone group home survey issues.
The residents identified will be re-assessed with the new format by June 6, 2007. Ferren Weeks regional administrator and QMRP is the responsible party to ensure that it's completed by June 6, 2007.
Please also refer to W 214.

W 234:
This section on the behavior programs will be a revised to be more specific. It is clear as to the concern and it will be corrected by 5/6/07. The Regional Administrator, Mr. Weeks will see that Nick Schmitt the QMRP meets with the Burke Home team to expand upon individual replacement behaviors for all residents in this home. The Regional Administrator will also meet with the psychologist Dr. Zohner by 4/01/07 to discuss these necessary changes and to have him critique the replacement behaviors in greater depth when signing the behavior management programs in the future.

W 278:
1. Individual # 2 - this finding refers to individual #2 then refers to the individual #3 on the following page. I can only surmise that it is in reference to individual #2 throughout. Individual #2 is no longer on Zyprexa. So this concern has been taken care of for this individual. As suggested during the survey we will be contacting one of the other corporate facilities

for more detailed information on less-restrictive alternatives. To prevent any future reoccurrences of this happening again all administrative staff, nursing staff, pharmacy, psychologist, and psychiatrist will be informed of the need to try least restrictive interventions prior to using medications for sleep and to be vitally clear on what it is being prescribed for. This will be completed by the regional administrator Ferren Weeks, the by 4/1/ 07.

2. Individual # 1 &
3. Individual # 3
We will review the level program with our psychologist, Dr. Alan Zohner, to reassess the level program and its usefulness in compliance with the Regs. The concerns identified in the stated deficiencies will be discussed. In the future we will review new placements and their behavior programs more individualized whether or not the level system is deemed appropriate. Individuals #1&#3 have had their levels revised according to the concerns listed regarding the level system. Level one, the most restrictive level has been eliminated from the levels system altogether. In addition to dropping level one, restrictions involving community outings and individual #3 having to earn the opportunity to work with the maintenance person have been dropped. A system has also been revised to better track any level changes imposed for each individual.

W 312:
These individuals' program plans will be revised by Nick Schmitt QMRP to include plans for the details listed as missing. We will also be reviewing the identified symptoms to be tracked by the staff with Dr. Zohner the psychologist. Ferren Weeks will also instruct our psychologist, Dr. Alan Zohner, to review the Psychotropic Medication Plan and Behavior Management Plan more closely before signing them. Making sure all objectives and instructions are covered in the plan, including depression anxiety, and sleep. We will also add this to our quarterly file review check list. This will be completed by April 15, 2007. The QMRP will be the responsible party for making changes. The regional administrator will be responsible in reviewing the revised documents by 5/1/ 07.

W 426:
To correct this deficiency the Burke home staff will be instructed to take weekly water temperatures and to immediately report any temperatures exceeding 110. They will be required to submit their readings each Thursday when submitting their homes census to the office manager, which

she will then give to the maintenance person. Any failure to test water temperatures or to report work high temperature readings immediately, will result in disciplinary action for those involved. Staff inservicing will take place by April 01, 2007. Times for checking temperatures will be alternated throughout the day so that the temperatures aren't being taken just at peak times when water could be at its lowest temperature. The staff will also be instructed to hand test the water when assisting individual #2 with water related programs. QMRP will be responsible for seeing that this is corrected by 4/1/07.

W 463:
As noted in this deficiency the Physicians recap orders hadn't been revised according to the dietician's assessment. The LPN has corrected this and notified the medical director. The facilities regional administrator will discuss this concern with the RN with respect to quarterly assurance checks so that such errors can be better identified and corrected. Ferren Weeks Regional administrator will be responsible for ensuring that this is completed by April 1 of 2007.

MM191 – Refer to W278.
MM197 – Refer to W312.

MM271 – All staff in the Burke house will be inserviced regarding this concern. Labeling of bottles will be included on all cleaning schedules to serve as a reminder that they must be labeled. This will be completed by Nick Schmitt prior to 4/01/07.

MM380 – Items a. b. and c. will be added to the night shift's cleaning schedule and they will be inserviced on the additions by Nick Schmitt prior to 4/01/07.
Items a, e, f, and g will be discussed with maintenance and the home's staff to properly report such items to maintenance and for maintenance to reply to their request in a timely fashion using the repair requisition forms already in place. This will be completed by Nick Schmitt prior to 4/01/07.

MM428 – Refer to W426.
MM537 – Refer to W111.
MM666 – Refer to W463.

MM696 – The thermometers have been purchased to replace the missing ones. This item will also be covered in an inservice with all home staff. Maintaining the thermometers in the fridge and the freezers will be added to the night shift's cleaning schedule. This will be completed by Nick Schmitt prior to 4/01/07.

MM724 – Refer to W214 and W225.
MM855 – Refer to W234.

Jerrin J. Weeks
Admin / RWRF

3/19/07