IDAHO DEPARTMENT OF

HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

May 26, 2010

Susan Broetje
Idaho State School and Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School and Hospital, provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho State School And Hospital, which was conducted on May 21, 2010.

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. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

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

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 **June 8, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 8, 2010. If a request for informal dispute resolution is received after June 8, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srp
Enclosures

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

PRINTED: 05/25/2010
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
	13G001		05/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(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	W 000		
	The following deficiencies were cited during the annual recertification and complaint survey.			
	The surveyors conducting your survey were: Jim Troutfetter, QMRP, Team Lead Barbara Dern, QMRP Michael Case, LSW, QMRP Monica Williams, QMRP Patricia O'Hara, RN		RECEIVED JUN 10 2010 FACILITY STANDARDS	
	Common abbreviations used in this report are: IDT - Interdisciplinary Team LSW - Licensed Social Worker PCP - Person Centered Plan QMRP - Qualified Mental Retardation Professional RN - Registered Nurse			
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &	W 148	SEE ATTACHED	
	The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.			
	This STANDARD is not met as evidenced by: Based on record review, and advocate and staff interviews, it was determined the facility failed to ensure significant events were promptly reported to guardians for 1 of 6 individuals (Individual #4) for whom continued emergency physical restraint had been used. This resulted in a lack of advocacy for an individual. The findings include:			
	1. Individual #4's 12/9/09 PCP stated he was an 18 year old male whose diagnoses included mild			

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

SBroetje — ADMINISTRATOR — 6/8/10

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.

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W 148	Continued From page 1 mental retardation, intermittent explosive disorder, and oppositional defiant disorder. He was admitted to the facility on 11/9/09. Individual #4's PCP stated he engaged in maladaptive behaviors which included physical assaults against staff and peers causing physical injury. Individual #4's record documented the following physical restraints: 11/09 - 4 physical restraints, including 1 prone restraint (being held face down on the floor). 12/09 - 2 physical restraints, including 1 prone restraint. 1/10 - 5 physical restraints, including 1 prone restraint. 2/10 - 1 physical restraint, which was a prone restraint. 3/10 - 6 physical restraints, including 5 prone restraints. 4/10 - 7 physical restraints, including 5 prone restraints. However, Individual #4's PCP did not include the use of physical restraint. During an interview on 5/20/10 at 9:50 a.m., the QMRP stated Individual #4's grandmother was in process of becoming Individual #4's legal guardian and acted as his advocate. The QMRP stated Individual #4's grandmother had not been notified of the use of any restraints. During a telephone interview on 5/20/10 from 6:35 - 6:45 p.m., Individual #4's grandmother stated she was in process of becoming Individual #4's guardian and was advocating for him. Individual #4's grandmother stated the facility did	W 148		

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W 148	Continued From page 2 communicate with her regarding Individual #4's care, but stated she was not aware Individual #4 had been restrained. Individual #4's grandmother stated she wanted to be made aware of restraint as an intervention for Individual #4's maladaptive behaviors in order to advocate for his rights. The facility failed to ensure Individual #4's grandmother was made aware of the use of emergency physical restraint.	W 148		
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 record review and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into the program plans for 1 of 6 individuals (Individual #4) who required physical restraint. This resulted in an individual being physical restrained without the intervention being included in his individual program plan. The findings include: 1. Individual #4's 12/9/09 PCP stated he was an 18 year old male whose diagnoses included mild mental retardation, intermittent explosive disorder, and oppositional defiant disorder. He was admitted to the facility on 11/9/09. Individual #4's PCP stated he engaged in	W 289	SEE ATTACHED	

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W 289	Continued From page 3 maladaptive behaviors which included physical assaults against staff and peers causing physical injury. Individual #4's record documented the following physical restraints: 11/09 - 4 physical restraints, including 1 prone restraint (being held face down on the floor). 12/09 - 2 physical restraints, including 1 prone restraint. 1/10 - 5 physical restraints, including 1 prone restraint. 2/10 - 1 physical restraint, which was a prone restraint. 3/10 - 6 physical restraints, including 5 prone restraints. 4/10 - 7 physical restraints, including 5 prone restraints. However, Individual #4's PCP did not include the use of physical restraint. During an interview on 5/19/10 from 4:15 - 4:30 p.m., the QMRP stated Individual #4's restraints were considered emergency restraints and had not been incorporated into a plan. The facility's Behavioral Restraint policy, dated 4/15/10, defined an emergency restraint as an "unplanned or unanticipated use of physical, mechanical, or chemical restraint for imminent danger to self or others." Additionally, the policy stated the IDT was to develop a comprehensive program "if there is reasonable anticipation that restraint will be used again," and stated a general rule for reasonable anticipation of restraint was "if the emergency restraint has occurred more than one time in a 30-day period of time or more than three times in a 90-day period of time."	W 289		

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W 289	Continued From page 4 During an interview on 5/19/10 from 4:15 - 4:30 p.m., the QMRP stated Individual #4's plan needed to be revised. The facility failed to ensure the use of restraint was incorporated into Individual #4's plan.	W 289		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing and complaint survey. The surveyors conducting your survey were: Jim Troutfetter, QMRP, Team Lead Barbara Dern, QMRP Michael Case, LSW, QMRP Monica Williams, QMRP Patricia O'Hara, RN Common abbreviations used in this report are: LSW - Licensed Social Worker QMRP - Qualified Mental Retardation Professional RN - Registered Nurse	M 000	RECEIVED JUN 10 2010 FACILITY STANDARDS	
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.	MM197	SEE ATTACHED	
MM231	16.03.11.080.03(a) Informed of Activities To be informed of activities related to the resident that may be of interest to them or of significant changes in the resident's condition; and This Rule is not met as evidenced by: Refer to W148.	MM231	SEE ATTACHED	

Bureau of Facility Standards

SBroetje ADMINISTRATOR 6/3/10

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

Pen + ink change

TAG #: W148 and M231 - per Administrator on 6.15.10 @ 8:45 am. M. Case, CSW

1. Corrective action for examples: Individual #4 did not have a guardian or identified representative at the time. However, his grandmother, who has shown a potential interest in gaining guardianship has been notified.

2. Other individuals with the potential to be affected and corrective action taken: This CSU was the only one in which it was identified that policy had not been followed. They had done so in the intent to reduce restraint. However, they have been reminded of policy requirements and the QMRP will ensure guardians/identified representatives (if applicable) have been notified.

3. Measures or a systemic change to ensure deficient practice does not recur: The facility will aggressively seek individual representatives for those individuals who do not have a legal guardian and for whom efforts to find a guardian have not yet been successful. Notifications will be made according to the guardian/representative preference.

4. Monitoring to ensure deficient practice does not recur: Notification requirements for emergency restraints have been added to Policy 01.07 Behavioral Restraints and Form 4101 Guardian/Representative Notification Information.

5. Date when correction action will be corrected (usually within 60 days):
The notifications for affected individuals will be made on or before 6/18/2010.

The assigned social worker will work with the individuals who do not have a guardian to identify potential representatives to advocate for their rights For individuals unable to identify representatives, the social worker will contact the family members and/or friends regarding interest in becoming a representative (this step has already been done for interest in guardianship). All contacts will be made by 7/16/2010.

All policy and form changes have been made.

Pen + ink

TAG #: ~~249~~ W289 and M197 - per Administrator on 6.15.10 @ 8:45 am. M. Case, CSW

1. Corrective action for examples: Restraint has been added to Individual #4's Behavior Support Plan.

2. Other individuals with the potential to be affected and corrective action taken: There were two other individuals who met criterion for inclusion of restraint in their Behavior Support Plans. The program changes and notifications will be completed and submitted to HRC by 6/25/2010.

3. Measures or a systemic change to ensure deficient practice does not recur: The QMRP will ensure that all emergency restraints are reviewed and documented in the team meeting minutes. The QMRP will ensure that restraint is added to a individual's BSP any time a individual meets the criteria outlined in Policy 01.07 Behavioral Restraint. Exceptions to this expectation will be made by the interdisciplinary team and documented justification in the team meeting minutes. All QMRPs have been reminded of this expectation.

4. Monitoring to ensure deficient practice does not recur: The restraint reduction committee reviews restraints on a monthly basis. They will notify the applicable QMRP and the Program Director if restraints at or above policy limit are identified that are not included in a individual's BSP.

5. Date when correction action will be corrected (usually within 60 days):

All steps will be completed by 6/30/2010.

Attachment 1: Changes to Page 9 of Policy 01.07 Behavioral Restraint:

1. It is important that restraint end as soon as possible for the safety of the individual. If an individual continues talking, making sounds, or even struggling, it does not necessarily indicate that restraint should continue. Within 5 or less minutes of the person showing signs of calming and/or states that he/she will calm if released, the individuals applying an emergency restraint should attempt release.

2. Staff will complete ISSH Form #6533 - Skin Check and submit to nursing.

3. The nurse will notify the guardian of the administration of the emergency physical restraint, if indicated by the guardian on the Guardian/Representative Notification Information (Form #4102), located in the individual record.

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May 27, 2010

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

FILE COPY

Provider #13G001

Dear Ms. Broetje,

On **May 21, 2010**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004602

Allegation: Individuals are unable to participate in off-campus activities due to insufficient numbers of staff.

Findings: An unannounced onsite complaint investigation was conducted from 5/17/10 - 5/21/10. During that time, observations, as-worked schedules and off-campus activity logs were reviewed, and interviews with individuals and staff were conducted with the following results:

Observations were conducted from 5/17/10 - 5/19/10 for a cumulative 38 hours 51 minutes. During that time, it was noted that individuals residing in five (5) Ten individuals' Off-Campus Activity logs were reviewed from 1/10 - 5/16/10. Those logs showed that, on average, individuals were attending off-campus activities at least seven (7) times a month. The activities included movies, shopping, horseback riding, bowling, playing pool, eating at restaurants, basketball games, hockey games, and purchase training.

Even though the as-worked schedules documented short shifts, individuals were provided sufficient opportunities to participate in off-campus activities.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srp