IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 6, 2015

Wanda Huber, Administrator
Preferred Community Homes - Bedford
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Bedford, Provider #13G039

Dear Ms. Huber:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Bedford, which was conducted on January 30, 2015.

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

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

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

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

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

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

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

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

After you have completed your Plan of Correction, return the original to this office by **February 19, 2015,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

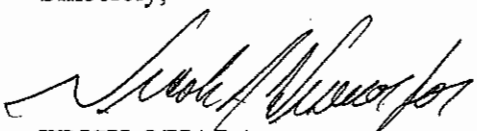
www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

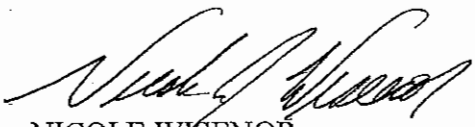
This request must be received by February 18, 2015. If a request for informal dispute resolution is received after February 18, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/pmt
Enclosures

February 12, 2015

Trish O'Hara
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RECEIVED
FEB 19 2015
FACILITY STANDARDS

RE: Bedford, Provider #13G039

Dear Trish O'Hara:

Thank you for your considerateness during the recent annual recertification survey at the Bedford home. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

W154
Aspire Human Services has recently gone through a structure change. The Program Manager and Clinical Director have split responsibilities. All investigations are reviewed by Clinical Director, and Program Manager to ensure all incidents are investigated; including possible incidents that may arise during the process. Any additional incidents that arise during the investigation will be investigated following policy and procedures. In addition the program supervisor team reviews all incidents on Mondays. All individuals living at the facility will be affected by this with the new structure and system reviewing investigations.

Person Responsible: Clinical Director, Program Manager
Completion Date: 5/1/15

W322
The follow up recommendations for individuals #2, 3 & 4 have been followed up on and are currently in each individuals file. All charts are being reviewed to verify that all follow up appointments and recommendations have been completed in a timely manner. Any discrepancies will be addressed immediately. Aspire Human Services has developed and implemented a tracking system to assist the LPN's to track recommendations to their completion. The form is kept in each individual's medical record. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the tracking form is in each individuals chart and being utilized appropriately. Identified errors are reported to the Clinical Director and immediate correction action is taken to correct any discrepancies.

Person Responsible: Clinical Director, LPN, QIDP
Completion Date: 5/1/15

W325

The Laboratory screening for individual #3 have been scheduled to occur. All charts in the facility are being reviewed to verify that Laboratory screenings have occurred as ordered. Any needed screenings are immediately being scheduled to occur. Aspire Human Services has developed and implemented a tracking system to assist the LPN's to trace recommendations to their completion. The form is kept in each individual's medical record. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the tracking form is in each individuals chart and being utilized appropriately. Identified errors are reported to the Clinical Director and immediate correction action is taken to correct any discrepancies.

Person Responsible: Clinical Director, LPN
Completion Date: 5/1/15

W440
Aspire Human Services currently has a Universal Monthly Checklist completed at all facilities. The monthly checklist will be revised to include documentation of when the fire drill was run for the month. After the checklist is completed the documentation is turned into the Program Manager each month and reviewed. This affects all individuals living within the facility ensuring they are participating in monthly fire drills.

Person Responsible: Program Manager, Program Supervisor
Completion Date: 3/2/15

MM170
Please see response given under W154 as it relates to Method for Investigating Grievances.

MM380
All repairs will be fixed by 5/1/15 affecting all 5 individuals living at the facility. When a repair is noticed it is documented on a maintenance request form. The Program Supervisor will review these forms and notifies maintenance immediately for all major incidents. Maintenance will sign off on then home maintenance request form when completed with initials and date. In the event of a major repair staff is to call the Program Supervisor immediately to start the process of needed repairs. Maintenance visits each facility at a minimum of once a week. A schedule has been set and repeats every week to provide each facility time for maintenance repairs. In addition, Aspire Human Services currently has a Universal Monthly Checklist completed at all facilities. After the checklist is completed the documentation is turned into the Program Manager each month and reviewed. A copy of the monthly checklist will also be provided to maintenance to ensure all repairs are fixed within a timely manner and nothing is missed left unrepaired.

Person Responsible: Program Manager, Program Supervisor, Maintenance
Completion Date: 5/1/15

MM735
Please see response given under W322 as it relates to Health Services.

MM750
Please see response given under W325 as it relates to Routine Screening Laborator Examinations.

Tom Moss
Tom Moss
Clinical Director

KBuchanan
Kristin Buchanan
Program Manager

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

NTE 05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G039	A. BUILDING _____ B. WING _____	01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - BEDFORD	398 EDGAR COURT MERIDIAN, ID 83642

(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 conducted from 1/26/15 to 1/30/15. The survey was conducted by: Trish O'Hara, RN, Team Lead Ashley Henscheid, QIDP Common abbreviations used in this report are: DVT - Deep Vein Thrombosis LPN - Licensed Practical Nurse MD - Doctor of medicine MI - Myocardial Infarction PCLP - Person Centered Lifestyle Plan PNA - Pneumonia p.r.n - As needed QIDP - Qualified Intellectual Disabilities Professional t.i.d. - Three times daily	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure a thorough investigation was conducted for all allegations of abuse, neglect, mistreatment and injuries of unknown origin for 1 of 7 individuals (Individual #3) involved in significant incidents. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include:	W 154		

RECEIVED FEB 19 2015 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Program Manager	2.18.15

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.

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

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OMB NO. 0938-0391

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	13G039		01/30/2015

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W 154	Continued From page 1 1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, documented staff were to immediately report any incident of possible neglect to the Administrator or the Administrator Designee. The policy's definition of neglect included "the failure to provide goods and services..." The policy contained a definition of medical neglect, which stated "Failure to provide care for existing medical problems. This includes but is not limited to (1) not taking action on medical problems, prescribed treatment, or therapies..." Individual #3's PCLP, dated 5/21/14, documented he was a 40 year old male whose diagnoses included profound intellectual disability. Individual #3's record included a Communication Log. The Communication Log documented in an entry dated 11/24/14 "Called [guardian name] to notify...Discussed concern with staff [and] incident not flushing j-tube [jejunostomy tube, a small tube inserted through the abdomen into the stomach]. Assured that staff no longer worked in the home." Facility investigations and Incident/Accident Reports, dated 10/15/14 - 1/26/15, were reviewed and did not include any documentation related to an incident of staff not flushing Individual #3's j-tube. When asked, during an interview on 1/30/15 from 1:30 - 2:45 p.m., the Program Manager stated the staff who allegedly neglected to flush Individual #3's j-tube was involved in a second allegation related to the elopement of another Individual around the same dates. The Program Manager	W 154		

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W 154	Continued From page 2 stated as a result the staff was removed from the facility and became the focus of the elopement investigation. The Program Manager stated he did not see that the allegation of medical neglect related to the staff not flushing Individual #3's j-tube was separately investigated. The facility failed to ensure all allegations of neglect were thoroughly investigated.	W 154		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. 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 provided with general and preventative medical care for 3 of 4 individuals (Individuals #2 - #4) whose medical records were reviewed. This resulted in individuals not receiving follow-up care as recommended. The findings include: 1. Individual #2's PCLP, dated 8/23/14, documented a 54 year old female whose diagnoses included profound intellectual disability. The Medical/Nursing Summary section of Individual #2's PCLP documented Individual #2 "was started on hormone replacement therapy on 1/17/14 after estrogen levels showed she was in menopause. [Individual #2's] father agreed to putting her on replacement therapy and an order for Prempro [a hormone supplement] was	W 322		

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W 322	Continued From page 3 received..." Individual #2's record contained a Consultant Pharmacist's Medication Regimen Review, dated 12/6/14, which asked "Does Prempro seem to be working for [Individual #2]? If not, then consider risk/benefit due that it [sic] has a warning for increased cardiac events (stroke, MI, DVT)." The review included a handwritten note that the form was faxed to the physician on 12/10/14. Individual #2's Physician's Orders, dated 1/2015, documented Individual #2 continued to receive Prempro each morning. However, additional documentation related to the use of Prempro could not be found. During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated there was no additional documentation related to the use of Prempro or follow-up of the pharmacist's note. Without defining and tracking Individual #2's symptoms related to the use of Prempro, the facility was unable to provide information in response to the pharmacist's review. The facility failed to ensure Individual #2 received follow-up to the pharmacy review. 2. Individual #3's PCLP, dated 5/21/14, documented he was a 40 year old male whose diagnoses included profound intellectual disability. a. Individual #3's record included notes from an office visit, dated 9/26/14. The notes documented "Patient is brought to clinic by	W 322		

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W 322	Continued From page 4 caregivers after being diagnosed with pneumonia in the emergency room...He does have frequent pooling of oral secretions." Under the section titled Plan, the notes included "PNA- the treatment course of Levaquin [an antibiotic drug]. Begin suctioning of oral secretions t.i.d. and p.r.n." Additionally, Individual #3's record contained a Medical Appointment Form, dated 11/13/14, which documented the appointment was to "Get approval for the use of a suction machine." Individual #3's Medication Administration Records, dated 9/2014 - 12/2014, were reviewed and did not include documentation of suctioning before 12/1/14. When asked about the delay in implementation from 9/26/14 - 12/1/14, during an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated the suction machine was an intervention requested by the facility at the appointment on 9/26/14. The LPN stated at that appointment they were given a referral to another office for the suction machine. The LPN stated the follow-up appointment for the suction machine referral took place on 11/13/14 and it was at that time the machine was ordered. The LPN stated the delay in obtaining the follow-up appointment was due to a lack of staff to take Individual #3 to the appointment. b. Individual #3's Nutrition Progress Notes contained an entry, dated 12/18/14, which included a recommendation to start ProMod (a protein supplement) and to "start Cerovite adv[anced] formula." A second entry, dated 12/22/14, documented "Order out to MD to start Promod..."	W 322		

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

PRINTED: 02/05/2015
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	13G039		01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - BEDFORD	398 EDGAR COURT MERIDIAN, ID 83642

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W 322	Continued From page 5 However, additional information related to the recommendations, including physician's orders, could not be found. During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated she received dietary recommendations on an order form from the dietician and faxed the form to the individual's physician. The LPN stated upon receiving the fax, the physician would sign off, send the form back and the recommendation would be implemented. The LPN stated receiving a prompt return fax from the physician could be difficult and Individual #3's recommendations could still be waiting on the physician. When asked about faxes, the LPN stated there was a fax book, but once a fax was sent it could be forgotten. The Clinical Director, also present during the interview, stated the facility was implementing a new form related to appointment tracking. The Clinical Director stated one benefit of the form would be to better ensure recommendations requiring follow-up were addressed. Without a system to monitor pending fax orders, the facility's ability to implement recommendations in a timely manner was impeded. The facility failed to ensure Individual #3 received follow-up to recommendations. 3. Individual #4's PCLP, dated 12/26/14, documented he was a 59 year old male whose diagnoses included profound intellectual disability.	W 322		

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 322	Continued From page 6 Individual #4's Medication Administration Records, dated 1/2014 - 10/2014, were reviewed and documented Individual #4 took a probiotic drug during that time. Individual #4's Nutritional Assessment, dated 12/22/14, included a recommendation for Individual #4 to "restart probiotic." However, additional information related to the probiotic recommendation could not be found. During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated she did not remember discussing that recommendation and did not see that anything had been sent from the physician. When asked what happened if the dietician made recommendations in notes directly and did not provide the facility with an order form, the LPN stated the notes were provided to the QIDP and the LPN, but could be missed. The facility failed to ensure Individual #4 received follow-up to dietary recommendations.	W 322		
W 325	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 4 individuals (Individual #3)	W 325		

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

FORM APPROVED
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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
	13G039		01/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 325	Continued From page 7 whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include: 1. Individual #3's PCLP, dated 5/21/14, documented he was a 40 year old male whose diagnoses included profound intellectual disability. a. Individual #3's Physician's Orders, dated 1/2015, included an order for lamotrigine (an anticonvulsant drug) 450 mg daily. The Physician's Orders also included a request for lamotrigine levels to be measured every six months. However, lamotrigine levels could not be found in Individual #3's record. During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated she could not find any lamotrigine levels. b. Individual #3's Nutrition Progress Notes contained an entry, dated 12/18/14, which included a recommendation to check Individual #3's basic metabolic panel lab levels. However, lab results more recent than 5/19/14 could not be found in Individual #3's record. During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated she could not find documentation that the labs had been completed or scheduled. The facility failed to ensure Individual #3 received laboratory screenings as ordered.	W 325		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	13G039		01/30/2015

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W 440	Continued From page 8	W 440		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. The facility's evacuation drill records, dated 2/28/14 through 1/11/15, were reviewed and did not include an evacuation drill for the fourth quarter of 2014 (October, November, December) for the night shift (11:00 p.m. - 7:00 a.m.). When asked, the Program Supervisor stated during an interview on 1/29/15 at approximately 11:45 a.m., the specified evacuation drill was missing. The facility failed to ensure evacuation drills were conducted on a quarterly basis for each shift.	W 440		

Bureau of Facility Standards

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G039		01/30/2015

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - BEDFORI

STREET ADDRESS, CITY, STATE, ZIP CODE: 398 EDGAR COURT, MERIDIAN, ID 83642

(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
M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 1/26/15 to 1/30/15. The survey was conducted by: Trish O'Hara, RN, Team Lead Ashley Henscheid, QIDP	M 000		
MM170	16.03.11.075.07(b)(ii) Method for Investigating Grievances The facility must have a written procedure for registering and resolving grievances and recommendations by residents or any individual or group designated by the resident as his representative. The procedure must ensure protection of the resident from any form of reprisal or intimidation. The written procedure must include: A method for investigating and assessing the validity of a grievance or recommendation; and This Rule is not met as evidenced by: Refer to W154.	MM170		
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:	MM380		

RECEIVED FEB 19 2015 FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Korinanen | TITLE: program manager | (X6) DATE: 2.18.15

Bureau of Facility Standards

NTE 5/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G039		01/30/2015

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - BEDFORI

STREET ADDRESS, CITY, STATE, ZIP CODE: 396 EDGAR COURT, MERIDIAN, ID 83642

(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 1 Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted with a direct care staff on 1/29/15 from 1:18 - 1:46 p.m. During that time, the following concerns were identified: - The middle drawer to the right of the stove was off track and missing stops on the backs to prevent it from falling out. - In Individual #2 and Individual #7's bedroom, there was an approximately two inch section of plaster missing from the wall near the closet. - Both drawers of Individual #2's end table were off track and missing stops on the backs to prevent them from falling out. - There was an approximately two inch section of plaster missing from the wall to the left of Individual #5's window. - In Individual #1 and Individual #4's bedroom, there was a patched spot behind the bedroom door, approximately four inches by four inches, which was without paint. - There was an approximately two inch hole in the wall near Individual #1's wardrobe. - No less than three feet of the front fence was falling forward into the yard. The facility failed to ensure environmental repairs	MM380		

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MM380	Continued From page 2 were maintained.	MM380		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM750	16.03.11.270.02(d)(ii) Routine Screening Laboratory Examinations Routine screening laboratory examinations, as determined necessary by the physician, and special studies when the index of suspicion is high. This Rule is not met as evidenced by: Refer to W325.	MM750		