



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

Matt Borchardt, Administrator
Preferred Community Homes - Cougar Creek
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Cougar Creek, Provider #13G037

Dear Mr. Borchardt:

This is to advise you of the findings of the Initial Medicaid/Licensure survey of Preferred Community Homes - Cougar Creek, 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

Matt Borchardt, Administrator
February 6, 2015
Page 2 of 2

6. 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 **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:

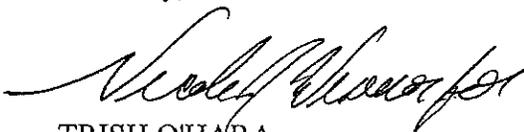
www.icfmr.dhw.idaho.gov

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

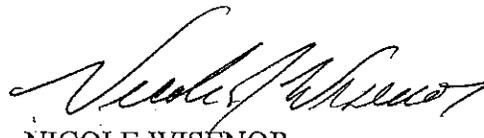
This request must be received by February 18, 2015. If a request for informal dispute resolution is received after February 18, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

RE: Cougar Creek, Provider #13G037

Dear Trish O'Hara:

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

W214

Individual #1's behavior assessment is being revised to include comprehensive information in relation to his behaviors of long showers and vocational attendance as they relate to his desire to control. In addition, the assessment is being revised to include information related to his diagnosis of PDD and Asperger's and how his behavior modifying medications effect impulsivity. All of the behavior assessments in the home are being reviewed and revised as necessary to include comprehensive information. Aspire Human Services has a Positive Behavior Support Specialist on staff. He is currently providing additional training to the QIDP's on administering behavior assessments. After the training is complete, the QIDP at the home will have the necessary skills to write behavior assessments for the home. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all behavior assessments are comprehensive. Identified errors are reported to the Clinical Director and revisions are made to the program plans.

Person Responsible: Clinical Director, QIDP

Completion Date: 5/1/15

W289

Individual #3's behavior assessment and plan are being revised to include comprehensive information in relation to his behaviors of isolation. Instructions for staff on how to respond are being added to his behavior plan. All of the behavior assessments and behavior plans in the home are being reviewed and revised as necessary to include comprehensive information. Aspire Human Services has a Positive Behavior Support Specialist on staff. He is currently providing additional training to the QIDP's on administering behavior assessments and behavior plans. After the training is complete, the QIDP at the home will have the necessary skills to write behavior assessments and behavior plans for the home. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all behavior assessments and behavior plans are comprehensive. Identified errors are reported to the Clinical Director and revisions are made to the program plans.

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

W369

The assigned LPN in the facility is in correspondence with Individual #3's physician to clarify how many sprays of Saline is required. Once the order is clarified, the LPN will modify the MAR sheet so individual #3 receives the appropriate amount of medication. The LPN is currently reviewing all MAR sheets to verify that medication dosages are clarified by each physician and the orders are clearly labeled on the MAR sheets. Aspire Human Services currently checks in each medication as it arrives to the facility to verify that the doctors' orders match each MAR sheet. In the event that a discrepancy is identified, immediate corrections are made. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all orders for medications are clearly written and identify dosage amounts. 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

W388

The assigned LPN in the facility is in correspondence with Individual #3's physician to clarify how many nasal sprays are required. Once the order is clarified, the LPN will modify the MAR sheet and medication label so individual #3 receives the appropriate amount of medication. The LPN is currently reviewing all MAR sheets to verify that medication dosages are clarified by each physician and the orders are clearly labeled on the MAR sheets. Aspire Human Services currently checks in each medication as it arrives to the facility to verify that the doctors' orders match each MAR sheet. In the event that a discrepancy is identified, immediate corrections are made. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all orders for medications are clearly written and identify dosage amounts. 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

MM197

Please see response given under W289 as it relates to written plans.

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.

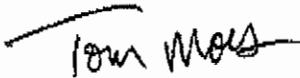
Person Responsible: Program Manager, Program Supervisor, Maintenance
Completion Date: 5/1/15

MM730

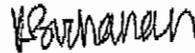
Please see response given under W214 as it relates to Diagnostic and Prognostic data.

MM736

Please see response given under W369 as it relates to Medical Services.



Tom Moss
Clinical Director



Kristin Buchanan
Program Manager

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2015
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COUGAR CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 EAST COUGAR CREEK MERIDIAN, ID 83642
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(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
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W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 1/28/15 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: IED - Intermittent Explosive Disorder LPN - Licensed Practical Nurse MAR - Medication Administration Record NOS - Not Otherwise Specified PA - Physician's Assistant PCLP - Person Centered Lifestyle Plan PDD - Pervasive Developmental Disorder QIDP - Qualified Intellectual Disabilities Professional	W 000		
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 observation, record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 1 of 2 individuals (Individual #1) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:	W 214		

REGISTERED
 FEB 19 2015
 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K. Buchanan</i>	TITLE Program Manager	(X6) DATE 2.18.15
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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

PRINTED: 02/05/2015
FORM APPROVED
OMB NO. 0938-0381

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W 214	<p>Continued From page 1</p> <p>1. Individual #1's PCLP, dated 3/17/14, documented he was a 27 year old male whose diagnoses included mild intellectual disability, PDD/Asperger's, impulsive disorder NOS, IED and bipolar disorder NOS.</p> <p>Individual #1's Behavioral Assessment, revised 1/19/15, stated he engaged in maladaptive behaviors which included physical aggression and disruptive behavior. However, the Behavioral Assessment did not include comprehensive information as follows:</p> <p>a. An observation was conducted at the facility on 1/27/15 from 11:02 - 11:58 a.m. with the Program Supervisor present. Upon arrival, the Program Supervisor stated Individual #1 was in the shower and often showered for long periods of time. The Program Supervisor stated Individual #1 took long showers as a way to control his environment. Additionally, Individual #1 was not observed to leave the facility during the observation.</p> <p>During an interview on 1/30/15 from 1:30 - 2:45 p.m., the QIDP stated Individual #1 was control-driven. She stated Individual #1 had a program related to shower duration as well as for vocational attendance, however, they were discontinued because Individual #1 failed to progress and refused to attend the vocational program.</p> <p>However, Individual #1's Behavioral Assessment did not contain any information related to prolonged showers, vocational attendance or a desire for control.</p> <p>b. Under the Analysis of Potential Causes section, Individual #1's Behavioral Assessment</p>	W 214		

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W 214	<p>Continued From page 2</p> <p>documented Individual #1's "diagnosis of Bipolar Disorder NOS plays a role in his aggressive behavior...per team discussion his Impulsive Disorder/IED may affect his physical aggression, but ultimately it stems from his Bipolar Disorder NOS." The assessment further stated Individual #1 "has a diagnosis of Bipolar Disorder NOS that often leads to disruptive behavior."</p> <p>Additionally, Individual #1's medication reduction plan, dated 1/29/15, included disruptive behavior under "Behavior related to the Current Diagnosis" for PDD/Asperger's.</p> <p>However, the assessment did not contain any information related to how PDD/Asperger's impacted his demonstrated maladaptive behaviors.</p> <p>c. Individual #1's Behavioral Assessment documented Individual #1 "takes psychotropic medications, Risperdal [an antipsychotic drug], Abilify [an antipsychotic drug], and Clonidine [an antihypertensive drug]." The assessment documented clonidine was prescribed on 8/28/14 to assist with impulsivity.</p> <p>The assessment did not contain any additional information related to impulsivity or how Individual #1's medications impacted his demonstrated maladaptive behaviors.</p> <p>During an interview on 1/30/15 from 1:30 - 2:45 p.m., the QIDP stated she was working with the Positive Behavior Support Coordinator to revise all behavioral assessments and plans.</p> <p>The facility failed to ensure Individual #1's Behavioral Assessment contained</p>	W 214		
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W 214	Continued From page 3	W 214			
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 interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 2 individuals (Individual #3) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include: 1. Individual #3's PCLP, dated 7/23/14, documented he was a 36 year old male whose diagnoses included moderate intellectual disability. Individual #3's Behavioral Assessment, dated 1/20/15, documented Individual #3 engaged in maladaptive behaviors, including isolation. The assessment documented Individual #3 "will isolate for the entire day, going without eating or drinking much, but he will take his medications. At times, it may be for a few hours, depending on [Individual #3's] mental health status. This behavior is tracked informally for the PA's	W 289			

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W 289	<p>Continued From page 4 information."</p> <p>Individual #3's QIDP Tracking Form, dated 9/2014 - 12/2014, was reviewed and documented Individual #3 engaged in isolation as follows:</p> <p>September: Blank October: 12 November: 9 December: 7</p> <p>However, Individual #3's behavior plan did not include any instructions to staff regarding how to intervene if Individual #3 isolated.</p> <p>When asked, during an interview on 1/30/15 from 1:30 - 2:45 p.m., the QIDP stated Individual #3's behavior plan did not include interventions for isolation.</p>	W 289		
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 3 individuals (Individual #3) observed to take medications. This resulted in an individual not receiving the ordered dose of a medication. The findings include:</p>	W 369		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 369	Continued From page 5 1. Individual #3's PCLP, dated 7/23/14, documented he was a 36 year old male whose diagnoses included moderate Intellectual disability. An observation was conducted at the facility on 1/27/15 from 7:00 - 8:40 a.m. During that time, Individual #3 was observed to take his morning medications with the assistance of a direct care staff. One of the medications was Deep Sea Premium Saline nasal spray. The direct care staff administered one spray in each of individual #3's nostrils. Individual #3's Physician's Orders and MAR, each dated 1/2015, documented the saline nasal spray was to be administered as indicated on its packaging. The bottle had an affixed label from the pharmacy which also documented to administer the sprays per packaging instructions. Individual #3's bottle of Deep Sea Premium Saline had an original product label which instructed consumers to squeeze the medication twice into each nostril as needed. During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated the dosage needed clarified with the physician as the medication was used on a daily basis.	W 369			
W 388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and	W 388			

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W 388	<p>Continued From page 6 practices.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure all medications were correctly labeled for 1 of 3 individuals (Individual #3) observed to take medications. This resulted in the potential for medication administration errors and subsequent negative impacts to an individual. The findings include:</p> <p>1. Individual #3's PCLP, dated 7/23/14, documented he was a 36 year old male whose diagnoses included moderate intellectual disability.</p> <p>An observation was conducted at the facility on 1/27/15 from 7:00 - 8:40 a.m. During that time, Individual #3 was observed to take his morning medications with the assistance of a direct care staff. One of the medications was Flonase nasal spray. The direct care staff administered one spray in each of Individual #3's nostrils.</p> <p>Individual #3's Physician's Orders and MAR, each dated 1/2015, documented the Flonase was to be administered as indicated on its packaging. The bottle had an affixed label from the pharmacy which also documented to administer the medication per packaging instructions.</p> <p>However, Individual #3's bottle of Flonase was stored in a plastic, pill bottle which had a duplicate label from the pharmacy. The original packaging with dosage instructions could not be found.</p>	W 388		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 388	Continued From page 7 During an interview on 1/30/15 from 1:30 - 2:45 p.m., the LPN stated the Flonase dosage would be clarified and changed on the label. The facility failed to ensure Individual #3's Flonase nasal spray was appropriately labeled.	W 388		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2015
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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		
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		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) 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	MM380		


 FACILITY STANDARDS BUREAU
 FEB 19 2015

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K. Garman</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>2.18.15</i>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COUGAR			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 EAST COUGAR CREEK 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 direct care staff on 1/29/15 from 1:52 - 2:30 p.m. During that time, the following concerns were identified: - The oven contained food spills and burnt on debris. - All five drawers of Individual #4's dresser were off track and missing stops on the backs to prevent them from falling out. - The ceiling of the garage was missing approximately six total square feet of drywall exposing the attic and stored items. The facility failed to ensure environmental repairs were maintained.	MM380			
MM730	16.03.11.270.01(d)(l) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730			
MM736	16.03.11.270.02(a) Medical Services Medical services must be provided as prescribed, both: This Rule is not met as evidenced by: Refer to W369.	MM736			