



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 5, 2015

Christina Plasencia, Administrator
Preferred Community Homes - Vineyards
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Vineyards, Provider #13G028

Dear Ms. Plasencia:

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

Christina Plasencia, Administrator
February 5, 2015
Page 2 of 2

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 18, 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,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures



February 12, 2015

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

RE: Vineyards, Provider #13G028

Dear Michael:

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

W262

Individual #2' currently has a written informed consent in his chart which HRC and Guardian approval. All charts are being reviewed at the facility to assure that HRC and Guardian approval has been obtained for any restrictive measures as outlined in the company policy and procedure manual. Training is scheduled for the QIDP of the facility on the policy and procedure for behavior management at the facility to assure an understanding of restrictive measures and the expectation that HRC and Guardian consent is obtained for all restrictive measures. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that informed consents are obtained when appropriate. Identified errors are reported to the Clinical Director and immediate correction action is taken to correct any discrepancies.

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

W263

Individual #2' currently has a written informed consent in his chart which HRC and Guardian approval. All charts are being reviewed at the facility to assure that HRC and Guardian approval has been obtained for any restrictive measures as outlined in the company policy and procedure manual. Training is scheduled for the QIDP of the facility on the policy and procedure for behavior management at the facility to assure an understanding of restrictive measures and the expectation that HRC and Guardian consent is obtained for all restrictive measures. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that informed consents are obtained when appropriate. Identified errors are reported to the Clinical Director and immediate correction action is taken to correct any discrepancies.

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

W368

The assigned LPN in the facility is in correspondence with Individual #3 and individual #4's physician to clarify how much PRN Rofitussin should be given. . Once the order is clarified, the LPN will modify the MAR sheet and medication label so individual's #3 & #4 receive 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, QIDP
Completion Date: 5/1/15

W382

Staff's personal insulin pens were placed in a locked container providing the proper storage for all 7 individuals living in the facility. All Program Supervisors will review their home for the proper storage of personal drugs ensuring everything is locked up. Program Supervisors will receive training to assure all new staff will have their personal items locked up if needed. Also, the QA department will look to ensure this is being met during their time out at the facilities. The Universal Monthly Checklist will be revised to ensure all facilities are checking this each month.

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

MM194

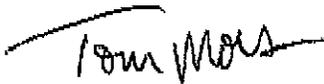
Please see W262 as it relates to the Human Rights Committee.

MM196

Please see W263 as it relates to the Consent of Parent or Guardian.

MM203

Please see W368 as it relates to individuals treated with consideration.



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: 13G028	(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 - VINEYARDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 WEST SONOMA DRIVE 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 recertification survey conducted from 1/26/15 - 1/30/15. The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: HRC - Human Rights Committee LPN - Licensed Practical Nurse OCD - Obsessive Compulsive Disorder PCLP - Person Centered Lifestyle Plan PRN - As needed QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 1 of 4 individuals (Individual #2) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include:	W 262		

RECEIVED
 FEB 19 2015
 FACILITY COMPLIANCE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K. Zimmerman</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
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W 262	<p>Continued From page 1</p> <p>1. Individual #2's PCLP, dated 6/3/14, documented a 46 year old male whose diagnoses included profound mental retardation, mood disorder and OCD.</p> <p>His record contained an Obtain Receipt training program, dated 6/12/13, documenting he was to be provided with one-on-one staffing while in the community due to elopement and maladaptive behaviors.</p> <p>However, his record did not contain documentation of HRC approval for the one-on-one staffing ratio.</p> <p>When asked during an interview on 1/30/15 from 10:10 - 10:50 a.m., the QIDP stated HRC approval had not been obtained for the program.</p> <p>The facility failed to ensure HRC approval was obtained prior to implementing Individual #2's one-on-one staffing.</p>	W 262		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure procedures that had the potential to violate an individual's rights were implemented only with the written Informed consent of the individual's</p>	W 263		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - VINEYARDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2226 WEST SONOMA DRIVE MERIDIAN, ID 83642
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W 263	<p>Continued From page 2</p> <p>guardian for 1 of 4 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior consent for the use of one-on-one staffing. The findings include:</p> <p>1. Individual #2's PCLP, dated 6/3/14, documented a 46 year old male whose diagnoses included profound mental retardation, mood disorder and OCD.</p> <p>His record contained an Obtain Receipt training program, dated 6/12/13, documenting he was to be provided with one-on-one staffing while in the community due to elopement and maladaptive behaviors.</p> <p>However, his record did not contain documentation of guardian consent for the one-on-one staffing ratio.</p> <p>When asked during an interview on 1/30/15 from 10:10 - 10:50 a.m., the QIDP stated guardian consent had not been obtained for Individual #2's one-on-one staffing.</p> <p>The facility failed to ensure guardian consent was obtained prior to the implementation of Individual #2's one-on-one.</p>	W 263		
W 368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it</p>	W 368		

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

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - VINEYARDS		STREET ADDRESS, CITY, STATE, ZIP CODE 2226 WEST SONOMA DRIVE MERIDIAN, ID 83842		
(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 368	<p>Continued From page 3</p> <p>was determined the facility failed to administer drugs as ordered by the physician for 2 of 4 individuals (Individuals #3 and #4) whose medical records were reviewed. This resulted in individuals receiving medications in a manner which was inconsistent with physician orders. The findings include:</p> <p>1. The facility utilized Routine Standing Orders and a PRN Medications From Standing Orders form to administer and document the use of routine PRN medications. The Routine Standing Orders were not administered in accordance with the physician's directions, as follows:</p> <p>a. Individual #4's PCLP, dated 4/10/14, documented a 66 year old female whose diagnoses included profound mental retardation. Her Routine Standing Orders stated she could receive Robitussin DM or generic (an expectorant drug) 2 teaspoons (10 cc) every 6 hours PRN for cough.</p> <p>However, Individual #4's 2014 PRN Medications From Standing Orders form documented she received the following:</p> <ul style="list-style-type: none"> - 12/1/14 at 9:00 a.m.: geritussin (generic Robitussin) 15 cc - 12/1/14 at 4:25 p.m.: guaifenesin (generic Robitussin) 15 cc - 12/3/14 at 10:00 a.m.: geritussin 15 cc - 12/4/14 at 8:00 a.m.: geritussin 15 cc <p>b. Individual #3's 7/23/14 PCLP stated he was a 51 year old male whose diagnoses included profound mental retardation. His Routine Standing Orders stated he could receive Robitussin DM or generic 2 teaspoons every 6</p>	W 368		

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

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - VINEYARDS	STREET ADDRESS, CITY, STATE, ZIP CODE 2226 WEST SONOMA DRIVE MERIDIAN, ID 83642
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W 368	Continued From page 4 hours PRN for cough. However, Individual #3's 2014 PRN Medications From Standing Orders form documented he received the following: - 2/10 at 10:50 p.m.: geritussin 15 cc - 2/12 at 8:00 a.m.: geritussin 15 cc During an interview on 1/30/15 from 10:10 - 10:50 a.m., the LPN stated nursing staff made the determination of what drug dose staff should administer. When asked about scope of practice, the LPN stated staff should only be administering drugs in accordance to what the physician had ordered.	W 368		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for harm in the event individuals accessed prescription medication. The findings include: 1. During an environmental review on 1/27/15	W 382		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2015
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W 382	<p>Continued From page 5</p> <p>from 9:55 - 10:30 a.m., two insulin pens containing Humalog and Lantus were noted to be stored in the door of the refrigerator located next to the pantry.</p> <p>The Program Supervisor, who was present during the environmental review, stated the insulin pens belonged to a direct care staff. The Program Supervisor stated she was not aware staff's personal medications had to be locked. The Program Supervisor then provided a locked container for the direct care staff to use.</p> <p>The facility failed to ensure all drugs were maintained under locked conditions.</p>	W 382		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G028	(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 - VINEYARI	STREET ADDRESS, CITY, STATE, ZIP CODE 2226 WEST SONOMA DRIVE MERIDIAN, ID 83642
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 1/26/15 - 1/30/15. The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: MSDS - Material Safty Data Sheet	M 000		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM203	16.03.11.075.12(a) Treated with Consideration Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W368.	MM203		

RECEIVED
 FEB 19 2015
 FACILITY STANDARDS

Bureau of Facility Standards
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Barman

TITLE

Program Manager

(X6) DATE

2.18.15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G028	(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 - VINEYARI

STREET ADDRESS, CITY, STATE, ZIP CODE
**2226 WEST SONOMA DRIVE
 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
MM271	<p>16.03.11.100.04(b) Storage of Toxic Chemicals</p> <p>All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to store all toxic chemicals under lock and key. This failure allowed the potential for accidental exposure to hazardous chemicals for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. The findings include:</p> <p>1. Observations were conducted throughout the day on 1/26/15 and 1/27/15. During those times, the following was noted:</p> <p>a. During an observation on 1/26/15 from 4:40 - 6:33 p.m., a one gallon container of Clorox bleach was noted to be unlocked in the laundry room.</p> <p>The MSDS for Clorox Bleach stated it may cause severe irritation or damage to eyes and skin, the vapor or mist may irritate, and the product was harmful if swallowed. The MSDS stated it caused severe skin and eye damage, and to contact poison control or a physician immediately if swallowed.</p> <p>A direct care staff was notified of the unlocked Clorox and secured it.</p> <p>b. During an environmental review on 1/27/15 from 9:55 - 10:30 a.m., the following chemicals were found to be unlocked in the hot water heater closet by the back porch:</p> <ul style="list-style-type: none"> - One spray container of Spectracide Wasp and Hornet killer. - One spray container of Raid Ant and Roach 	MM271		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/30/2015
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - VINEYARI		STREET ADDRESS, CITY, STATE, ZIP CODE 2226 WEST SONOMA DRIVE 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
MM271	Continued From page 2 killer. The MSDS for Spectracide Wasp and Hornet killer stated to contact poison control or a physician immediately if swallowed. The MSDS for Raid Ant and Roach killer stated aspiration into the lungs could cause severe health effects and to seek medical attention for ingestion. The Program Supervisor, who was present during the environmental review, stated the door should have been locked. The facility failed to ensure all toxic chemicals were kept locked to avoid accidental exposure to individuals residing at the facility.	MM271		
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753		