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

May 11, 2015

Lisa Young, Administrator
Preferred Community Homes - Milliken
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Milliken, Provider #13G053

Dear Ms. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Milliken, which was conducted on May 1, 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 **May 24, 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 May 24, 2015. If a request for informal dispute resolution is received after May 24, 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,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures

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

PRINTED: 05/11/2015
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
	13G053		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7804 ARLINGTON DRIVE NAMPA, ID 83686

(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 4/27/15 to 5/1/15. The survey was conducted by: Jim Troutfetter, QIDP, Team Lead Ashley Henscheid, QIDP Common abbreviations used in this report are: HRC - Human Rights Committee IEP - Individual Education Program LPN - Licensed Practical Nurse PCLP - Person Centered Lifestyle Plan PRN - As needed QIDP - Qualified Intellectual Disabilities Professional SIB - Self-Injurious Behavior	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure outside services met the needs for 2 of 3 individuals (Individuals #1 and #2) who attended a local school and whose PCLPs were reviewed. This resulted in a lack of coordination of services with the school. The findings include: 1. Individual #1's PCLP, dated 7/9/14, documented an 18 year old male. Appendix A of	W 120		

RECEIVED
MAY 26 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kachanan	Program Manager	5.22.2015

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 120	Continued From page 1 Individual #1's record, dated 4/27/15, documented his diagnoses included mild intellectual disability. He attended a local high school Monday through Friday from 8:30 a.m. to 3:30 p.m. An observation was conducted at Individual #1's school on 4/27/15 from 12:45 to 1:45 p.m. Individual #1's teacher was interviewed on 4/27/15 at 1:30 p.m. The teacher stated she had not been invited to Individual #1's PCLP meeting at the facility. She stated she did not receive a copy of the PCLP or any of Individual #1's training or behavior programs from the facility. The teacher stated Individual #1 did have a behavior plan at the school which had been developed by school staff. Individual #1's Vice Principal was interviewed on 4/27/15 at approximately 1:10 p.m. The Vice Principal stated he had not had much contact from the QIDP. He stated he knew there had been turnover in the facility and he was not certain who was his point-of-contact for Individual #1. Individual #1's record was reviewed and the most recent copy of his IEP was dated 10/30/12. During an interview on 5/1/15 from 1:45 - 2:50 p.m., which included the QIDP, the Program Manager and the Clinical Director, the QIDP stated due to the turnover in the facility there was a chance the school was attempting communication through old employee phone numbers or emails. The Program Manager stated Individual #1's team had made multiple attempts to update their contact information with the school. The Clinical Director stated they	W 120		

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W 120	Continued From page 2 would locate any documented evidence they had of communication with the school and would submit the information. However, as of the 5/8/15, no documentation had been submitted. The facility failed to ensure Individual #1's services were sufficiently coordinated with the school. 2. Individual #2's PCLP, dated 1/23/15, documented a 14 year old male whose diagnoses included severe intellectual disability and infantile autism. An observation was conducted at Individual #2's school on 4/27/15 from 2:35 to 3:26 p.m. Individual #2's teacher was interviewed on 4/27/15 at 3:00 p.m. Individual #2's teacher stated Individual #2's IEP meeting was held in late February. She stated she had not had contact with anyone from the facility, besides the direct care staff that accompanied Individual #2 to school, since the IEP meeting. The teacher stated contacting the facility was "hit and miss" and she was not always sure who to call. Individual #2's teacher stated she knew she was sent drafts of Individual #2's PCLP and behavior plan, but was not sure if she was given finalized copies of the facility's plans. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the Program Manager stated the communication with the school had taken place through the phone and e-mail and she would submit documentation. However, as of 5/8/15, no documentation of the communication had been submitted.	W 120		

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W 120	Continued From page 3	W 120		
	The facility failed to ensure Individual #2's services were sufficiently coordinated with the school.			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		
	The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.			
	This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure guardians were provided with comprehensive information necessary to make informed decisions for 3 of 3 individuals (Individuals #1 - #3) whose consents were reviewed. This resulted in insufficient information being provided to guardians on which to base consent decisions. The findings include:			
	1. Individual #1 - #3's Written Informed Consents were reviewed, and did not include sufficient information, as follows:			
	a. Individual #1's PCLP, dated 7/9/14, documented an 18 year old male. Appendix A of Individual #1's record, dated 4/27/15, documented his diagnoses included mild intellectual disability.			
	Individual #1's record contained Written Informed			

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W 124	Continued From page 4 Consents for the following: - Tenex (an antihypertensive drug) and chlorpromazine (an antipsychotic drug), dated 2/10/15, - Chlorpromazine PRN, dated 4/8/15, - Individual #1's behavior plan, including the use of a one-person, one-arm restraint and bite release, dated 4/8/15, - One-on-one male staff within line of sight, dated 4/8/15, and - Use of video camera surveillance in the facility, dated 2/14/14. However, none of Individual #1's consents included information related to the guardian's right to withdraw consent at any time without risk of punitive action. Additionally, Individual #1's Written Informed Consent for the use of Tenex and chlorpromazine was reviewed. The consent documented side effects of chlorpromazine included, but were not limited to, twitching or uncontrollable movements, seizure, high fever, "slow breathing (breathing may stop)" and unusual thoughts or behavior. The 2015 Nursing Drug Handbook included thrombocytopenia (low platelets), leukopenia, agranulocytosis (a shortage of certain white blood cells) and aplastic anemia (a lack of blood cell production) as potential side effects, all of which were listed in black, italicized font, indicating "life-threatening reaction."	W 124		

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W 124	Continued From page 5 However, Individual #1's consent did not include information related to the potentially fatal side effects documented in the Nursing Drug Handbook. b. Individual #2's PCLP, dated 1/23/15, documented a 14 year old male whose diagnoses included severe intellectual disability and infantile autism. Individual #2's record contained Written Informed Consents for the following: - Abilify (an antipsychotic drug) and Clonidine (an antihypertensive drug), dated 2/10/15, - A restraint board used for dental procedures, dated 2/10/15, and - Video camera surveillance, dated 2/14/14. However, none of Individual #2's consents included information related to the guardian's right to withdraw consent at any time without risk of punitive action. Additionally, Individual #2's Written Informed Consent for the use of Abilify and Clonidine was reviewed. The consent documented a list of conditions the patient should inform their doctor of prior to taking either of the drugs (e.g. a history of kidney disease, history of heart attack or stroke, etc...). The consent did not include the possible side effects of either drug. When asked on 5/1/15 from 1:45 - 2:50 p.m., the LPN stated the consent should have included information related to the side effects.	W 124		

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W 124	Continued From page 6 c. Individual #3's PCLP, dated 12/5/14, documented a 18 year old male whose diagnoses included moderate intellectual disability and intermittent explosive disorder. Individual #3's record contained Written Informed Consents for the following: - Video camera surveillance, dated 4/25/15, - The use of Abilify (an antipsychotic drug), dated 4/25/15, - Trileptal (an anticonvulsant drug), dated 4/25/15, and - The use of one person arm control, dated 4/25/15. However, none of Individual #3's consents included information related to the guardian's right to withdraw consent at any time without risk of punitive action. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the Clinical Director stated they had not included information related to the right to withdraw consent in the documents in the past. The Clinical Director stated the company was in the process of changing their current practice for compiling consents. The facility failed to ensure Individual #1 - #3's consents contained comprehensive information on which to base consent decisions.	W 124		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 214		

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W 214	Continued From page 7 identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior assessments contained comprehensive information for 1 of 3 individuals (Individual #1) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's PCLP, dated 7/9/14, documented an 18 year old male. Appendix A of Individual #1's record, dated 4/27/15, documented his diagnoses included mild intellectual disability. Individual #1's Behavioral Assessment, dated 4/7/15, documented he engaged in maladaptive behaviors which included false allegations and physical aggression. His assessment did not include accurate, comprehensive information, as follows: a. The definition of false allegations in Individual #1's assessment included "as exhibited by allegations that someone has hurt him or done something to violate his rights..." However, the assessment did not contain any information about Individual #1's right to report allegations of abuse, neglect or mistreatment. b. Individual #1's Behavioral Assessment documented "It often appears that [Individual #1] is experiencing anger or frustration when he	W 214		

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W 214	Continued From page 8 makes statements of false allegations." The replacement behaviors were identified as positive attention seeking and gaining control. However, Individual #1's Behavior Intervention Plan, dated 4/12/15, documented Individual #1's false allegations would be replaced with positive attention seeking, gaining control and coping skills. c. Individual #1's Behavioral Assessment documented he engaged in aggression when he did not want to comply with something, when he was bored or when someone else was getting attention he wanted. The replacement behaviors were identified as positive attention seeking, gaining control and coping skills. However, Individual #1's Behavior Intervention Plan, dated 4/12/15, documented Individual #1's physical aggression would be replaced with positive attention seeking, gaining control and socially appropriate boundary skills. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the QIDP stated Individual #1's Behavioral Assessment needed to be revised to include more specific information related to false allegations. Further, the QIDP stated coping skills were applicable to each behavior and should be included for all. She stated the documentation of replacement behaviors in the behavior plans was accurate and the assessment needed revised. The facility failed to ensure Individual #1's Behavioral Assessment included comprehensive information.	W 214		

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W 262 W 262	Continued From page 9 483.440(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 observation, 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 2 of 3 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's PCLP, dated 7/9/14, documented an 18 year old male. Appendix A of Individual #1's record, dated 4/27/15, documented his diagnoses included mild intellectual disability. Individual #1's record contained a Written Informed Consent, dated 1/11/15, for the use of Tenex and chlorpromazine. The consent documented verbal consent, as well as a signature, was obtained from Individual #1's guardian on 2/19/15. However, the consent documented HRC had already approved the intervention on 2/17/15. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the QIDP confirmed that the HRC reviewed	W 262 W 262		

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W 262	Continued From page 10 and approved the use of the medications prior to guardian consent being obtained. The Clinical Director, also present during the interview, stated it was previously thought that consents being renewed did not have the same requirements as initial consents. The facility failed to ensure Individual #1's restrictive interventions were approved by the HRC only after guardian consent had been obtained. 2. Individual #2's PCLP, dated 1/23/15, documented a 14 year old male whose diagnoses included severe intellectual disability and infantile autism. His record documented he was admitted to the facility on 12/28/14. During an observation on 4/27/15 from 4:25 - 5:40 p.m., video cameras were noted to be installed in the common areas. However, HRC approval for the use of the video monitoring for Individual #2 was not obtained until 2/10/15. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the Clinical Director stated the late approval was due to an oversight. The facility failed to ensure HRC approval was obtained prior to the implementation of a restrictive intervention.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	W 263		

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W 263	Continued From page 11 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. This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the guardian for 1 of 3 individuals (individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals on restrictive interventions. The findings include: 1. Individual #2's PCLP, dated 1/23/15, documented a 14 year old male whose diagnoses included severe intellectual disability and infantile autism. His record documented he was admitted to the facility on 12/28/14. During an observation on 4/27/15 from 4:25 - 5:40 p.m., video cameras were noted to be installed in the common areas. However, guardian approval for the use of the video monitoring for individual #2 was not obtained until 2/10/15. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the Clinical Director stated the late approval was due to an oversight. The facility failed to ensure guardian approval was obtained prior to the implementation of a	W 263		

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

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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
	13G053		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

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W 263	Continued From page 12 restrictive intervention.	W 263		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's PCLP that was directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without a plan that accurately identified how the drugs may change in relation to progress or regress. The findings include: 1. Individual #1's PCLP, dated 7/9/14, documented an 18 year old male. Appendix A of Individual #1's record, dated 4/27/15, documented his diagnoses included mild intellectual disability. Individual #1's record contained a medication reduction plan, dated 2/12/15. The medication reduction plan was reviewed and did not contain accurate, comprehensive information, as follows: a. The plan documented Individual #1 received	W 312		

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W 312	Continued From page 13 Tenex (an antihypertensive drug) 3 mg and chlorpromazine (an antipsychotic drug) 237.5 mg daily for aggression. However, Individual #1's Tenex and chlorpromazine included a goal for reducing SIB as well as breaking objects in addition to aggression before the medications would be considered for reduction. b. Individual #1's medication reduction plan documented he utilized a PRN dose of chlorpromazine for ongoing physical aggression at his parents' house. However, Individual #1's plan did not include criteria related to the eventual reduction of the chlorpromazine PRN. On 4/30/15 at approximately 8:30 a.m., the QIDP stated she noticed that criteria for the reduction of the chlorpromazine PRN had been missed on the medication reduction plan. The QIDP provided an updated copy which included handwritten criteria for the PRN, dated 4/30/15. During an interview on 5/1/15 from 1:45 - 2:50 p.m., the Clinical Director stated Individual #1's medication reduction plan needed revised to align Tenex and chlorpromazine with physical aggression only. The facility failed to ensure Individual #1's medication reduction plan contained accurate and comprehensive information related to his use of behavior modifying drugs.	W 312		
W 315	483.450(e)(4)(i) DRUG USAGE	W 315		

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W 315	Continued From page 14 Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual was provided with general and preventative medical care for 1 of 3 individuals (Individual #2) whose medical records were reviewed. This resulted in an individual not receiving health care services in accordance with his needs. The findings include: 1. Individual #2's PCLP, dated 1/23/15, documented a 14 year old male whose diagnoses included severe intellectual disability and infantile autism. His record contained Physician's Orders, dated 3/31/15, documenting he received Abilify (an antipsychotic drug) 5 mg each evening The 2015 Nursing Drug Handbook documented Abilify had the potential to cause tardive dyskinesia (an abnormal involuntary movement disorder). However, his record did not contain documentation he had been assessed for tardive dyskinesia. When asked on 5/1/15 from 1:45 - 2:50 p.m., the LPN stated a tardive dyskinesia assessment had not been completed for Individual #2. The facility failed to ensure Individual #2 received	W 315		

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W 315	Continued From page 15 an evaluation for tardive dyskinesia.	W 315		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to obtain special studies as recommended for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in an individual not receiving thyroid lab tests as requested by the facility's dietician. The findings include: 1. Individual #3's PCLP, dated 12/5/14, documented an 18 year old male whose diagnoses included moderate intellectual disability and intermittent explosive disorder. Individual #3's record contained a dietary modification assessment signed by the physician on 5/9/14. The assessment recommendation for lab tests include a TSH (Thyroid Stimulating Hormone) and T4 (a test to help determine thyroid function). However, his record did not contain evidence the tests had been completed. When asked on 5/1/15 from 1:45 - 2:50 p.m., the LPN stated the tests had not been completed. The facility failed to ensure Individual #3 received lab tests as recommended.	W 326		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440		

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W 440	Continued From page 16 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 6 of 6 individuals (Individuals #1 - #6) 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 5/13/14 through 3/31/15, were reviewed. The records did not include an evacuation drill for the first quarter (January, February, March) of 2015 for the night shift (10:00 p.m. - 6:00 a.m.). When asked, the Program Supervisor stated during an interview on 4/28/15 at approximately 10:40 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		
W 481	483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, review of menus and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days which directly impacted 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals to not	W 481		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 481	Continued From page 17 receive an adequate variety of food. The findings include: 1. A meal observation was conducted at the facility on 4/27/15 from 4:25 - 5:40 p.m. The facility's menu was reviewed and documented the dinner would be "Client Choice." During the observation the dinner was observed to consist of: - Pizza - Green salad - French bread - Juice and milk When asked about the documentation of the "Client Choice" menu, on 4/28/15 at 10:20 a.m., the Program Supervisor stated the content of the dinner had not been documented. The facility failed to ensure accurate documentation of food actually served was kept.	W 481		

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Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 4/27/15 to 5/1/15. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Lead Ashley Henscheid, QIDP	M 000		
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164		
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	MM196		

RECEIVED MAY 26 2015 FACILITY STANDARDS

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [illegible] TITLE: Program Manager (X6) DATE: 5.12.2015

Bureau of Facility Standards

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MM196	Continued From page 1 or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197		
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 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 4/28/15 from 9:55 - 10:15 a.m. During that time, the following was noted: - The light switch in Individual #1's bedroom was broken.	MM380		

Bureau of Facility Standards

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MM380	Continued From page 2 - There was a build up of debris in the window tracks of Individual #2 and #6's bedroom window. - One of the plastic grab bars on the bathtub in the medication room was missing. - There was a piece of flooring approximately 3 inches wide coming loose to the left of the medication room door. - The toilet paper tissue holder shaft was missing from the toilet paper holder in Individual #5's bathroom. The facility failed to ensure environmental repairs were maintained.	MM380		
MM573	16.03.11.210.05(e) Health Care Complaints Notation record of the individual resident's health care complaints and problems together with evaluation and action followed. This Rule is not met as evidenced by: Refer to W315.	MM573		
MM672	16.03.11.07(a) Menu Preparation Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to W481.	MM672		

Bureau of Facility Standards

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MM730	Continued From page 3	MM730		
MM730	16.03.11.270.01(d)(i) 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		
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 W326.	MM750		
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859		

5/15/15

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

RECEIVED
MAY 26 2015
FACILITY STANDARDS

RE: Milliken Heights, Provider #13G053

Dear Jim Troutfetter:

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

W120 Services Provided With Outside Services

1. The IEP's for individuals #1 and #2 are currently on file in the facilities QIDP books. In addition, the current IPP's including the BMP's for individuals #1 and #2 have been sent to their school in an effort to coordinate services.
2. All of the individuals residing at the facility have a current copy of the IEP in their QIDP book for review. In addition, for all individuals residing in the facility that attend the Valley view School District a current copy of their IPP and BMP's have been sent to verify the schools have current copies. Also, the school district has been sent a current phone list of contacts so they have the ability to contact the Program Manager, Program Supervisor, LPN, QIDP, Clinical Director and the facility.
3. A training is scheduled for the IDT to discuss how to document efforts to coordinate services in the event and individual attends a school. The training will focus on documenting conversations with school professionals, documenting when IPP's and BMP's are given to the schools etc.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that outside services are adequately coordinated. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director, QIDP & LPN.
6. Completion Date: 6/21/15

W124 Protection of Client Rights

1. The guardians for individuals #1 and #3 are being notified of their right to withdraw their written consents at any time without the risk of punitive action. The guardian of individual #2 is being informed of the side effects of his medications.
2. In addition, all legal guardians in the home that have given a written informed consent are being notified of their right to withdraw their written consents at any time without the risk of punitive action. All Written Informed Consents are being reviewed to verify that the side effect list is comprehensive.
3. Aspire Human Services has revised the written informed consent document and the language "I give my consent for the above stated medication/medical procedure/restrictive program/mechanical or physical restraint. I understand that I have the right to withdraw my consent at any time."
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that all advocates and legal guardians have been informed that they have the right to withdraw their written informed consents. The review also verifies that Written Informed Consents contain comprehensive information. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director, QIDP & LPN.
6. Completion Date: 6/21/15

W214 Individual Program Plan

1. Individual #1's behavior assessment is currently being reviewed and revised to include that he has the right to report allegations of abuse, neglect or mistreatment. The assessment is also being revised to include accurate replacement behaviors.
2. All of the behavior assessments in the home are being reviewed to verify that they are comprehensive. If it is identified that any assessment is not comprehensive, the IDT will revise the assessment to assure it is comprehensive.
3. The Positive Behavior Support Specialist has scheduled a series of trainings related to the assessment of negative behaviors. The QIDP from the Milliken Heights home is scheduled to attend the trainings to gain a better understanding of how to develop comprehensive assessments.
4. Aspire Human Services is currently revising the policy and procedure to more clearly outline the role of the Human Rights Committee. Specifically clarifying that the committee can only give consent after the legal guardian has consented to a restrictive intervention.
5. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that behavior assessments are comprehensive. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
6. Person Responsible: Program Manager, Program Supervisor, Clinical Director, QIDP & Positive Behavior Support Specialist.

7. Completion Date: 6/21/15

W262 Program Monitoring and Change

1. The Written Informed Consents for individuals #1 and #2 are scheduled to be discussed at the next Human Rights Committee meeting. The HRC team will focus on verifying that restrictive interventions are approved only after the guardian gives approval.
2. In addition, all of the Written Informed Consents in the home are being revised to verify that the Human Rights Committee consented to restrictive procedures only after the legal guardian gave written or verbal approval. If it is identified that the Human Rights Committee consented to restrictive procedures without verifying that the legal guardian gave approval, the will be scheduled to be discussed at the next Human Rights Committee meeting. The HRC team will focus on verifying that restrictive interventions are approved only after the guardian gives approval.
3. Aspire Human Services is currently revising the policy and procedure to more clearly outline the role of the Human Rights Committee. Specifically clarifying that the committee can only give consent after the legal guardian has consented to a restrictive intervention.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the Human Rights Committee approved restrictive interventions only after the legal guardian consented. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director & QIDP.
6. Completion Date: 6/21/15

W263 Program Monitoring and Change

1. Individual #2 currently has a Signed Written Informed consent on file with signatures from the legal guardian and the Human Rights Committee for the use of the video cameras.
2. All individuals living the facility currently have a Signed Written Informed consent on file with signatures from the legal guardian and the Human Rights Committee for the use of the video cameras.
3. Aspire Human Services is currently in the process of revising the company policy and procedure for admissions. One part of the revision of policies will include clarification that consents for restrictive measures including the use of video cameras must be obtained prior to an individual moving into the facility. After the policy revision, the QIDP's will receive training on the policy revisions.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the all written unformed consents are current and on file. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director & QIDP.
6. Completion Date: 6/21/15

W312 Drug Usage

1. Individual #1's medication reduction plans are being revised to assure they are accurate and comprehensive. Aspire Human Services currently does not utilize his PRN at the

facility and there are no future plans to incorporate a PRN while in the care of Aspire Human Services.

2. All of the medication plans at the Milliken Heights home are being revised to assure accuracy, any identified discrepancies will be revised by the IDT.
3. The Positive Behavior Support Specialist has scheduled a series of trainings related to the assessment of negative behaviors. The QIDP from the Milliken Heights home is scheduled to attend the trainings to gain a better understanding of how to develop comprehensive and accurate assessments including reduction plans for medications. .
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that behavior assessments and medication reduction plans are comprehensive. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director, QIDP & Positive Behavior Support Specialist.
6. Completion Date: 6/21/15

W315 Drug Usage

1. Individual #1 has received an evaluation for tardive dyskinesia.
2. All individuals in the home that utilize a medication with the possible side effect of tardive dyskinesia have receive an evaluation for tardive dyskinesia.
3. Aspire Human Services is currently in the process of revising the nursing policy and procedures. One part of the revision will include specific instructions on the tracking of tardive dyskinesia evaluations.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that Tardive Dyskinesia assessments are completed as required by the Nursing Drug Handbook. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director & QIDP.
6. Completion Date: 6/30/15

W326 Physician Services

1. Individual #3 has received the recommended lab test as outlined in his dietary assessment.
2. The Nursing Department is currently reviewing all files to assure that all recommended orders for have been completed. Any recommended labs that have not been obtained will be scheduled for completion.
3. Aspire Human Services is currently in the process of revising the nursing policy and procedures. One part of the revision will include specific instructions on the tracking of recommended labs and how the facility will track the recommended labs to completion.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that labs are completed as recommended by outside professionals. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director & QIDP.
6. Completion Date: 6/30/15

W440 Evacuation Drills

1. Fire drill evacuations will be discussed at the next administrator meeting. Also, a discussion explaining quarters and the time frame to run a missed fire drill within a specific quarter will occur.
2. In addition, all program supervisors will review their home fire drill calendar to ensure all fire drills are being ran as required per quarter.
3. Aspire Human Services currently has a Universal Home Checklist. A revision under the Emergency Evacuation Plan section will include date and time of each month's fire drill.
4. Aspire Human Services is currently completing a monthly Universal Home Checklist. This checklist is reviewed by the program supervisor, program manager and maintenance each month. The Universal Home Checklist is due to the Program Manager prior to the end of the month.
5. Person Responsible: Program Manager & Program Supervisor
6. Completion Date: 6/21/15

W481 Menus

1. Menu logs have been placed in all 6 individuals floor book residing at the facility and data is being recorded.
2. Each month when the data is replaced the program supervisor will review all floor books to ensure all data sheets are replaced for all 6 individuals residing in the facility.
3. The program supervisor and QIDP will randomly choose floors books throughout the month to ensure all data sheets are in place.
4. During facility visits the program manager or clinical director will randomly choose floor books for review to ensure all proper paperwork is provided and available if needed.
5. Person Responsible: Program Manager, Program Supervisor, QIDP, & Clinical Director
6. Completion Date: 6/1/15

MM164

Please see the response given under W124 as it relates to the Development of the Plan of Care.

MM194

Please see the response given under W262 as it relates to the Approval of the Human Rights Committee.

MM196

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

MM197

Please see the response given under W312 as it relates to Written Plans.

MM380

1. All repairs will be fixed by 6/12/15 affecting all 6 individuals living at the facility.
2. When a repair is noticed it is documented on a maintenance request form. The Program Supervisor reviews these forms and notifies maintenance immediately for all major incidents. Maintenance signs off on the 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.

3. Maintenance visits each facility at a minimum of once a week. A schedule is set and repeats every week to provide each facility time for maintenance repairs.
4. In addition, Aspire Human Services currently has a Universal Monthly Checklist completed in 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 is also provided to maintenance to ensure all repairs are fixed within a timely manner and nothing is missed left unrepaired.
5. Person Responsible: Program Manager, Program Supervisor, & Maintenance
6. Completion Date: 6/21/15

MM573
Please see the response given under W315 as it relates to Health Care Complaints.

MM672
Please see the response given under W481 as it relates to Menu Preparation.

MM730
Please see the response given under W214 as it relates Diagnostic and Prognostic Data.

MM750
Please see the response given under W326 as it relates to Laboratory Examinations.

MM859
Please see the response given under W120 as it relates to Supervision of Training and Habilitation.

KBuchanan

Kristin Buchanan
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Administrator