



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
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May 11, 2015

Kristin Buchanan, Administrator
Preferred Community Homes - Sunset
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Sunset, Provider #13G052

Dear Ms. Buchanan:

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

Kristin Buchanan, Administrator

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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 21, 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 21, 2015. If a request for informal dispute resolution is received after May 21, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2015
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey conducted from 4/27/15 to 5/1/15.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Ashley Henscheid, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment HRC - Human Rights Committee PCLP - Person Centered Lifestyle Plan PRN - As needed QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 1 of 3 individuals (Individual #1) whose records were reviewed. This resulted in a lack of complete and accurate information in an individual's record. The findings include:</p> <p>1. Individual #1's PCLP, dated 4/23/15, documented a 20 year old female. Appendix A of</p>	W 111	<p style="text-align: center; font-size: 2em; opacity: 0.5;">RECEIVED</p> <p style="text-align: center; font-size: 1.5em; opacity: 0.5;">MAY 21 2015</p> <p style="text-align: center; font-size: 1.5em; opacity: 0.5;">FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Program Manager	(X8) DATE 5.21.2015
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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.

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W 111	Continued From page 1 Individual #1's record, dated 4/27/15, documented her diagnoses included mild intellectual disability. Individual #1's record contained a Physician's Sheet And [sic] Progress Notes entry, dated 2/16/12, which documented Individual #1's "behaviors have increased but is dealing with sister's death." However, no additional information related to the death of Individual #1's sister could be located in her record. During an interview on 5/1/15 from 1:00 - 1:45 p.m., the QIDP stated she was not aware Individual #1's sister had passed away. The facility failed to maintain comprehensive documentation related to Individual #1's social information.	W 111			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS 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.	W 124			

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FORM APPROVED
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W 124	<p>Continued From page 2</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 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:</p> <p>1. Individual #1 - #3's Written Informed Consents were reviewed, and did not include sufficient information, as follows:</p> <p>a. Individual #1's PCLP, dated 4/23/15, documented a 20 year old female. Appendix A of individual #1's record, dated 4/27/15, documented her diagnoses included mild intellectual disability.</p> <p>Individual #1's record contained Written Informed Consents for the following:</p> <ul style="list-style-type: none"> - Zyprexa (an antipsychotic drug), dated 2/9/15, - Bupropion (an antidepressant drug), dated 2/9/15, - Fluoxetine (an antidepressant drug), dated 2/9/15, - Line of sight supervision following suicidal ideation, dated 2/11/15, and - Use of video camera surveillance in the facility, dated 2/14/14. <p>However, none of individual #1's consents</p>	W 124			

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W 124	<p>Continued From page 3</p> <p>included information related to the guardian's right to withdraw consent at any time without risk of punitive action.</p> <p>b. Individual #2's PCLP, dated 10/16/14, documented a 16 year old female whose diagnoses included moderate intellectual disability.</p> <p>Individual #2's record contained Written Informed Consents for the following:</p> <ul style="list-style-type: none"> - Zyprexa (an antipsychotic drug) for daily use, dated 10/16/14, - Zyprexa PRN, dated 10/16/14, - One-on-one line-of-sight supervision, dated 10/16/14, - Use of video camera surveillance in the facility, dated 10/16/14, and - Use of a two-person body control restraint, dated 10/16/14. <p>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.</p> <p>c. Individual #3's PCLP, dated 11/5/14, documented a 17 year old female. Appendix A of Individual #3's record, dated 11/5/14, documented her diagnoses included mild intellectual disability.</p> <p>Individual #3's record contained Written Informed Consents for the following:</p>	W 124			

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W 124	Continued From page 4 - Melatonin (a supplemental drug), dated 1/20/15, - Zoloft (an antipsychotic drug), dated 1/20/15, - Line of sight supervision in the restroom and following suicidal ideation, dated 1/20/15, and - Use of video camera surveillance in the facility, dated 10/3/14, 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 1:00 - 1:45 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 individuals' consents contained comprehensive information on which to base consent decisions.	W 124			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by:	W 125			

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W 125	<p>Continued From page 5</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure each individual's need for guardianship was addressed for 1 of 3 individuals (Individual #1) whose PCLPs were reviewed. This resulted in the potential for a lack of advocacy for an individual. The findings include:</p> <p>1. Individual #1's PCLP, dated 4/23/15, documented a 20 year old female. Appendix A of Individual #1's record, dated 4/27/15, documented her diagnoses included mild intellectual disability. Individual #1's PCLP documented she was her own guardian.</p> <p>However, Individual #1's Social Service Evaluation, dated 4/15/15, documented "It is felt that [Individual #1] does not fully understand her rights and responsibilities." Individual #1's CFA, reviewed 4/14/15, documented under the section titled Basic Rights that Individual #1 required light physical assistance to "protect self from excessive/unnecessary/medication [sic] or restraint."</p> <p>Individual #1's PCLP included a service objective which stated Individual #1 "will be assisted in obtaining a Legal Guardian, by quarterly contacts being made in attempts to do so [sic], for 12 consecutive months." Individual #1's PCLP indicated attempts to pursue guardianship would be documented in Individual #1's contact log.</p> <p>Information related to the status of guardianship for Individual #1, including a contact log, could not be found in her record.</p> <p>During an interview on 5/1/15 from 1:00 - 1:45 p.m., the QIDP stated she made contact with</p>	W 125			

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W 125	Continued From page 6 Individual #1's father to discuss guardianship after noticing attempts to pursue guardianship for Individual #1 had not been made in three months. The QIDP stated that was the only contact she had made and stated the contact log was something they probably did not have. The Clinical Director, who was also present during the interview, stated pursuing guardianship and documenting those attempts was something they needed to work on.	W 125		
W 234	The facility failed to ensure guardianship was being pursued for Individual #1. 483.440(c)(5)(I) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the Individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clear, consistent direction to staff was provided in each written training program for 1 of 3 individuals (Individual #3) whose training plans were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program strategies. The findings include: 1. Individual #3's PCLP, dated 11/5/14, documented a 17 year old female. Appendix A of Individual #3's record, dated 11/5/14, documented her diagnoses included mild intellectual disability. Individual #3's programs did not include sufficient instructions to staff regarding how to implement the intervention strategies, as follows: a. Individual #3's record included a Behavior	W 234		

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W 234	<p>Continued From page 7</p> <p>Intervention Plan, dated 1/20/15, for uncooperative behavior. The program documented if individual #3 became uncooperative, staff were to "remind her why it's important to comply with the request to take care of herself. If [Individual #3] refuses, recue after five minutes. If she refuses 3 times with 5 [sic] minute break in between prompts give her a 10 minute break. If [Individual #3] refuses a 4th time document as a refusal on the data sheet."</p> <p>Individual #3's record contained an Individual Support Plan for each of her nine training objectives. Eight of the plans included a section titled "Refusal," which stated, "If [Individual #3] states that she does not want to do something, leave [sic] the area or ignores cues, allow her to refuse. Let her know that she can work on something else for now if she chooses. Recue [Individual #3] to task after 15 minutes, if she refuses again remind her that she needs to complete all of her work, but that she can work on something else. Recue [Individual #3] to task in 15 minutes. If she refuses again allow her to do so and document as a refusal for the day."</p> <p>The Individual Support Plan for finding an item in the store, dated 3/10/15, documented if Individual #1 "does not want to do something, leave [sic] the area or ignores cues, allow her to walk around the store within line of sight for 3-5 minutes, then recue. If [Individual #3] refuses again leave the store without making a purchase."</p> <p>When asked, during an interview on 5/1/15 from 1:00 - 1:45 p.m., the QIDP stated staff should follow the uncooperative behavior plan instructions. The QIDP stated the other programs needed revised.</p>	W 234		

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W 234	Continued From page 8 b. Individual #3's record contained a psychiatric note, dated 11/20/14, which documented Individual #3's Abilify (an antidepressant drug) was being reduced and ultimately eliminated. The medication was discontinued in 12/2014. However, Individual #3's Individual Support Plan for assistance with medications, dated 3/10/15, documented Individual #3 "will state a side effect of her Abilify with a non-specific verbal prompt in 10 of 12 trials per month for three consecutive months." During an interview on 5/1/15 from 1:00 - 1:45 p.m., the QIDP stated when she revised the program in March, she took the program off the company drive and did not correct the medication name. The facility failed to ensure program instructions included accurate, sufficient information for staff to implement Individual #3's programs.	W 234		
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 2 of 3 individuals	W 262		

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W 262	<p>Continued From page 9</p> <p>(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:</p> <p>1. Individual #1 and #2's Written Informed Consents were reviewed, and documented HRC approval concerns, as follows:</p> <p>a. Individual #1's PCLP, dated 4/23/15, documented a 20 year old female. Appendix A of Individual #1's record, dated 4/27/15, documented her diagnoses included mild intellectual disability. Individual #1's PCLP documented she was her own guardian.</p> <p>Individual #1's record contained Written Informed Consents for the following:</p> <ul style="list-style-type: none"> - Zyprexa (an antipsychotic drug), dated 2/9/15, - Bupropion (an antidepressant drug), dated 2/9/15, - Fluoxetine (an antidepressant drug), dated 2/9/15, and - Line of sight supervision following suicidal ideation, dated 2/11/15. <p>Each of the consents were signed by Individual #1 on 2/25/15. However, the consents documented HRC had already approved the interventions on 2/17/15.</p> <p>During an interview on 5/1/15 from 1:00 - 1:45 p.m., the QIDP confirmed that the HRC reviewed and approved the use of the interventions prior to</p>	W 262			

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W 262	<p>Continued From page 10 guardian consent being obtained.</p> <p>b. Individual #2's PCLP, dated 10/16/14, documented a 15 year old female whose diagnoses included moderate Intellectual disability.</p> <p>Individual #2's record contained Written Informed Consents for the following:</p> <ul style="list-style-type: none"> - Zyprexa (an antipsychotic drug) for daily use, dated 10/16/14, - Zyprexa PRN, dated 10/16/14, - One-on-one line-of-sight supervision, dated 10/16/14, - Use of video camera surveillance in the facility, dated 10/16/14, and - Use of a two-person body control restraint, dated 10/16/14. <p>All consents were signed by the guardian on 10/16/14. However, the facility's HRC had not signed off on the consents until 2/17/15.</p> <p>During an interview on 5/1/15 from 1:00 - 1:45 p.m., the QIDP Clinical Director stated it was previously thought that consents being renewed did not have the same requirements as initial consents, but that process was being changed.</p> <p>The facility failed to ensure Individual #1's restrictive interventions were approved by the HRC only after guardian consent had been obtained.</p>	W 262			

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET			STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686		
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W 440 W 440	Continued From page 11 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 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 11/29/14 through 1/25/15, were reviewed. The records did not include evacuation drills for the second quarter (April, May, June) of 2014 or 2015 and the third quarter (July, August, September) of 2014 for the night shift (10:00 p.m. - 6:00 a.m.). When asked, the Program Manager stated during an interview on 4/29/15 at approximately 1:10 p.m., the specified evacuation drills had not been done. The facility failed to ensure evacuation drills were conducted on a quarterly basis for each shift.	W 440 W 440			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2015
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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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		
MM221	16.03.11.080.01(a) Parent or Legal Guardian Is unwilling The resident's parent or legal guardian is unable	MM221		

RECEIVED
MAY 21 2015
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K. Kavanan</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>5.21.15</i>
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2015
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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MM221	Continued From page 1 or unwilling to participate or is unavailable after reasonable efforts to contact them; and This Rule is not met as evidenced by: Refer to W125.	MM221		
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 9:20 - 9:50 a.m. During that time, the following was noted: - The Lazy Susan in the kitchen did not close. - There was a hole approximately 3 inches in diameter, in the wall to the right of the front kitchen window. - There was a build up of debris in the window tracks of Individuals #2, #4, #5 and #6's bedroom windows. - The screen was missing from the bedroom	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2015
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MM380	Continued From page 2 window of Individual #6. The facility failed to ensure environmental repairs were maintained.	MM380		
MM534	16.03.11.210 Resident Record Requirements A record must be maintained for each resident of the facility. This Rule is not met as evidenced by: Refer to W111.	MM534		
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W234.	MM855		



5/15/15

Jim Troutfetter
Idaho Department of Health and Welfare
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

RE: Sunset Oaks, Provider #13G052

Dear Mr. Troutfetter:

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

W111 Client Records

1. Individual #1's record is currently being revised to include information in regards to the passing of a family member in 2012.
2. All individual files are being reviewed to verify that the records are accurate. Any discrepancies will be addressed by the IDT and the client records will be revised if needed.
3. Aspire Human Services is currently in the process of revising the Individual Program Plan format. The goal of the revision is to outline that all assessments are to be completed before the IPP meeting and the QIDP will bring all documents to the meeting. The IDT can then verify that the records are accurate and identify any required revisions.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that client records are accurate. 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

Please see the plan of correction given under W234 as it relates to the facility's failure to ensure program instructions include accurate information for staff to implement individual #3's programs.

W124 Protection of Client Rights

1. The guardians for individuals #1, #2 and #3 are being notified of their right to withdraw their written consents at any time without the risk of punitive action.
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.
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. 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

W125 Protection of Client Rights

1. Aspire Human Services has verified that individual #1 has a program objective in her Individual Program Plan to assist her to obtain a legal guardian. The QIDP is being provided additional documented training on how to assist individuals with intellectual disabilities to obtain a legal guardian.
2. In addition, all of the files in the home are being reviewed to verify that if an individual does not have a legal guardian that an objective is incorporated in the program plan and there are corresponding documents supporting efforts to obtain guardianship.
3. One of the revisions to the programs clarifies that the facility Social Worker will be responsible for assuring that efforts are being made instead of the QIDP.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that all objectives on the IPP are being implemented as specified, including the objectives for assisting individuals in obtaining legal guardianship. 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 & LSW.
6. Completion Date: 6/21/15

W234 Individual Program Plan

1. The program instructions for all of individual #3's programs are being revised to include sufficient information for staff to implement her programs.
2. In addition, all of the IPP's in the home are being reviewed to verify that they contain sufficient instructions for staff to implement the plans. In the event that it is identified that a plan does not include sufficient instructions, the program will be revised to include sufficient instructions.
3. The Sunset Oaks home has recently been assigned a new QIDP. In addition, the QIDP's Aspire Human Services - Boise are scheduled to receive additional training in relation to

the Individual Program Plans. The training will focus on verifying that each program contains sufficient instructions for the staff in the home to implement the plans.

4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the program plans are accurate and contain sufficient information for staff to implement the plans. 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 & LSW.
6. 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, they 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 & LSW.
6. Completion Date: 6/21/15

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. For the 2015 second quarter, the program supervisor will ensure all drills are completed as Sunset is still in this quarter.
2. In addition, all program supervisors will review their home fire drill calendar to ensure all fire drills are being run 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

MM164

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

MM194

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

MM221

Please see the response given under W125 as it relates to Parent or Legal Guardian unwilling.

MM380

1. All repairs will be fixed by 6/21/15 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

MM534

Please see the response given under W111 as it relates to Resident Record Requirements.

MM855

Please see the response given under W234 as it relates to the Training and Habilitation Record.



Kristin Buchanan
Program Manager

Amy Sevy
Program Supervisor
Administrator

