



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

June 29, 2015

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

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

Dear Mr. Borchardt:

This is to advise you of the findings of the complaint survey of Preferred Community Homes - Cougar Creek, which was conducted on June 22, 2015.

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

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Matt Borchardt, Administrator
June 29, 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 **July 13, 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 July 13, 2015. If a request for informal dispute resolution is received after July 13, 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: 13G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/22/2015
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COUGAR CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 EAST COUGAR CREEK MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the complaint survey conducted from 6/18/15 to 6/22/15,</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>PCLP - Person Centered Lifestyle Plan QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</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 a behavioral assessment contained comprehensive information for 1 of 3 individuals (Individual #1) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #1's PCLP, dated 3/24/15, documented a 44 year old male whose diagnoses included mild Intellectual disability and bipolar disorder, type II.</p> <p>His record contained a Behavioral Assessment,</p>	W 214	<p style="text-align: center;">RECEIVED JUL 14 2015 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>W. B. ...</i>	TITLE <i>Program Manager</i>	(X8) DATE <i>7.14.15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/22/2015
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COUGAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 EAST COUGAR CREEK MERIDIAN, ID 83642		
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W 214	<p>Continued From page 1 dated 3/23/15, documenting "When [Individual #1's] mental health is poor he will isolate and refuse to eat or drink."</p> <p>However, his assessment did not include information on how his mental health diagnosis or psychotropic medications were related to his isolation behavior.</p> <p>When asked on 6/22/15 at 1:04 - 1:15 p.m., the QIDP stated Individual #1's behavior assessment should have included his diagnoses, medications and how they related to his isolation behavior.</p> <p>The facility failed to ensure Individual #1's Behavioral Assessment contained comprehensive information.</p>	W 214			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/22/2015
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M 000	16.03.11 Initial Comments The following deficiency was cited during the complaint survey conducted from 6/18/15 to 6/22/15. The survey was conducted by: Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000		
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		

RECEIVED
JUL 14 2015
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Handwritten Signature]

7/14/2015



July 10th, 2015

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

RE: Cougar Creek, Provider #13G037

Dear Jim Troutfetter:

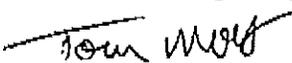
Thank you for your considerateness during the recent unannounced on-site complaint investigation at the Cougar Creek home. Please see our response below for the citation and please give us a call if you have any questions or concerns.

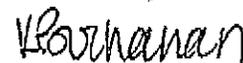
W214

1. Individual #1's behavior assessment is being revised to include comprehensive information in relation to his how his mental health diagnosis and psychotropic medications relate to his isolation behavior.
2. All of the behavior assessments in the home are being reviewed and revised as necessary to include comprehensive information.
3. A training occurred on 7/9/15. During the training the Positive Behavior Support Specialist provided additional training to the QIDP's in relation to how to include how to assess behavior by including items such as how a mental health diagnosis and psychotropic medication can relate to negative behavior such as isolation.
4. Aspire Human Services is currently performing peer reviews. One element of the peer reviews is verifying that all behavior assessments are comprehensive. Identified errors are reported to the Clinical Director and revisions are made to the program plans.
5. Person Responsible: Clinical Director
6. Completion Date: 8/1/5/15

MM730

Please see the response given under W214 as it relates to diagnostic and prognostic data.


Tom Moss
Clinical Director


Kristin Buchanan
Program Manager..



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June 29, 2015

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

Provider #13G037

Dear Mr. Borchardt:

An unannounced on-site complaint investigation was conducted from June 18, 2015 to June 22, 2015 at Preferred Community Homes - Cougar Creek. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007059

Allegation #1: Individuals do not receive adequate supervision to meet their needs.

Findings #1: During the investigation, observations, staff interviews, policy review and record reviews were conducted with the following results:

Observations were conducted at the facility on 6/18/15 from 11:15 - 12:00 p.m. and on 6/19/15 from 8:30 - 9:30 a.m. During the observations, staff were observed working with 5 individuals. All staff were aware of where individuals were at all times.

Interviews were conducted with a total of 8 direct care staff who worked the morning and evening shifts. All direct care staff stated they had not observed and were not aware of other staff members not providing adequate supervision for individuals residing in the facility. All direct care staff stated the procedures to implement and follow should an individual require one-on-one or line of sight supervision (i.e. increased supervision for suicide watch). In addition there were no individuals requiring one-on-one supervision for suicide watch at the time of the observations.

The facility's Incident and Accident reports and investigations, from 1/31/15 - 6/18/15, for 5 individuals were reviewed. The Incident and Accident reports and investigations did not identify any staff not providing or any individual not receiving adequate supervision to meet their needs.

Matt Borchardt, Administrator
June 29, 2015
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It could not be established that individuals did not receive adequate supervision to meet their needs. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals are not allowed to spend their own money on items of their choice.

Findings #2: During the investigation individual interviews were conducted. Individual records, the facility's Incident and Accident reports and investigations were reviewed with the following results:

The facility's Incident and Accident reports and investigations, from 1/31/15 - 6/18/15, for 5 individuals were reviewed. No documentation of restrictions to any individual's money management program was noted.

The money management programs for 4 individuals were reviewed and did not document the individuals were restricted from spending their money on items of their choice.

Four individuals were interviewed. Each of the individuals stated they spent their money on items of their choice and they were not restricted from making purchases with their own money.

It could not be established that individuals were not allowed to spend their money on items of their choice. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,


JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt