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

July 9, 2015

Shantelle Kates, Administrator
Preferred Community Homes - Mallard
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Mallard, Provider #13G032

Dear Ms. Kates:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Mallard, which was conducted on June 25, 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 **July 22, 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 22, 2015. If a request for informal dispute resolution is received after July 22, 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,

ASHLEY HENSCHEID
Health Facility Surveyor
Non-Long Term Care

Michael A Cone, LSW
NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 07/09/2015
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
	13G032		06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MALLARD	699 SOUTH OTTER MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation and annual recertification survey conducted from 6/18/15 to 6/25/15. The surveyors conducting your survey were: Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP Common abbreviations used in this report are: AOD - Administrator On Duty CFA - Comprehensive Functional Assessment HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan MAR - Medication Administration Record ng/ml - Nanogram per millimeter NOS - Not Otherwise Specified NSAID - Non-Steroidal Anti-Inflammatory Drug PCLP - Person Centered Lifestyle Plan PRN - As needed QHS - Every night at bedtime QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000	RECEIVED JUL 23 2015 FACILITY STANDARDS	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review, interview of facility staff, HRC members, family members and advocates, policy review and a review of the	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kirmeneen | TITLE: Program Manager | (X6) DATE: 7-22-15

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 104	Continued From page 1 facility's compliance history, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This failure resulted in the governing body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include: 1. The governing body failed to provide sufficient monitoring and oversight necessary to achieve and sustain regulatory compliance, as follows: a. The facility was previously cited at W104 during the annual recertification survey, dated 8/14/14, and during the follow-up survey, dated 11/4/14. b. Refer to W124 as it relates to the governing body's failure to ensure consents contained comprehensive information to enable guardians to make informed decisions related to restrictive interventions. The facility was previously cited at W124 during the annual recertification survey, dated 8/14/14. c. Refer to W159 as it relates to the governing body's failure to ensure the QIDP provided sufficient monitoring and oversight. The facility was previously cited at W159 during the annual recertification survey, dated 8/14/14. d. Refer to W214 as it relates to the governing body's failure to ensure individuals' assessments contained comprehensive information. The facility was previously cited at W214 during the annual recertification survey, dated 8/14/14. e. Refer to W223 as it relates to the governing	W 104		

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W 104	Continued From page 2 body's failure to ensure social assessments contained accurate, comprehensive information. The facility was previously cited at W223 during the annual recertification survey, dated 8/14/14. f. Refer to W249 as it relates to the governing body's failure to ensure there was no delay between program plan meetings and program plan implementation. The facility was previously cited at W249 during the annual recertification survey, dated 8/14/14. g. Refer to W289 as it relates to the governing body's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into an individual's behavior plan. The facility was previously cited at W289 during the annual recertification survey, dated 8/14/14. h. Refer to W312 as it relates to the governing body's failure to ensure behavior modifying drugs were used only as a comprehensive part of individuals' program plans that were directed specifically towards the reduction and eventual elimination of their use. The facility was previously cited at W312 during the annual recertification survey, dated 8/14/14, and during the follow-up survey, dated 11/4/14. i. Refer to W322 as it relates to the governing body's failure to ensure an individual received general and preventative medical care. The facility was previously cited at W322 during the annual recertification survey, dated 8/14/14. j. Refer to W331 as it relates to the governing body's failure to ensure individuals were provided with nursing services in accordance with their needs. The facility was previously cited at W331	W 104		

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W 104	Continued From page 3 during the annual recertification survey, dated 8/14/14. The governing body failed to take actions that identified and resolved systematic problems. 2. Refer to W113 as it relates to the governing body's failure to ensure the release of confidential information was addressed in policy. 3. Refer to W264 as it relates to the governing body's failure to ensure the HRC reviewed and monitored the company's policies and procedures related to restrictive practices.	W 104		
W 113	483.410(c)(3) CLIENT RECORDS The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure polices and procedures governing the release of personal information were sufficiently developed and implemented for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in an individual's personal information being released inappropriately. The findings include: 1. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's 9/16/14 PCLP stated she	W 113		

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W 113	Continued From page 4 was her own guardian, but listed the name of a person who acted as her advocate. The facility's "Authorization to Release Information - Form Instructions and Procedures" document, revised 9/2008, stated form number H-01 was to be used to request information from another entity, conduct marketing activities, obtain permission for on-going discussions with an entity regarding an individual, or request psychotherapy notes and records. However, there was no information regarding how information was to be released to an advocate. Additionally, Individual #4's record did not include information regarding the advocate (e.g., contact information, relationship to the individual, information regarding responsibilities, etc.). During a telephone interview on 6/25/15 from 8:15 - 8:40 a.m., the advocate stated she knew Individual #4 because she was a former employee of the facility. The advocate stated she had not signed a contract or agreement with the facility to be Individual #4's advocate, but the facility provided her with Individual #4's health and psychiatric information, as well as information about potential rights violations. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the Clinical Director stated policies and procedures regarding the use of advocates, including polices regarding release of information to advocates, had not been developed. The facility failed to ensure policies and procedures were sufficiently developed and implemented related to releasing Individual #4's personal information to an advocate.	W 113		

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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. 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 4 of 4 individuals (Individuals #1 - #4) 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 - #4's Written Informed Consents were reviewed, and did not include sufficient information, as follows: a. Individual #1's PCLP, dated 12/12/14, documented a 61 year old male. Appendix A of Individual #1's PCLP, dated 6/17/15, documented his diagnoses, which included severe intellectual disability. Individual #1's record contained Written Informed Consents for the following: - Lexapro (an antidepressant drug), dated 12/15/14, - Risperdal (an antipsychotic drug), dated	W 124		

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W 124	Continued From page 6 12/15/14, - Individual #1's behavior plan, which included the use of bite release, dated 12/15/14, - Bandage wraps on Individual #1's arms due to self-abuse, dated 12/15/14, - A gait belt, dated 12/15/14, - Video camera surveillance in the facility, dated 12/15/14, and - A facility dog, dated 9/28/10. 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 Consents for medications were reviewed. The consents did not include information related to potentially fatal conditions from the medications, as follows: - The consent for Lexapro documented side effects included, but were not limited to, constipation, dry mouth, heartburn and trouble sleeping. The 2016 Nursing Drug Handbook included suicidal behavior as a potential side effect. - The consent for Risperdal documented side effects included, but were not limited to, aggressive behavior, changes in vision, memory problems, tic-like or twitching movements and trouble sleeping.	W 124		

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W 124	Continued From page 7 The 2016 Nursing Drug Handbook included neuroleptic malignant syndrome (a neurological disorder) and suicide attempt. Both conditions were listed in black, italicized font, indicating "life-threatening reaction." However, Individual #1's medication consents did not include information related to the potentially fatal side effects documented in the Nursing Drug Handbook. b. Individual #2's IPP, dated 10/3/14, documented a 53 year old male. Appendix A of Individual #2's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #2's record contained Written Informed Consents for the following: - Lorazepam (an anxiolytic drug) for medical appointments, dated 1/14/15, - Clonidine (an antihypertensive drug), dated 10/13/14, - Zoloft (an antidepressant drug), dated 10/13/14, - Zyprexa (an antipsychotic drug), dated 10/13/14, - Risperdal (an antipsychotic drug), dated 10/13/14, - Ambien (a hypnotic drug), dated 10/13/14, - Video camera surveillance in the facility, dated 10/4/12, and - A facility dog, dated 10/13/14.	W 124		

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W 124	Continued From page 8 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 Consents for medications were reviewed. The consents did not include information related to potentially fatal conditions from the medications, as follows: - The consent for Clonidine documented side effects included, but were not limited to, constipation, loss of appetite, mental depression, chest pain or discomfort and fever. The 2016 Nursing Drug Handbook included bradycardia (very slow heartbeat) and severe rebound hypertension. Both conditions were listed in black, italicized font, indicating "life-threatening reaction." - The consent for Zoloft documented side effects included, but were not limited to, acid or sour stomach, belching, constipation, confusion, drowsiness and nosebleeds. The 2016 Nursing Drug Handbook included suicidal behavior as a potential side effect. - The consent for Zyprexa documented side effects included, but were not limited to, coma, confusion, headache, nausea or vomiting and shortness of breath. The 2016 Nursing Drug Handbook included neuroleptic malignant syndrome, suicide attempt and leukopenia (low white blood cell count). All of	W 124		

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W 124	Continued From page 9 the conditions were listed in black, italicized font, indicating "life-threatening reaction." - The consent for Risperdal documented side effects included, but were not limited to, aggressive behavior, changes in vision, memory problems, tic-like or twitching movements and trouble sleeping. The 2016 Nursing Drug Handbook included neuroleptic malignant syndrome and suicide attempt as potential side effects. - The consent for Ambien documented side effects included, but were not limited to, clumsiness or unsteadiness, confusion, depression and sleepiness or unusual drowsiness. The 2016 Nursing Drug Handbook included anaphylaxis (a severe allergic reaction) and angioedema (swelling under the skin). Both of the conditions were listed in black, italicized font, indicating "life-threatening reaction." However, Individual #2's medication consents did not include information related to the potentially fatal side effects documented in the Nursing Drug Handbook. c. Individual #3's 8/21/14 PCLP stated she was a 64 year old female whose diagnoses included profound intellectual disability, mood disorder, and autistic disorder. Individual #3's record contained Written Informed Consents for the following: - Halcion (a hypnotic drug) prior to a tooth	W 124		

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W 124	Continued From page 10 extraction, during which a papoose board was also used, dated 3/9/15, - Cataract surgery with the use of general anesthesia, dated 10/23/14, - Video camera surveillance in the facility, dated 7/29/14, and - A facility dog, dated 7/29/14. 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. Additionally, Individual #3's Written Informed Consent for Halcion was reviewed. The consent documented side effects included, but were not limited to, somnolence, dizziness, coordination problems, tachycardia and visual disturbances. The 2016 Nursing Drug Handbook included anaphylaxis and angioedema as potential side effects. However, Individual #3's consent did not include information related to the potentially fatal conditions documented in the Nursing Drug Handbook. d. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's record contained Written Informed Consents for the following:	W 124		

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W 124	Continued From page 11 - Lorazepam for daily use, dated 3/6/15, - Lorazepam PRN for anxiety, dated 3/6/15, - Clonidine, dated 3/6/15, - Prozac (an antidepressant drug), dated 3/6/15, - Risperdal, dated 3/6/15, - Lamictal (an anticonvulsant drug), dated 3/6/15, and - Video camera surveillance in the facility, dated 10/4/12. However, none of Individual #4's consents included information related to the guardian's right to withdraw consent at any time without risk of punitive action. Additionally, Individual #4's Written Informed Consents for medications were reviewed. The consents did not include information related to potentially fatal conditions from the medications, as follows: - The consent for Clonidine documented side effects included, but were not limited to, constipation, loss of appetite, mental depression, chest pain or discomfort and fever. The 2016 Nursing Drug Handbook included bradycardia and severe rebound hypertension. - The consent for Prozac documented side effects included, but were not limited to, hives, itching or skin rash, inability to sit still,	W 124		

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W 124	Continued From page 12 restlessness, chills or fever and joint or muscle pain. The 2016 Nursing Drug Handbook included suicidal behavior and respiratory distress as potential side effects. Both conditions were listed in black, italicized font, indicating "life-threatening reaction." - The consent for Risperdal documented side effects included, but were not limited to, aggressive behavior, changes in vision, memory problems, tic-like or twitching movements and trouble sleeping. The 2016 Nursing Drug Handbook included neuroleptic malignant syndrome and suicide attempt as potential side effects. - The consent for Lamictal documented side effects included, but were not limited to, blurred vision, clumsiness or unsteadiness, double vision, poor coordination and skin rash. The 2016 Nursing Drug Handbook included toxic epidermal necrolysis (a rash followed by the peeling of skin), Stevens-Johnson syndrome (a form of toxic epidermal necrolysis) and seizures. All of the conditions were listed in black, italicized font, indicating "life-threatening reaction." However, Individual #4's medication consents did not include information related to the potentially fatal side effects documented in the Nursing Drug Handbook. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the Clinical Director stated after the concern with consent information was identified in a	W 124		

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W 124	Continued From page 13 previous survey, letters were written to all guardians to make them aware of their right to withdraw consent without punitive action. The QIDP, who was also present during the interview, stated she had not sent any of the letters to the guardians. During the same interview, the QIDP stated the potentially fatal conditions identified were not included in individuals' medication 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: Based on record review and staff and family interviews, it was determined the facility failed to ensure individuals' rights were promoted for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in the potential for an individual's rights to be violated. The findings include: 1. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder	W 125		

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W 125	Continued From page 14 NOS. Her Social Service Evaluation, dated 11/17/14, stated Individual #4's sister was her "voluntary guardian." However, her PCLP stated "[Individual #4] does not understand her rights but is her own guardian. She does have an advocate that assists [Individual #4] with her rights." Additionally, Individual #4's record documented her PCLP meeting had been attended by the advocate and all consents for restrictive interventions had been signed by the advocate. There was no documentation that Individual #4's sister had been involved in her care decisions, and no legal paperwork regarding guardianship could be found. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated she believed Individual #4 was her own guardian. The Clinical Director, who was present during the interview, stated Individual #4's sister was historically the guardian, but had not been involved for several years. When asked, the Clinical Director could not provide documentation to clarify if Individual #4 was her own guardian or if her sister was her guardian. During the same interview, when asked what efforts had been made to contact Individual #4's sister, the QIDP stated she had attempted to call Individual #4's sister on two occasions over the past year and a half, but stated the calls were not answered and she did not document the efforts. The QIDP stated no other efforts had been made to contact Individual #4's sister. The QIDP stated the advocate was looking for a pro bono attorney to assist with obtaining guardianship.	W 125		

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W 125	Continued From page 15 During a telephone interview on 6/25/15 from 9:55 - 10:10 a.m., Individual #4's sister stated the last time she was contacted by the facility was "over a couple of years ago." Individual #4's sister stated she had intended to become Individual #4's guardian, but had not been able to complete the process due to financial reasons. The facility failed to ensure Individual #4's guardian status was known and that efforts had been made to establish guardianship as needed.	W 125		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review, staff and family interviews and review of evacuation drills, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight of individuals' program plans for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in a lack of sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of assessments, objectives and program development. The findings include: 1. The program plans for two individuals indicated the IDT meeting for program planning was held without updated assessment information, as follows: a. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included	W 159		

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W 159	Continued From page 16 moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's PCLP documented the PCLP meeting date was 9/16/14. However, Individual #4's CFA was not completed until 10/14/14. b. Individual #2's IPP, dated 10/3/14, documented a 53 year old male. Appendix A of Individual #2's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #2's IPP documented the IPP meeting date was 8/27/14. However, Individual #2's CFA was not completed until 9/25/14. When asked what data was reviewed during planning meetings, during an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated she held the planning meetings with current programs individuals were working on in addition to their old CFA. The facility failed to ensure the QIDP ensured individuals' program plans were only developed once updated assessment information had been obtained. 2. Refer to W124 as it relates to the facility's failure to ensure the QIDP ensured consents contained comprehensive information to enable guardians to make informed decisions related to restrictive interventions. 3. Refer to W125 as it relates to the facility's failure to ensure the QIDP ensured guardianship was aggressively pursued for an individual with an assessed need.	W 159		

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W 159	Continued From page 17 4. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' assessments contained comprehensive information. 5. Refer to W223 as it relates to the facility's failure to ensure the QIDP ensured social assessments contained accurate, comprehensive information. 6. Refer to W239 as it relates to the facility's failure to ensure the QIDP ensured a functional replacement behavior was created for an individuals' depressive symptoms. 7. Refer to W240 as it relates to the facility's failure to ensure the QIDP ensured comprehensive instructions were in place for an individual's mechanical supports. 8. Refer to W249 as it relates to the facility's failure to ensure the QIDP ensured there was no delay between program plan meetings and program plan implementation. 9. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured techniques used to manage inappropriate behavior were sufficiently incorporated into an individual's behavior plan. 10. Refer to W303 as it relates to the facility's failure to ensure the QIDP ensured an individual's record documented the use of restraints. 11. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured behavior modifying drugs were used only as a	W 159		

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W 159	Continued From page 18 comprehensive part of individuals' program plans that were directed specifically towards the reduction and eventual elimination of their use. 12. Refer to W317 as it relates to the facility's failure to ensure the QIDP ensured medication reductions were only attempted with the implementation of supports for an individual. 13. Refer to W322 as it relates to the facility's failure to ensure the QIDP ensured an individual received general and preventative medical care. 14. Refer to W331 as it relates to the facility's failure to ensure the QIDP ensured individuals were provided with nursing services in accordance with their needs. 15. Refer to W376 as it relates to the facility's failure to ensure the QIDP ensured an individual's physician was immediately notified of a medication administration error. 16. Refer to W382 as it relates to the facility's failure to ensure the QIDP ensured all medications were stored securely. 17. Refer to W448 as it relates to the facility's failure to ensure the QIDP ensured evacuation drills were reviewed for the identification of potential issues. 18. Refer to W449 as it relates to the facility's failure to ensure the QIDP ensured corrective action was taken for problems that occurred during evacuation drills.	W 159		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		

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W 214	Continued From page 19 The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments contained comprehensive information for 3 of 4 individuals (Individuals #1, #2 and #4) whose assessments were reviewed. This resulted in a lack of behavioral and developmental information on which to base program intervention decisions. The findings include: 1. Individuals' assessments were found to have insufficient information, as follows: a. Individual #2's IPP, dated 10/3/14, documented a 53 year old male. Appendix A of Individual #2's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #2's CFA, dated 9/25/14, was reviewed and contained multiple areas that were deemed "not applicable" and were subsequently not assessed. Each area included a task, prompt required and comments section. Examples of areas assessed as "N/A" for the prompt required included, but were not limited to, the following: - The toileting task "Opens/closes the fly on pants to urinate (male)." The comments section included "[Individual #2] prefers to wear elastic waist band pants/shorts." - The showering task "Closes shower curtain." The comments section stated "[Individual #2]	W 214		

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W 214	Continued From page 20 prefers to take a bath." - The toothbrushing task "Spits water into the sink." The comments section was blank. - The undressing task "Unfastens buttons or snaps on a shirt, blouse, or dress." The comments section was blank. - The eating task "Makes a sandwich." The comments section was blank. When asked about the assessment process, during an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated she assessed Individual #2 based on the behaviors and/or skills he exhibited at the facility. For example, Individual #2 required a pureed diet, so food skills were not comprehensively assessed. The QIDP stated it had not occurred to her to look at all base tasks. b. Individuals' behavior assessments did not contain sufficient information related to medication use, as follows: - Individual #1's PCLP, dated 12/12/14, documented a 61 year old male. Appendix A of Individual #1's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #1's Physician's Order, dated 4/2015, documented he received Risperdal (an antipsychotic drug) 3 mg and Lexapro (an antidepressant drug) 10 mg daily. Individual #1's Behavioral Assessment, dated 6/22/15, documented "Currently [Individual #1] takes psychotropic medications Lexapro and	W 214		

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W 214	Continued From page 21 Risperdal, which is used in conjunction with the behavior management plan to decrease his maladaptive behavior." However, the assessment did not include information about how the drugs impacted his maladaptive behaviors. - Individual #2's IPP, dated 10/3/14, documented a 53 year old male. Appendix A of Individual #2's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #2's Physician's Order, dated 4/2015, documented he received Clonidine (an antihypertensive drug) 0.15 mg, Risperdal 5 mg, Zoloft (an antidepressant drug) 50 mg and Zyprexa (an antipsychotic drug) 12.5 mg daily. Additionally, the orders documented Individual #2 received Ambien (a hypnotic drug) 5 mg for an average of less than 8 hours of sleep over a 2-day period and lorazepam (an anxiolytic drug) 2 mg for medical appointments. Individual #2's Behavioral Assessment, dated 10/2/14, documented "[Individual #2] does have a formal behavior management plan and takes psychotropic medications, Risperdal, Zyprexa, Zoloft, and Clonidine used in conjunction with his support plan. [Individual #2] takes Zolpidem Tartrate [sic] [the generic name for Ambien] to assist with sleep." However, the assessment did not include information related to the use of lorazepam or information about how Individual #2's medications impacted his maladaptive behaviors. - Individual #4's 9/16/14 PCLP stated she was a	W 214		

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W 214	Continued From page 22 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's record documented she received Risperdal 5.5 mg, Clonidine 0.15 mg, Lamotrigine (an anticonvulsant drug) 300 mg, lorazepam 2 mg, and Prozac (an antidepressant drug) 20 mg daily. She also received lorazepam 0.5 mg PRN up to 4 times daily for anxiety. However, Individual #4's Behavioral Assessment, revised 3/30/15, did not include information about the drugs and how they may impact his maladaptive behaviors. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated medication information could be found in the Written Informed Consents, but not in the Behavioral Assessment. The facility failed to ensure assessments included comprehensive information.	W 214		
W 223	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include social development. This STANDARD is not met as evidenced by: Based on record review and staff and family interviews, it was determined the facility failed to ensure comprehensive functional assessments included social development for 3 of 4 individuals (Individuals #1, #3 and #4) whose program plans and assessments were reviewed. This resulted in a lack of information on which to base	W 223		

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W 223	Continued From page 23 decisions related to individuals' guardianship and interpersonal skills needs. The findings include: 1. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's Social Service Evaluation, dated 10/17/14, did not include updated or comprehensive information, as follows: a. Individual #4's Social Service Evaluation stated her sister was her "voluntary guardian." Under the Family Involvement section, the evaluation stated Individual #4 "has no legal guardian at this time. [Advocate name] is [Individual #4's] advocate and attends her PCLP meetings. She keeps apprised of any medication changes for [Individual #4] as well. [Individual #4] has no interest in seeing her family and does not see them or hear from them." During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated she believed Individual #4 was her own guardian. The Clinical Director, who was present during the interview, stated Individual #4's sister was historically the guardian. When asked, the Clinical Director could not provide documentation to clarify if Individual #4 was her own guardian or if her sister was her guardian. During a telephone interview on 6/25/15 from 9:55 - 10:10 a.m., Individual #4's sister stated the last time she was contacted by the facility was "over a couple of years ago." Individual #4's sister stated she had intended to become Individual #4's guardian, but had not been able to	W 223		

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W 223	Continued From page 24 complete the process due to financial reasons. Individual #4's Social Service Evaluation did not provide clear information regarding the status of her legal guardianship. b. Under the Family Members section, the evaluation stated Individual #4 had 3 brothers and 1 sister. Individual #4's mother was alive, but her father was deceased. It documented Individual #4's mother, sister and 2 of her brothers lived in another town within the state. Her third brother, described as Individual #4's "friend, younger brother, and playmate" lived in another state. The Family Medical History section stated Individual #4 had returned to the facility with several bruises on her legs and a bruise on her eye following a family visit. The evaluation stated "At this time the bruises are unexplained. [Individual #4] has not visited her family without supervision since her return from the Thanksgiving visit in 2007." The evaluation did not contain additional information regarding relationships in Individual #4's life, how relationships with her family might be maintained or rebuilt, or what interpersonal skills needed to be addressed in order for Individual #4 to establish and maintain appropriate roles and fulfilling relationships with others. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the Clinical Director stated the evaluation needed to be updated. The facility failed to ensure Individual #4's Social Service Evaluation included updated and	W 223		

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W 223	Continued From page 25 complete information. 2. Individual #3's 8/21/14 PCLP stated she was a 64 year old female whose diagnoses included profound intellectual disability, mood disorder, and autistic disorder. Her Social Service Evaluation, dated 9/17/14, stated Individual #3's sisters had co-guardianship, and stated one sister was the primary contact. The evaluation stated "At fourteen she developed a behavior of nuzzling residents and biting their ears." There was no additional information regarding relationships in Individual #3's life, or what interpersonal skills needed to be addressed in order for Individual #3 to establish and maintain appropriate roles and fulfilling relationships with others. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the Clinical Director stated the evaluation needed to be updated. The facility failed to ensure Individual #3's Social Service Evaluation included updated and complete information. 3. Individual #1's PCLP, dated 12/12/14, documented a 61 year old male. Appendix A of Individual #1's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. His Social Service Evaluation, dated 9/18/14, stated Individual #1's sister had guardianship. The evaluation included a "Family History" section which documented Individual #1 had	W 223		

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W 223	Continued From page 26 three sisters, one of whom was deceased, and his parents were also deceased. There was no additional information regarding relationships in Individual #1's life, or what interpersonal skills needed to be addressed in order for Individual #1 to establish and maintain appropriate roles and fulfilling relationships with others. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the Clinical Director stated the evaluation needed to be updated. The facility failed to ensure Individual #1's social evaluation included updated and complete information.	W 223		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors for 1 of 4 individuals (Individual #4) whose behavior plans were reviewed. This resulted in an individual not receiving functional training to replace her maladaptive behaviors. The findings include:	W 239		

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W 239	Continued From page 27 1. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's Behavioral Assessment, revised 3/30/15, stated she engaged in anxiety (defined as engaging in self-abusive behaviors and/or yelling, screaming, and repetitive/continuous talking) and depressive type symptoms (defined as isolating, crying/laughing for no apparent reason, decrease in appetite, and sleep disturbance). The replacement behavior listed for both anxiety and depressive-type symptoms was "Coping Skills." Individual #4's Individual Support Plan for coping skills, revised 6/17/15, stated she would learn to ask for her "beads or water pipes" when feeling anxious. However, there was no information related to dealing with depressive type symptoms. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated the coping skills program was for Individual #4's anxiety, and a replacement behavior plan for depressive symptoms had not been developed. The facility failed to ensure appropriate replacement behaviors were developed to address Individual #4's depressive-type symptoms.	W 239		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN	W 240		

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W 240	Continued From page 28 The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the individual program plan described relevant interventions to support independence for 1 of 4 individuals (Individual #3) whose program plans were reviewed. This resulted in insufficient information being available to staff related to an individual's gait belt use. The findings include: 1. Individual #3's 8/21/14 PCLP stated she was a 64 year old female whose diagnoses included profound intellectual disability, mood disorder, and autistic disorder. Individual #3's Physical Therapy Evaluation, dated 8/19/14, stated she walked with one-person assistance inside and outside, and required a gait belt for safety while outside. Individual #3's PCLP stated she could "stand and walk around her home for long periods of time without complaints of fatigue, requiring guidance with a gate [sic] belt for safety reasons." There was no additional information in the PCLP regarding the gait belt (e.g., how it was to be applied, if staff were to be holding it at all times, if staff were to be holding it from one particular side, etc.). Additionally, it was not clear if the gait belt was to be worn at all times or only outside, as indicated in the Physical Therapy Evaluation. Observations were conducted at the facility on 6/18/15 from 1:00 - 1:55 p.m., from 3:15 - 4:05	W 240		

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W 240	Continued From page 29 p.m. and from 5:00 - 5:45 p.m. and on 6/19/15 from 6:50 - 7:45 a.m. and from 9:00 - 9:40 a.m. During those times, Individual #3 was observed to be wearing a handle-style gait belt that buckled in the front and had handles/loops in the back. The gait belt was observed to be used inconsistently by direct care staff throughout the observations. Examples included, but were not limited to, the following: - 6/18/15 at 1:35 p.m.: A direct care staff verbally cued Individual #3 to stand. The direct care staff stood to the right side of Individual #3 and grasped the gait belt on either side, but did not grasp the handles. Individual #3 leaned on the direct care staff as they walked down the hall to Individual #3's bedroom. - 6/18/15 at 1:40 p.m.: A direct care staff walked with Individual #3 from her bedroom to the living room. Individual #3's gait belt was turned sideways so the buckle was on one side and the handles were on the other. The direct care staff grasped the belt near the buckle and edge, but was not grasping the belt by the handles. - 6/18/15 at 3:15 p.m.: A direct care staff was holding Individual #3's left hand with her left hand, and had her right hand through one of the gait belt handles with her palm against Individual #3's back. The direct care staff walked Individual #3 down the hallway and out the front door. - 6/18/15 at 3:45 p.m.: A direct care staff was walking in the hallway with Individual #3. Individual #3's gait belt was on backwards with the buckle in back and the handles in front. The direct care staff was holding onto the belt by the buckle.	W 240		

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W 240	Continued From page 30 - 6/19/15 at 7:30 a.m.: The Lead Worker was standing directly behind Individual #3 with her arms under Individual #3's arms and extended around in front of her. Individual #3 was holding onto the Lead Worker's forearms. The Lead Worker was not holding on to Individual #3's gait belt. The Lead Worker walked with Individual #3 in a rocking motion down the hallway to the laundry room, then to the kitchen. - 6/19/15 at 9:20 a.m.: Individual #3 was pacing back and forth in the dining room. A direct care staff was walking with her, but was not holding the gait belt. Individual #3 walked towards a chair and appeared to be going to walk into it, at which point the direct care staff grasped the gait belt by the handles and redirected Individual #3 away from the chair. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated Individual #3 wore the gait belt at all times. The QIDP stated there was no additional clarification or protocol for the use of Individual #3's gait belt. The facility failed to ensure Individual #3's PCLP specified when and how the gait belt was to be used.	W 240		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program	W 249		

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W 249	Continued From page 31 plan. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals received training and services consistent with their program plans for 2 of 4 individuals (Individuals #2 and #4) whose programs were reviewed. This resulted in individuals not receiving training in accordance with their identified needs. The findings include: 1. The program plans for two individuals were found to have been implemented a significant amount of time after the planning meeting, as follows: a. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. Individual #4's PCLP documented the PCLP meeting date was 9/16/14. However, the PCLP implementation date was documented as 10/27/14, more than a month after the PCLP meeting. b. Individual #2's IPP, dated 10/3/14, documented a 53 year old male. Appendix A of Individual #2's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #2's IPP documented the IPP meeting date was 8/27/14. However, the IPP implementation date was documented as	W 249		

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W 249	Continued From page 32 10/3/14, more than a month after the IPP meeting. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the Clinical Director stated they made changes to ensure future plans are implemented within 7 days of the meetings, but stated the facility did not go back and revise all plans when the change was made. The facility failed to ensure individuals' program plans were implemented as soon as possible after the planning meetings.	W 249		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on policy review and HRC and staff interview, it was determined the facility failed to ensure the HRC sufficiently monitored the facility's policies and procedures related to restrictive practices. This resulted in the potential for individuals' rights to be violated. The findings include: 1. The facility's Human Rights Committee policy, dated 12/14/11, stated the purpose of the	W 264		

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W 264	Continued From page 33 committee was as follows: - To "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." - To "insure that these programs are conducted only with written informed consent of the client, parents (if the client is a minor) or legal guardian." - To "review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, control of inappropriate behavior, and protection of client rights and funds, and any other areas that the committee's leaves [sic] need to be addressed." The policy stated the committee would meet quarterly or as needed in emergency situations. A telephone interview was conducted with the HRC Chair on 6/25/15 from 8:15 - 8:40 a.m. The HRC Chair stated the committee reviewed information and consent forms for any medication changes or restriction to rights that the facility gave them. When asked if the committee had reviewed any of the facility's policies related to behavioral intervention or potential rights violations, the HRC Chair stated she did not recall ever reviewing any policies and stated she did not know what behavior policies might be in place or what they might include. The HRC Chair stated the only document reviewed in addition to the consents presented was a 1 or 2 page document of individuals' rights.	W 264		

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W 264	Continued From page 34 During an interview on 6/25/15 from 1:03 - 1:21 p.m., the Clinical Director stated he thought the HRC had reviewed the policy, but would have to look for any documentation to show they had. No additional documentation was provided as of 7/9/15. The facility failed to ensure the Human Rights Committee sufficiently reviewed and monitored the facility's policies related to restrictive practices.	W 264		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 4 individuals (Individual #4) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include: 1. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder	W 289		

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W 289	Continued From page 35 NOS, bipolar disorder and depressive disorder NOS. Individual #4's Behavioral Assessment, revised 3/30/15, stated she engaged in anxiety (defined as engaging in self-abusive behaviors and/or yelling, screaming, and repetitive/continuous talking). The assessment stated "These behaviors include biting her arm, biting her lip, biting her finger..." The Behavior Intervention Plan for anxiety, revised 3/30/15, stated if Individual #4 became "anxious by engaging in self-abusive behaviors" staff were to do the following: - "If [Individual #4] attempts to display self-abuse, ask her to stop and try to redirect her into her coping skills program or another positive activity. Once [Individual #4] has reached the point of self abusive [sic] behavior, she is intending to cause harm to herself." - "Immediately respond to the situation by asking her to stop." - "If [Individual #4] continues to engage in anxiety type symptoms for 1 Consecutive Hour, staff will follow her PRN Guidelines and call the program supervisor or AOD for permission to administer the PRN. It is very important to utilize the PRN when needed as this will calm [Individual #4] and prevent further self-abusive behaviors." There were no additional directions to staff as to how to stop Individual #4's self-abusive behaviors (e.g., blocking, pillows, physical redirection of hands, bite releases, etc.). As written, Individual #4 could engage in self-abusive behaviors for an	W 289		

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W 289	Continued From page 36 hour without intervention other than being told to stop. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated if Individual #4 did not stop self-abusive behaviors after being asked to stop, staff would have to use an emergency restraint. The QIDP stated the plan methods needed to be revised. The facility failed to ensure techniques to manage Individual #4's self-abusive behaviors were sufficiently incorporated into her behavior plan.	W 289		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a record of restraint was maintained for 1 of 2 individuals (Individual #3) for whom dental restraint was used. Failure to keep a comprehensive record of restraint usage impeded the ability of the IDT, the facility's HRC, and an individual's guardian to make informed decisions and/or recommendations regarding the use of restraint. The findings include: 1. Individual #3's 8/21/14 PCLP stated she was a 64 year old female whose diagnoses included profound intellectual disability, mood disorder, and autistic disorder. Her record included a Dental Visit Papoose Board and Medication Reduction Plan, dated 9/16/14,	W 303		

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W 303	Continued From page 37 which stated Individual #3 required the use of a papoose board (an adult mechanical restraint device) for safety during dental procedures. Individual #3's Nursing Progress Notes documented dental appointments were completed on 11/7/14 and 3/19/15. However, documentation of the use of the papoose board could not be found in her record. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated the papoose board was used during the dental appointments but a record of the use had not been completed. The facility failed to ensure the use of the papoose board for Individual #3 was documented.	W 303		
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 individuals' program plans that were directed specifically towards the reduction of, and eventual elimination of, the behaviors for which the drugs were employed for 2 of 4 individuals (Individuals #2 and #3) whose medication reduction plans were reviewed. This	W 312		

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W 312	Continued From page 38 resulted in individuals receiving behavior modifying drugs without plans that identified the drug usage and how it may change in relation to progress or regression. The findings include: 1. Individual #3's 8/21/14 PCLP stated she was a 64 year old female whose diagnoses included profound intellectual disability, mood disorder, and autistic disorder. Individual #3's record included a Dental Visit Papoose Board and Medication Reduction Plan, dated 9/16/14, which stated Individual #3 received Triazolam (a hypnotic drug) 0.125 mg 1 hour prior to dental appointments. Individual #3's record documented dental appointments were completed on 11/7/14 and 3/19/15. Her MAR for both dates were reviewed and documented Individual #3 received Triazolam 0.25 mg 1 hour prior to each dental appointment. Individual #3's Medication Reduction Plan did not include the current, higher dose, Individual #3 was receiving. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated the reduction plan needed to be updated. The facility failed to ensure Individual #3's Triazolam was accurately incorporated into a plan. 2. Individual #2's IPP, dated 10/3/14, documented a 53 year old male. Appendix A of Individual #2's record, dated 6/17/15, documented his diagnoses included severe intellectual disability.	W 312		

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W 312	Continued From page 39 Individual #2's medication reduction plan, dated 6/18/15, documented Individual #2 received Risperdal (an antipsychotic drug) and Clonidine (an antihypertensive drug) for self-injurious behavior and self-stimulatory behavior. Under "Med Reduction Criteria," the plan for Risperdal documented "[Individual #2's] Risperdal was reduced to 2 mg QHS 8/14. He began to engage in self-abuse and did cause injury to himself. It was increased back to 3 mg QHS. The team is considering this a failed medication challenge." No criteria for potential reductions in the future could be found for Risperdal. Additionally, under "Med Reduction Criteria," the plan for Clonidine documented "The team will discuss a reduction in [Individual #2's] Clonidine when he displays self-abuse 0 times per month for nine consecutive months." No criteria related to the use of Clonidine for self-stimulatory behavior could be found. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated she would seek criteria clarification from Individual #2's psychiatric provider. The facility failed to ensure Individual #2's medications were sufficiently incorporated into a plan.	W 312		
W 317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a	W 317		

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W 317	Continued From page 40 carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used to control behavioral symptoms were gradually withdrawn in a carefully monitored program for 1 of 4 individuals (Individual #4) who received behavior modifying drugs. This resulted in an individual receiving no supportive interventions during a drug reduction. The findings include: 1. Individual #4's 9/16/14 PCLP stated she was a 59 year old female whose diagnoses included moderate intellectual disability, psychotic disorder NOS, bipolar disorder and depressive disorder NOS. A Physician's Order And Progress Notes, dated 4/30/14, stated Individual #4's Risperdal (an antipsychotic drug) was to be reduced from 3 mg twice daily to 3 mg in the a.m. and 2.5 mg in the p.m. Individual #4's MAR documented the reduction took place 5/1/15. Individual #4's record documented she could receive lorazepam (an anxiolytic drug) 0.5 mg PRN up to 4 times daily. The record documented Individual #4 received the lorazepam once in March, did not receive it in April, but received it 9 times in May after the reduction of Risperdal. However, documentation that other, less restrictive supports had been implemented to	W 317		

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	13G032		06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 317	Continued From page 41 assist Individual #4 through the medication reduction (e.g., increased outings, increased reinforcements, increased coping skills training, changes to the environment, etc.) could not be found in the record. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP stated no changes had been made to assist Individual #4 through the drug reduction. The facility failed to ensure plans were developed to assist Individual #4 through the gradual withdrawal of her Risperdal.	W 317		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in the potential for an individual's medical needs to go unaddressed. The findings include: 1. Individual #1's PCLP, dated 12/12/14, documented a 61 year old male. Appendix A of Individual #1's record, dated 6/17/15, documented his diagnoses included severe intellectual disability. Individual #1's record included an informed	W 322		

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W 322	Continued From page 42 consent, dated 12/15/14, for the use of Risperdal, an antipsychotic drug. The website for the National Center for Biotechnology Information, accessed 7/9/15, identified hyperprolactinemia (high levels of prolactin) as a possible side effect of Risperdal. Prolactin is a hormone secreted by the pituitary gland that stimulates lactation (milk production). Individual #1's medical record included a Psychiatric Update, dated 10/30/14, which documented "Lab: Prolactin level." Individual #1's laboratory records were reviewed. A laboratory report, dated 11/1/14, documented Individual #1's prolactin level was measured on 10/31/14 and was found to be 44.4 ng/mL. The report documented the normal level for prolactin was 0 - 15.0 ng/mL. The laboratory report included two handwritten entries. One entry, dated 11/3/14, documented the results were faxed to Individual #1's psychiatric provider. The second entry, dated 11/20/14, documented the psychiatric provider requested the level be re-measured in 3 months. A corresponding Psychiatric Update, dated 11/20/14, documented "Prolactin level in 3 mo." Individual #1's laboratory records included a laboratory report, dated 2/19/15. The report documented Individual #1's prolactin level was measured that day and was found to be 53.9 ng/mL. The report included a handwritten entry, dated 2/20/15, which documented the report was faxed to Individual #1's psychiatric provider. However, follow-up to Individual #1's second laboratory report could not be found despite	W 322		

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W 322	Continued From page 43 Individual #1's results being further out of range than during the initial test. During an interview on 6/24/15 from 1:00 - 3:30 p.m., the RN stated the psychiatric provider would document her recommendations on the Psychiatric Update or on a Physician's Sheet And Progress Notes form. The RN stated the psychiatric provider would sometimes sign the laboratory report indicating it had been read. The RN stated he did not see any notation from the psychiatric provider on the 2/19/15 laboratory report. Individual #1's record contained a Physician's Sheet And Progress Notes entry, dated 3/26/15. The entry was completed by the psychiatric provider and documented Individual #1's information was reviewed. However, the entry did not include any information related to Individual #1's second prolactin level. During the interview on 6/24/15 from 1:00 - 3:30 the RN stated since there was no documentation in the psychiatric provider's notes related to Individual #1's prolactin, he was not sure what had been discussed. The Clinical Director, who was also present during the interview, stated in the past, notes related to psychiatric appointments had not been kept, so there was no additional documentation to reference. The facility failed to ensure Individual #1 was provided with general and preventative medical care related to his prolactin level.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing	W 331		

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W 331	Continued From page 44 services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided for 4 of 4 individuals (Individuals #1 - #4) whose routine standing physician's orders were reviewed. This resulted in a lack of clear physician's orders being available to staff. The findings include: 1. Individual #1 - #4's routine standing physician's orders were reviewed. The documents included PRN medications which were duplicative and did not consistently include specific individualized orders, as follows: Individual #1 - #3's Routine Standing Orders, signed by the physician on 4/7/15, and Individual #4's Routine Standing Orders, signed by the physician on 4/15/15, stated they were to receive Tylenol (an analgesic drug) 650 mg for pain or fever every 4 hours. Individual #1 - #4's orders each stated they could also receive Ibuprofen (an NSAID) 400 mg for pain or fever every 4 - 6 hours. The orders did not include specific information regarding how to determine which medication to use and when. Additionally, the Ibuprofen orders did not specify when a repeat dose could be administered (i.e. 4, 5 or 6 hours after the first dose). Individual #1 - #4's Routine Standing Orders stated they could use antibiotic ointment (a topical drug), calamine lotion (a topical drug) and hydrocortisone 1% (a corticosteroid topical drug) as needed for insect bites. The orders did not include specific information regarding how to	W 331		

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W 331	Continued From page 45 determine which medication to use and when. Further, Individual #1 - #4's orders stated they were to receive diphenhydramine (an antihistamine drug) 50 mg for an allergic reaction, itching and congestion every 4 - 6 hours. The orders did not specify when a repeat dose could be administered (i.e. 4, 5 or 6 hours after the first dose). During an interview on 6/24/15 from 1:00 - 3:30 p.m., the RN stated the orders would be clarified for all individuals. The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were specific.	W 331		
W 376	483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the physician was notified of drug administration errors for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in the potential for potential negative impacts on an individual's health and well-being. The findings include: 1. Individual #2's IPP, dated 10/3/14, documented he was a 53 year old male. Appendix A of his record, dated 6/17/15, documented his diagnoses included severe intellectual disability.	W 376		

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W 376	Continued From page 46 An Incident/Accident Report, dated 4/3/15 and timed 12:40 p.m., documented Individual #2 ingested an incorrect medication. The attached Investigation Report, dated 4/8/15, documented, "It was reported that [Individual #2] was given a peers [sic] medication...Staff immediately noticed the mistake and called nursing. Nursing advised staff to take [Individual #2] to Emergency [sic] Room." Documentation that Individual #2's physician was notified of the error could not be found in the report. During an interview on 6/25/15 at 12:10 p.m., the RN stated Individual #2's physician was not notified of the incident. The facility failed to ensure Individual #2's physician was notified of a drug administration error.	W 376		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for harm in the event individuals accessed and ingested a	W 382		

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W 382	Continued From page 47 drug. The findings include: 1. Observations were conducted at the facility on 6/18/15 from 1:00 - 1:55 p.m., from 3:15 - 4:05 p.m. and from 5:00 - 5:45 p.m. and on 6/19/15 from 6:50 - 7:45 a.m. and from 9:00 - 9:40 a.m. During those times, individuals' drugs were observed to be unlocked, as follows: a. On 6/18/15 at 1:05 p.m., the bottom cabinet in the medication area was observed to be unlocked and no one was in the room. A direct care staff entered the room with Individual #4 and removed Individual #4's medication box from the bottom cabinet and set it on the counter. The direct care staff then left the medication area to get a spray bottle and the phone. The medication cabinet remained unlocked. The direct care staff returned and assisted Individual #4 with her medication administration program. At 1:15 p.m., the direct care staff locked the cabinet and left the room. b. On 6/19/15 at 6:50 a.m., upon entering the facility, it was noted that the lower cabinet in the medication area was unlocked and standing open. Two plastic tool boxes, one labeled "Control Count" and the other with Individual #6's name, were sitting open on the counter with padlocks sitting beside them. No one was in the room. A direct care staff, who was present in the facility, stated he had opened the cabinet and the drug boxes in order to do a control count when the day shift arrived. The direct care staff stated the boxes had been opened at approximately 6:40 a.m.	W 382		

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W 382	Continued From page 48 At 6:55, the direct care staff and a day shift staff entered the medication area and completed a control count, at which time the drugs were locked. At 7:15 a.m., a direct care staff was observed to prepare Individual #7's morning medications. The direct care staff measured out Citrucel (a laxative drug) and Milk of Magnesia (a laxative drug) and placed the pre-measured drugs in the locked cabinet. The direct care staff left the room to cue Individual #7 to take his medications. However, the Citrucel and Milk of Magnesia bottles were left unattended on the table in the medication area. During an interview on 6/19/15 from 12:35 - 1:10 p.m., the RN stated all drugs should remain locked at all times unless they are in the process of administration. The RN stated drugs should not be left unlocked and unattended during the administration process. The facility failed to ensure all drugs were maintained locked.	W 382		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on review of the facility's evacuation reports and staff interview, it was determined the facility failed to ensure all problems with evacuation drills were investigated for 7 of 7 individuals (Individuals #1 - #7) residing in the	W 448		

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W 448	Continued From page 49 facility. This resulted in the potential for identified problems continuing without being investigated. The findings include: 1. The facility's evacuation drills from 7/14/14 - 6/18/15 were reviewed and documented the following concerns: - 9/6/14 at 1:00 a.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 6 minutes to evacuate the facility. - 12/3/14 at 1:00 a.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 5 minutes to evacuate the facility. - 3/18/15 at 11:16 p.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 12 minutes to evacuate the facility. - 6/18/15 at 11:05 p.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 10 minutes to evacuate the facility. An interview was conducted on 6/25/15 from 1:03 - 1:21 p.m. with the Program Supervisor, QIDP, and Clinical Director. The QIDP and Clinical Director both stated the Program Supervisor was the only one reviewing evacuation drills. The Program Supervisor stated she had noted the increased times, and stated they were a result of the drills on 9/6/14 and 12/3/14 being run improperly. When asked if she had completed any type of investigation about the improper running of the drills or the increased time the drills were now taking, the Program Supervisor stated she was not aware she needed to. The facility failed to ensure all problems with	W 448		

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W 448	Continued From page 50 evacuation drills were investigated.	W 448		
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on review of the facility's evacuation drill reports and staff interview, it was determined the facility failed to take actions to correct problems that were identified during quarterly evacuation drills for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for identified problems continuing with no corrective action taken. The findings include: 1. The facility's evacuation drills from 7/14/14 - 6/18/15 were reviewed and documented the following concerns: - 9/6/14 at 1:00 a.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 6 minutes to evacuate the facility. - 12/3/14 at 1:00 a.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 5 minutes to evacuate the facility. - 3/18/15 at 11:16 p.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 12 minutes to evacuate the facility. - 6/18/15 at 11:05 p.m., an evacuation drill was conducted with Individuals #1 - #7 which required over 10 minutes to evacuate the facility. An interview was conducted on 6/25/15 from 1:03	W 449		

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W 449	Continued From page 51 - 1:21 p.m. with the Program Supervisor, QIDP, and Clinical Director. The QIDP and Clinical Director both stated the Program Supervisor was the only one reviewing evacuation drills. The Program Supervisor stated she had noted the increased times, and stated they were a result of the drills on 9/6/14 and 12/3/14 being run improperly. The Program Supervisor stated she had corrected the way the drills were run, but had taken no corrective action related to the extensive times noted during the 3/18/15 and 6/18/15 drills. The Program Supervisor stated she had no documentation related to corrective action of problems noted during drills. The facility failed to ensure corrective action was identified for extended evacuation times.	W 449		

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint investigation and licensure survey conducted from 6/18/15 to 6/25/15. The surveyors conducting your survey were: Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP	M 000		
MM112	16.03.11.050.01(d) Residential Facility The residential facility is to admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. This Rule is not met as evidenced by: Refer to W223.	MM112	RECEIVED JUL 23 2015 FACILITY STANDARDS	
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		
MM182	16.03.11.075.09 (a)(iv) Resident placed in Restraints	MM182		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: KBurhanan | TITLE: Program Manager | (X6) DATE: 7-22-15

Bureau of Facility Standards

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MM182	Continued From page 1 The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and This Rule is not met as evidenced by: Refer to W303.	MM182		
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 W264.	MM194		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289, W312 and W317.	MM197		
MM199	16.03.11.075.11 Assurance of Confidentiality Assurance of Confidentiality. Each resident admitted to the facility must be assured confidential treatment of his personal and medical records, and must be permitted to approve or refuse their release to any individual outside the facility except: This Rule is not met as evidenced by:	MM199		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MALLARI	699 SOUTH OTTER MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM199	Continued From page 2 Refer to W113.	MM199		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W249.	MM212		
MM226	16.03.11.080.02 Who Will Represent the Resident Who Will Represent the Resident. The administrator of the facility must assure that all residents will be represented by individuals who are not employed by the facility. The priority for selection of representatives will be in the following order: This Rule is not met as evidenced by: Refer to W125.	MM226		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all chemicals were labeled for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in spay bottles being without labels that identified their contents. The findings include: 1. An environmental review was conducted on	MM271		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G032		06/25/2015

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - MALLARI

STREET ADDRESS, CITY, STATE, ZIP CODE: 699 SOUTH OTTER, MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 3 6/19/15 from 10:25 - 11:00 a.m. During that time, the following was noted: - An unmarked bottle containing a blue liquid was located in a cabinet in the bathroom shared by Individuals #5 - #7. - Two unmarked bottles containing a blue liquid were located in the cabinets in the laundry room. - An unmarked bottle containing a blue liquid was located in a cabinet in the mediation administration area. - An unmarked bottle containing a blue liquid was located in a cabinet in the kitchen. A direct care staff who was present during the review, stated the blue liquid was Mr. Clean multi-surface cleaner with Febreze. During an interview on 6/19/15 from 12:35 - 1:10 p.m., the Program Manager stated chemical bottles should all be labeled. The facility failed to ensure all chemicals were properly labeled.	MM271		
MM336	16.03.11.110.04(b) Emergency Plans Emergency plans must be thoroughly tested and used as necessary to assure rapid and efficient function. This Rule is not met as evidenced by: Refer to W448 and W449.	MM336		
MM520	16.03.11.200.03(a) Establishing and Implementing polices	MM520		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G032		06/25/2015

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - MALLARI

STREET ADDRESS, CITY, STATE, ZIP CODE: 699 SOUTH OTTER, MERIDIAN, ID 83642

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MM520	Continued From page 4 The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W104.	MM520		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
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		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or	MM735		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G032		06/25/2015

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - MALLARI

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MM735	Continued From page 5 physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753		
MM759	16.03.11.27.02(f)(v) Medication Error Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W376.	MM759		
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W331.	MM760		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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MM855	Continued From page 6	MM855		
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 W239 and W240.	MM855		

ASPIRE
HUMAN SERVICES, LLC

RECEIVED
JUL 23 2015
FACILITY STANDARDS

7/22/15

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

RE: Mallard Landing, Provider #13G032

Dear Ashley Henscheld:

Thank you for your considerateness during the visit at the Mallard Landing home on June 25, 2015. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

W104

- Please refer to the response given under W124 as it relates to the written informed consents.
- Please refer to the response given under W159 as it relates to the QIDP's monitoring and oversight.
- Please refer to the response given under W214 as it relates to individual's assessments.
- Please refer to the response given under W223 as it relates to social assessments containing comprehensive information.
- Please refer to the response given under W249 as it relates to program plan implementation.
- Please refer to the response given under W289 as it relates to incorporating techniques used to manage inappropriate behavior were incorporated into the program plan.
- Please refer to the response given under W312 as it relates to using behavior modifying drugs.
- Please refer to the response given under W322 as it relates to individuals receiving general and preventative medical care.
- Please refer to the response given under W331 as it relates to individuals receiving nursing care in accordance with their needs.
- Please refer to W113 as it relates to confidential information.
- Please refer to W264 as it relates to the HRC reviewing and monitoring company policy and procedures.

W113

1. A policy and procedure clarifying how information pertaining to an individual will be released to their advocates. One part of the policy will outline that the individual will sign a release of information giving consent to give their advocate information about them.
2. All individuals supported by Aspire Human Services will be effected by the revised policy.
3. Once the policy is developed, the facility QIDP's will be provided with training on the policy. At this time each individual supported that does not have a legal guardian and has an advocate will be identified and the policy will be implemented.
4. Aspire Human Services is currently performing peer reviews. One element of the peer reviews will be verifying that in the event an individual has an advocate that the policy has been implemented. Identified errors are reported to the Clinical Director and revisions are made to the program plans.
5. Person Responsible: Program Manager, Clinical Director & QIDP
6. Completion Date: 9/1/15

W124

1. All of the guardians in the home have been notified of their right to withdraw their written consents at any time without the risk of punitive action. All of the Written Informed Consents in the home are being revised to include comprehensive information including information from the 2016 drug handbook.
2. All of the individuals in the home will be effected by the corrective action outlined in bullet point #1.
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." In addition, all QIDP's are being re-trained on how to include comprehensive information in the written informed consent.
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: 9/1/15.

W125

1. Aspire Human Services is currently assisting individual #4 to obtain a legal guardian. Individual #4's Social Service Evaluation is currently being revised to include the status of her guardianship.
2. Aspire Human Services is currently assisting each individual served that does not have a legal guardian to obtain a legal guardian.
3. Aspire Human Services has developed a standardized Individual Program Plan document. One part of the document includes a service objective for each individual without a legal

guardian which is developed by the Interdisciplinary Team. The Service Objective will outline how the team will assist the individual to obtain a legal guardian.

4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that Aspire Human Services is assisting each individual served that does not have a legal guardian to obtain a legal guardian. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, & QIDP.
6. Completion Date: 9/1/15.

W159

1. The QIDP is currently re-assessing individuals #2 & #4. The re-assessment includes conducting a revised comprehensive functional assessment and various professional assessments. Once the assessments are completed the QIDP will schedule a time for the IDT to create revised Individual Program Plans.
2. All of the IPP's in the home are being reviewed and revised as necessary to assure that the assessments were completed before the IPP meetings.
3. Aspire Human Services has recently created a standardized IPP process which outlines that all assessments including the CFA are completed before the IPP meeting.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that assessments are completed before the IPP meetings. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, & QIDP.
6. Completion Date: 9/1/15.

- Please refer to the response given under W124 as it relates to the written informed consents.
- Please refer to the response given under W125 as it relates to pursuing guardianship.
- Please refer to the response given under W214 as it relates to individual's assessments.
- Please refer to the response given under W223 as it relates to social assessments containing comprehensive information.
- Please refer to W240 as it relates to comprehensive instructions for mechanical supports.
- Please refer to the response given under W249 as it relates to program plan implementation.
- Please refer to the response given under W289 as it relates to incorporating techniques used to manage inappropriate behavior were incorporated into the program plan.
- Please refer to W303 as it relates to record of restraints.
- Please refer to the response given under W312 as it relates to using behavior modifying drugs.
- Please refer to W317 as it relates to the implementation of medication reductions only with supports for an individual.
- Please refer to the response given under W322 as it relates to individuals receiving general and preventative medical care.
- Please refer to W331 as it relates to ensuring nursing services are provided in accordance with individual's needs.

- Please refer to W376 as it relates to ensuring an individual's physician was immediately notified of a medication error.
- Please refer to W382 as it relates to storage of medications.
- Please refer to W448 as it relates to the review of evacuation drills.
- Please refer to W449 as it relates to corrective action taken for problems that occurred during evacuation drills.

W214

1. Individual #2's CFA is being revised to include comprehensive information. The behavior assessments for individuals #1, #2 and #4 are being revised to include comprehensive information related to how their medications may impact their maladaptive behaviors.
2. All of the CFA's in the home are being reviewed and revised as necessary to assure they contain comprehensive information. All of the behavior assessments are being reviewed to assure that it is outlined in the assessments how medications may impact maladaptive behaviors. Revisions will be made as errors are identified.
3. All QIDP's are currently being trained on the expectation that CFA's are comprehensive and that the "N/A" box will not be indicated, even if the individual does not choose to participate in that particular activity being assessed. In addition, the Positive Behavior Support Coordinator has recently met with the QIDP's and provided additional training on the importance of assuring that when medications are utilized, that the potential impact of the medications on the identified behavior is assessed and included in the behavior assessment.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that assessments are comprehensive and that the impact of medications is available in the behavior assessments. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, & QIDP.
6. Completion Date: 9/1/15.

W223

1. Individual #4's social service evaluation is being revised to include clear information on the status of her guardianship. Individual #4's social service evaluation is being revised to contain information on how relationships with her family might be maintained or rebuilt and what interpersonal skills she might need to fulfill relationships with others. Individual #3's social service evaluation is being revised to include information on relationships in her life, what interpersonal skills could be addressed in order for her to establish and maintain appropriate roles and fulfilling relationships with others. Individual #1's social services evaluation is being revised to include additional information on his relationships with others and what interpersonal skills he may need to maintain appropriate roles and fulfilling relationships with others.
2. All of the social service evaluations are being revised to include information on relationships with others and what interpersonal skills might be needed to fulfill relationships with others.
3. The Clinical Director, LSW is currently researching tools which might be utilized to assess the relationships and interpersonal skills of the individuals served. Once a tool is

identified, all individuals served will be assessed and addendums written for each social service evaluation.

4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that social service evaluations contain information related to relationships in the lives of each individual and that the evaluations contain information related to assessing interpersonal skills needed in order for individuals to maintain appropriate and fulfilling relationships with others. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, & QIDP.
6. Completion Date: 9/1/15.

W239

1. Individual #4's behavior assessment is being revised to ensure appropriate replacement behaviors are developed to address her depressive type symptoms.
2. All behavior assessments in the home are being reviewed and revised as necessary to assure replacement behaviors are appropriate.
3. The Positive Behavior Support Coordinator has recently met with the QIDP's and provided additional training on the importance of assuring that each identified maladaptive behavior has an appropriate replacement behavior in the behavior assessment.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that appropriate replacement behaviors are developed. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, Positive Behavior Support Coordinator & QIDP.
6. Completion Date: 9/1/15.

W240

1. The QIDP has scheduled a team meeting to review assessments and create a protocol for individual #3's gait belt.
2. The team will verify that all individuals in the home that use adaptive equipment have a protocol in place for the equipment which specifies how and when to use the equipment.
3. Aspire Human Services has recently developed a standardized IPP document. One part of the document captures each piece of adaptive equipment and outlines specifics on how the equipment is being used.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that all adaptive equipment is identified on the IPP and instructions are given to the staff on how and when to utilize the equipment. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor & QIDP.
6. Completion Date: 9/1/15.

W249

1. The program plans for individuals #2 and #4 are currently being implemented as written.

2. All program plans in the home are currently being implemented as written.
3. Aspire Human Services has recently revised the Policy and Procedure for Active Treatment. The current policy specifies that program plans will be implemented as soon as possible after the planning meetings. All QIDP's are being trained on the revised policy and procedure to assure an understanding that program plans will be implemented as soon as possible after the planning meetings.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that program plans are written as soon as possible after planning meetings. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor & QIDP.
6. Completion Date: 9/1/15.

W264

1. Training has been scheduled for the Human Rights Committee in relation to the facilities policies related to restrictive practices.
2. The policy and procedure for the Human Rights Committee has been revised to include specific information related to the expectation that the Human Rights Committee will review and monitor the policies related to restrictive practices.
3. The Human Rights Committee will be trained on the revised policy which outlines that the committee will monitor policies related to restrictive practices. Documentation of the training and discussion will be maintained in the HRC notes.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the Human Rights Committee has been trained on company policies related to restrictive measures. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor & QIDP.
6. Completion Date: 9/1/15.

W289

1. The treatment team for individual #4 is currently re-assessing her behavior needs. One part of the re-assessment includes revising the methods given to staff in the event that she participates in self-injurious behavior.
2. All of the behavior assessments and behavior programming is currently being reviewed to verify appropriate methods are given to the staff in the home so they can respond to the needs of each individual. Revisions will be made if the team identifies insufficient methods.
3. The Positive Behavior Support Coordinator has met with the QIDP's to develop an approach on how to better develop behavior assessments and programming. With the new plan a schedule has been made to where the PBSC will be available to provide direction to the QIDP's while they are developing behavior assessments and programming.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that behavior programs contain adequate methods to meet the needs of the individuals served. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.

5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, Positive Behavior Support Coordinator & QIDP.
6. Completion Date: 9/1/15.

W303

1. 2 & 3.
   The policy and procedure for documentation of physical and mechanical restraints is being revised to include specific instructions that the nursing staff and/or direct support professionals that attend medical appointments will complete a behavior log if any type of restraint is utilized. The policy will also clarify that if an emergency restraint is required that an Incident and Accident report will be completed and the Administrator or Designee will be notified immediately. The policy revisions will effective every individual served including individual#2 and #3.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that all restraints utilized during medical appointments are documented on a behavior log which includes a detailed record of restraint. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor & QIDP.
6. Completion Date: 9/1/15.

W312

1. The medication reduction plans for individuals #2 and #3 are currently being revised to incorporate all behavior modifying medications into their reduction plans.
2. All of the medication reduction plans in the home are being reviewed to verify that all of their behavior modifying medications is incorporated into their reduction plans. The treatment team will make corrections as needed.
3. The Positive Behavior Support Coordinator has met with the QIDP's to develop an approach on how to better develop behavior assessments and programming. With the new plan a schedule has been made to where the PBSC will be available to provide direction to the QIDP's while they are developing behavior assessments and programming.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that all behavior modifying medications are incorporated into a medication reduction plan. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, Positive Behavior Support Coordinator & QIDP.
6. Completion Date: 9/1/15.

W 317

1. The Positive Behavior Support Coordinator is currently assisting in revising Individual #4's behavior assessment. She has recently visited with her LPN and is experiencing

another medication decrease due to meeting criteria on her reduction plan. He is assisting with developing written strategies to help her through the reduction process successfully.

2. All individuals in the home which meet their medication reduction plan criteria and a medication reduction is given will have a written plan on how the team will assist them through a successful reduction process.
3. The Positive Behavior Support Coordinator has met with the QIDP's to develop an approach on how to better develop behavior assessments and programming. With the new plan a schedule has been made to where the PBSC will be available to provide direction to the QIDP's while they are developing behavior assessments and programming.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that written instructions are incorporated into IPP's when an individual is experiencing a medication reduction to help the individual have a successful reduction. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, Positive Behavior Support Coordinator & QIDP.
6. Completion Date: 9/1/15.

W322

1. Aspire Human Services will obtain a written response from individual #1's doctor prolactin levels capturing her feeling about his high levels. This information will be shared with the IDT and individual #1's guardian.
2. For each individual in the home that prolactin levels are measured Aspire Human Services is obtaining written documentation of how the prescribing professional would like the levels addressed.
3. Aspire Human Services is currently updating the policy and procedures for nursing services. One element is clarifying that when labs are shared with outside professionals that a written note is required from the professional describing their response and that a signature verifying they reviewed the labs would not be sufficient.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that lab work is shared with outside professionals and documentation is in the record capturing that the labs were reviewed. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, RN, LPN & QIDP.
6. Completion Date: 9/1/15.

W331

1. 2 & 3.
   All routine standing orders are in the process of being revised to include specific information on when to utilize Tylenol and when to utilize Ibuprofen. These revisions are being made company wide and all individuals will be affected.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the use of Tylenol and Ibuprofen is clarified on the routine

standing orders for each individual served. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.

5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, RN, LPN & QIDP.
6. Completion Date: 9/1/15.

W376

1. 2 & 3.
   The nursing policy and procedures are currently being revised to include specific procedures in the event that an individual receives incorrect medications. One element of the policy clarifies that the individual's doctor must be notified even if the individual received immediate medical attention from an emergency room doctor.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that verifying that documentation that an individual's doctor is notified in the event that an incorrect medication is consumed. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor, RN, LPN & QIDP.
6. Completion Date: 9/1/15.

W382

1. On June 19, 2015 the program supervisor implemented training with all employees covering: all medications must be locked at all times, all control count must be double locked at all times, and meds keys must be on the person of a med pass at all times. This affected all 7 individuals.
2. All homes will receive training on W382 ensuring the medications are never left unattended and unlocked.
3. Currently the nursing policy is being revised to specifically address the storage of medication. Also, Aspire Human Services will refer to the policy for guidance on next steps to ensure the deficient practice does not recur.
4. During observations in the home the IDT will provide medication checks to ensure all medications are properly locked up.
5. Personal Responsible: Program Manager, Clinical Director, Program Supervisor, QIDP, RN, and LPN
6. Completion Date: 9/1/15.

W448

1. Aspire Human Services fire drill form will be revised to include a comment section for staff to explain what was different or hindering them from running a successful fire drill affecting all 7 individuals. Additionally, a comment section for management will be added for follow up and, if needed, the next plan for improvement.
2. The fire drill form will be implemented across all locations. Program Supervisor's and QIDP's will receive training on the new form.
3. The program supervisor will continue to do random observations during evacuation drills and the QIDP will review fire drill data during monthly.

4. The fire drill form will be reviewed monthly by the program supervisor and QIDP to address any issues within a timely manner. Signature will be provided on the form once reviewed.
5. Personal Responsible: Program Manager, Clinical Director, Program Supervisor, QIDP,
6. Completion Date: 9/1/15.

W449

1. Aspire Human Services fire drill form will be revised to include a comment section for staff to explain what was different or hindering them from running a successful fire drill affecting all 7 individuals. Additionally, a comment section for management will be added for follow up and, if needed, the next plan for improvement.
2. The fire drill form will be implemented across all locations. Program Supervisor's and QIDP's will receive training on the new form.
3. The program supervisor will continue to do random observations during evacuation drills and the QIDP will review fire drill data during monthly.
4. The fire drill form will be reviewed monthly by the program supervisor and QIDP to address any issues within a timely manner. Signature will be provided on the form once reviewed.
5. Personal Responsible: Program Manager, Clinical Director, Program Supervisor, and QIDP
6. Completion Date: 9/1/15.

MM112
Please see response given under W223.

MM164
Please see response given under W124.

MM182
Please see response given under W303.

MM194
Please see response given under W264.

MM197
Please see response given under W289, W312 & W317.

MM199
Please see response given under W113.

MM212
Please see response given under W249.

MM226
Please see response given under W125.

MM271

- Proper labels have been placed on all bottles in the home affecting all 7 individuals. The Universal Home Checklist includes all items are in labeled containers. This will be monitored during observations in the home and monthly while completing the Universal Home Checklist. Universal Home Checklist is turned into the Program Manager and maintenance department each month for review.
- Personal Responsible: Program Manager, Clinical Director, Program Supervisor, and QIDP
- Completion Date: 9/1/15.

MM336
Please see response given under W448 and W449.

MM520
Please see response given under W104.

MM725
Please see response given under W159.

MM730
Please see response given under W214.

MM735
Please see response given under W322.

MM753
Please see response given under W382.

MM759
Please see response given under W376.

MM760
Please see response given under W331.

MM855
Please see response given under W239 and W240.

Tom Moss
Clinical Director
Licensed Social Worker

Kristin Buchanan
Program Manager

RECEIVED
JUL 31 2015
FACILITY STANDARDS

7/27/15

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

RE: Mallard Landing, Provider #13G032 – Addendum to the Plan of Correction submitted 7/15/15

Dear Ashley Henscheld:

Please see our additions to the Plan of Correction as they relate to W159, W264 and W376.

W159
Please refer to the response given under W339 as it relates to functional replacement behaviors.
W264

1. Training has been scheduled for the Human Rights Committee on policies related to restrictive practices. The Clinical Director will provide training to all existing HRC members.
2. The policy and procedure for the Human Rights Committee has been revised to include specific information related to the expectation that all Human Rights Committee members receive training on policies related to restrictive practices before they participate in the Human Rights Committee meetings.
3. The Human Rights Committee will be trained on the revised policy which outlines that the committee will monitor policies related to restrictive practice. In addition, the Human Rights Committee will be trained on company policies related to restrictive practices. The Clinical Director or designee will provide the training to all future Human Rights Committee members before they participate with the Committee. Documentation of the training will be maintained with the HRC notes.
4. Aspire Human Services is currently performing chart reviews. One element of the chart reviews is verifying that the Human Rights Committee has been trained on company policies related to restrictive measures by reviewing the Human Rights Committee book and verifying documentation is present. Identified errors are reported to the Clinical Director and immediate corrective action is taken to correct errors.
5. Person Responsible: Program Manager, Clinical Director, Program Supervisor & QIDP.
6. Completion Date: 9/1/15.

W376
Individual #2's doctor has been notified that on 4/3/15 that he was given a peers medication.

Tom Moss
Clinical Director
Licensed Social Worker

Kristin Buchanan
Program Manager

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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July 15, 2015

Shantelle Kates, Administrator
Preferred Community Homes - Mallard
12553 W Explorer Dr Suite 190
Boise, ID 83713

Provider #13G032

Dear Ms. Kates:

An unannounced on-site complaint investigation was conducted fromJune 18, 2015 to June 25, 2015 at Preferred Community Homes - Mallard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007061

Allegation #1: The facility does not identify abuse, neglect and mistreatment and subsequently, individuals are left unprotected.

Findings #1: During the investigation, observations, staff interview and review of facility policy, incident reports and investigations were conducted with the following results:

The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, documented various examples of inappropriate interactions employees "are required to actively strive to prevent and/or report..." No concerns with the policy were identified.

The facility's incident reports and investigations of abuse, neglect or mistreatment, from 11/4/14 - 6/18/15, including those in-process, were reviewed. All incidents of potential abuse, neglect or mistreatment were appropriately identified with no concerns noted. On 6/18/15 at 9:00 a.m., the Clinical Director stated there was an in-process investigation of potential verbal abuse.

During an interview on 6/18/15 from 11:25 - 11:45 a.m., the Program Manager stated for the in-process investigation, the Program Supervisor, Qualified Intellectual Disabilities Professional and Clinical Director were all assisting with the investigation. The Program Manager stated a direct care staff alleged a second staff member was verbally abrupt with an individual. The Program Manager stated the incident was being investigated as potential verbal abuse. The Program Manager stated so far in the investigation process, the accused staff member had been suspended, interviews had been conducted with potential witnesses and the Program Supervisor was obtaining written statements.

Observations were conducted at the facility on 6/18/15 and 6/19/15 for a cumulative 4 hours and 5 minutes. During that time, staff were noted to consistently interact appropriately with individuals.

On 6/19/15 at approximately 11:30 a.m., the Clinical Director stated the in-process investigation revealed the reporting direct care staff failed to immediately communicate her concerns to the Administrator and was suspended pending the conclusion of the investigation. As a result, all staff in the facility were being re-trained on the abuse policy.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility fails to follow through with decisions made for individuals by their Interdisciplinary Teams.

Findings #2: During the investigation, review of records and staff interviews were conducted with the following results:

Four sample individuals were selected for review. Each individuals' program plan, meeting minutes and psychiatric Interdisciplinary Team (IDT) notes were reviewed.

One individual's IDT notes, dated 11/18/14, documented a medication change had been recommended. However, the team did not agree, so the changes were not made. The note stated the individual's advocate wanted to discuss the recommendations with the psychiatric provider, but was not sure she could attend the meeting. The team decided to not recommend any changes until after the holidays.

An IDT note, dated 2/24/15, documented the team recommended a medication change in order to prepare the individual for a decrease in Risperdal (an antipsychotic drug).

An IDT note, dated 4/21/15, documented the individual tolerated the medication change well and a recommendation was being made to reduce the Risperdal by a small dose, preferably one day a week. The individual's record documented the Risperdal was decreased from 3 mg twice a day to 3 mg in the a.m. and 2.5 mg in the p.m. on 5/1/15.

During an interview on 6/24/15 from 1:00 - 3:30 p.m., the QIDP and Clinical Director both stated the IDT met with the psychiatric provider and requested holding one dose of Risperdal one day a week, but the psychiatric provider stated the reduction needed to be consistent and would not order a held dose. During the appointment the decision was made to reduce the Risperdal by 0.5 mg daily.

The QIDP and Clinical Director both stated the individual's advocate was notified of the reduction the day of the psychiatric appointment, but stated the order of a daily reduction versus a one day a week reduction was not clarified until the following week. When asked for clarification regarding the individual's advocate, the Clinical Director stated the facility did not have a formal agreement or contract with the advocate, but stated the advocate was just someone that previously worked with the individual.

During a telephone interview on 6/25/15 from 8:15 - 8:40 a.m., the advocate stated she was interested in pursuing guardianship of the individual, but stated there was no formal contract or agreement with the facility to act as the individual's advocate. The advocate stated she had been under the impression the IDT was requesting a held dose of Risperdal once a week, and stated she did not find out about the reduction until a week after the appointment. The advocate stated she did meet with the facility and resolved communication issues and felt things were better.

An interview was conducted with a second sample individual's guardian on 6/25/15 at 8:44 a.m. During that time, the guardian stated she had no complaints regarding the facility. The guardian stated she was invited to interdisciplinary meetings and was afforded opportunities to provide input regarding the individual's care.

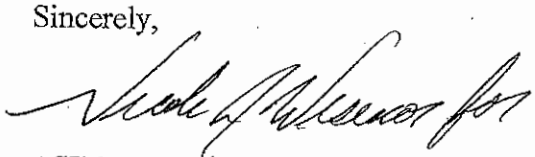
One individual had someone acting as an advocate. That advocate was not informed of a change in a medication reduction that had varied from what the IDT was originally requesting. However, a portion of the IDT was present at the psychiatric appointment for discussion when the change was made. Additionally, there was nothing in place to allow the person acting as the individual's advocate to legally do so.

Therefore, 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,



ASHLEY HENSCHEID
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt