IDAHO DEPARTMENT OF

HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 27, 2016

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

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

Dear Ms. Young:

This is to advise you of the findings of the complaint survey of Preferred Community Homes - Milliken, which was conducted on January 21, 2016.

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 **February 8, 2016**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

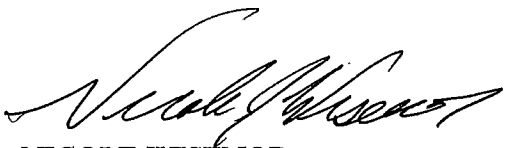
Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by February 8, 2016. If a request for informal dispute resolution is received after February 8, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 01/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation conducted from 1/19/16 - 1/21/16. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional STD - Sexually Transmitted Disease	W 000	RECEIVED FEB 08 2016 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 policy review, record review and staff interview, it was determined the facility's Governing Body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. This failure directly impacted 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed and had the potential to impact 5 of 5 individuals (#1 - #5) residing at the facility. This resulted in the Governing Body providing insufficient monitoring and supervision of abuse policy implementation, and of the QIDP to ensure job duties were completed. The findings include:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RBuchanan — program manager — 2-8-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 1. Refer to W149 as it relates to the Governing Body's failure to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored. 2. Refer to W159 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight.	W 104		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored. This failure directly impacted 2 of 6 individuals (Individuals #1 and #6) whose incident and accident reports and investigations were reviewed, and had the potential to impact all individuals (Individuals #1 - #5) currently residing at the facility. This resulted in a lack of investigations being completed in a thorough and timely manner. The findings include: The facility's Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source policy, revised 10/12/15, stated "Abuse, neglect, or mistreatment will not be tolerated or allowed at [sic] anywhere or at any time." The policy stated all staff were "required to actively strive to prevent and/or report any incidents or alleged incidents of	W 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 2 abuse, neglect, mistreatment, or injuries of an unknown source of suspicious nature..." Additionally, the policy stated the Administrator or designee would "establish evidence and documentation that all allegations have been thoroughly investigated." The policy stated the "results of internal investigations must be reported to the Administrator or State Operations Manager within 5 working days." The facility failed to ensure the policy was sufficiently implemented. 1. Refer to W154 as it relates to the facility's failure to ensure all allegations of abuse, neglect and mistreatment were thoroughly investigated. 2. Refer to W156 as it relates to the facility's failure to ensure the results of all investigations were completed and reported as required within five working days.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure thorough investigations were conducted for all allegations of abuse, neglect and mistreatment, and injuries of an unknown source which directly impacted 2 of 2 individuals (Individuals #1 and #6) involved in a facility investigation, and had the potential to impact all individuals (Individuals #1 - #5) currently residing	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 3 at the facility. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include: The facility's Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source policy, revised 10/12/15, stated the Administrator or designee would "establish evidence and documentation that all allegations have been thoroughly investigated." 1. Individual #6 no longer resided at the facility. The facility provided an Officer Report, dated 12/4/15, from a local police department. The report stated Individual #6 had presented to a local emergency department on 9/24/15 and was diagnosed with an STD. However, an internal investigation by the facility into the incident could not be found. During an interview on 1/20/16 from 11:33 - 11:40 a.m., the Program Manager stated an internal investigation was not completed due to police asking them not to interview individuals as they were investigating possible sexual assault of Individual #6. The facility failed to complete an internal investigation related to Individual #6. Additionally, the Officer Report was reviewed and documented additional concerns that included, but were not limited to, the following: a. DCS A was interviewed by police, on 10/14/15 at 11:00 a.m., and stated Individual #6 would spend long periods of time in the shower. DCS B	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 4 was interviewed by police, on 10/21/15 at 10:00 a.m., and stated Individual #6 would stay in the bath for "3 or 4 hours." However, there was no information indicating the facility had investigated why Individual #6 was remaining in the shower or bath for such extended periods of time. During an interview on 1/21/16 from 8:50 - 9:12 a.m., the Program Manager stated she had received and reviewed the Officer Report at some point during the middle of December 2015. The Program Manager stated she did not know if Individual #6 was actually spending long periods of time in the bath or shower as reported, and stated no investigation into the concern had been completed. b. DCS A reported to police that DCS B "has a short temper, and I saw it the other day when he was handling [Individual #6] with behaviors." Additionally, the Program Supervisor was interviewed by police on 10/21/15 at 8:00 a.m. During the interview, the Program Supervisor stated DCS B "does get aggravated sometimes and we are constantly on him" and DCS B "just tends to get aggravated..." However, no information related to DCS B's "short tempter" or getting "aggravated" could be found. During an interview on 1/21/16 from 8:50 - 9:12 a.m., the Program Supervisor stated DCS B would come to work aggravated about things at home and she would have to tell him to leave it outside work. The Program Supervisor stated	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 5	W 154		

being "constantly on him" referred to cleaning tasks at the facility. She was not able to provide any additional information related to what "aggravated" meant. The Program Manager, who was present during the interview, stated the concerns had not been investigated.

Without thorough investigation into all identified concerns, it would not be possible to ensure abuse or neglect was not occurring, that staff were appropriately identifying issues of concern, that staff were appropriately reporting concerns, etc.

During an interview on 1/21/16 from 8:50 - 9:12 a.m., the Program Manager stated concerns identified in the Officer Report had not been addressed or investigated.

2. During an interview on 1/19/16 from 3:05 - 3:15 p.m., DCS C stated Individual #1 arrived home from school around noon each day. DCS C stated on 1/7/16 she arrived at work at approximately 11:55 a.m. and was waiting for Individual #1 to arrive. DCS C stated Individual #1 was still not home by 12:25 p.m., so she walked through the facility and found Individual #1 asleep in his bed.

DCS C stated she contacted the Program Manager and the Clinical Director at the time she found Individual #1. DCS C stated no further incidents had occurred and she now arrived for work at 11:30 a.m.

The facility's Incident/Accident Reports and Investigations, from 5/1/15 - 1/19/16, had been reviewed. However, the reports did not include information related to the incident reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 6 have taken place on 1/7/16. During an interview on 1/20/16 at 10:12 a.m., the Program Manager stated she had spoken with the bus driver on 1/8/16 and found Individual #1 had been dropped off early. The Program Manager stated she had spoken with Individual #1's teacher as well, and a plan was implemented for the school to contact the facility if Individual #1 was going to be dropped off early. However, a written investigation was not completed related to the incident. During a follow-up interview on 1/21/16 from 8:50 - 9:12 a.m., the Program Manager stated no information had been gathered to see if the incident was an isolated event or an ongoing issue that had not previously been reported. The facility failed to ensure a thorough investigation had been completed related to Individual #1 being left unsupervised. 3. The facility's Incident/Accident Reports, dated 5/1/16 - 1/19/16, were reviewed. The documentation did not include evidence that injuries of unknown origin were being thorough investigated. For example: - An Incident/Accident Report, dated 9/20/15 at 11:00 a.m., stated Individual #1 had bruising on his upper left and right arms. Attached to the report were 5 DCS statements all indicating they did not know where the bruises came from. The "Conclusion" section of the report stated "It has been determined that [Individual #1] does have bruises on his right upper arm and left forearm area and it is unknown how he got these	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 7 bruises." However, no additional information related to how Individual #1 may have received the bruises (additional staff interview, environmental review, review of maladaptive behaviors, etc.) could be found. - An Incident/Accident Report, dated 9/28/15 at 12:50 p.m., stated Individual #1 had "some Bruises [sic] on [left] and [right] upper arm." Attached to the report were statements from 3 DCS that stated they did not know where the injuries came from, and 1 DCS that stated in the past she had witnessed school staff "block" a different individual during maladaptive behavior. The "Corrective Action Taken" section of the report stated the Program Supervisor was going to speak with school staff regarding the incident. However, no additional information related to interviews with school staff could be found. Additionally, no information related to other possible causes (environmental factors, medical concerns, maladaptive behaviors at the facility, etc.), could be found. During an interview on 1/20/16 from 11:33 - 11:40 a.m., the Program Manager stated issues related to Incident/Accident Report review and completion, including the review of injuries of unknown source, had been identified at the beginning of January 2016. As a result, the Program Manager was now reviewing all Incident/Accident Reports with the Program Supervisor each week. The facility failed to ensure injuries of an unknown origin were thoroughly investigated.	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, incident/accident reports, investigations and staff interview, it was determined the facility failed to ensure the results of all investigations were reported within 5 working days for 2 of 2 individuals (Individuals #1 and #6) for whom significant incidents had occurred. This resulted in the potential for appropriate corrective action being delayed. The findings include: The facility's Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source policy, revised 10/12/15, stated the Administrator or designee would "establish evidence and documentation that all allegations have been thoroughly investigated." The policy stated the "results of internal investigations must be reported to the Administrator or State Operations Manager within 5 working days." 1. The facility provided a file folder containing multiple documents which they described as an investigation related to Individual #6, who no longer resided at the facility. The file folder stated Individual #6 had presented to a local emergency department and was diagnosed with an STD. Also present in the file folder was an Officer Report from a local police department, dated 12/4/15, multiple confidentiality statements signed	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 9 by various facility staff, hand written notes related to phone calls to police and various agencies, and a list of facility staff and when they had worked at the facility. However, an internal investigation by the facility into the incident could not be found. During an interview on 1/20/16 from 11:33 - 11:40 a.m., the Program Manager stated an internal investigation was not completed due to police asking them not to interview individuals as they were investigating possible sexual assault of Individual #6. During a follow-up interview on 1/21/16 from 8:50 - 9:12 a.m., the Program Manager stated she received and reviewed the police investigation some time in the middle of December 2015. The Program Manager stated no additional internal investigation was completed once the police investigation was concluded. The facility failed to ensure an internal investigation was completed for Individual #6. 2. The facility's Incident/Accident Reports, dated 5/1/15 - 1/19/16, were reviewed. The reports documented injures of unknown origin that were not investigated within the five day time frame. For example: - An Incident/Accident Report, dated 9/19/15 at 7:35 p.m., stated Individual #1 showed staff a small cut on his lip. The "Investigation" section of the report was not completed until 10/3/15, ten working days after the incident was reported. - An Incident/Accident Report, dated 9/20/15 at	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 10 11:00 a.m., documented bruises on Individual #1's right upper arm and left forearm. However, the "Investigation" section of the report was not completed until 10/3/15, ten working days after the incident was reported. During an interview on 1/20/16 from 11:33 - 11:40 a.m., the Program Manager stated issues related to Incident/Accident Report review and completion, including the review of injuries of unknown source, was identified at the beginning of January 2016. As a result, the Program Manager was now reviewing all Incident/Accident Reports with the Program Supervisor each week. The facility failed to ensure the results of all investigations were completed and reported within five working days.	W 156		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed, and had the potential to impact all individuals (Individuals #1 - #5) residing at the facility. This failure resulted in a lack of sufficient QIDP monitoring and oversight related to individuals' program data summaries. The findings include: 1. During the entrance conference on 1/19/16 from 9:02 - 9:12 a.m., the Clinical Director stated	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 11 the QIDP quit "a couple weeks ago." The Clinical Director stated he was acting as the QIDP until a replacement could be found. The facility utilized a Program Summaries form to monitor individuals' program progress. Individual #1 - #3's Program Summaries were reviewed and documented the following: a. Individual #1's 9/23/15 IPP stated he was a 14 year old male whose diagnoses included moderate intellectual disability and autism spectrum disorder. He was admitted to the facility on 9/5/15. Individual #1's record included one Program Summaries form which stated it was for "October - December 2015." The form was signed by the Clinical Director on 1/18/16. b. Individual #2's 1/7/16 IPP stated he was a 15 year old male whose diagnoses included severe intellectual disability and autistic disorder. Individual #2's record included a Program Summaries form for April 2015, dated 5/8/15 by the former QIDP. The next Program Summaries form stated it was for "May 2015 - December 2015" and was signed by the Clinical Director on 1/12/16. c. Individual #3's 7/6/15 IPP stated he was a 19 year old male whose diagnoses included mild intellectual disability, autism, and intermittent explosive disorder. Individual #3's record included a Program Summaries form for August 2015, dated 9/5/15 by the former QIDP. The next Program	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 12 Summaries form stated it was for "September and October 2015" and was signed by the Clinical Director on 1/8/16. A third Program Summaries form stated it was for "November and December 2015" and was signed by the Clinical Director on 1/8/16. Without regular and consistent review of individuals' program and behavioral data, it would not be possible to make accurate and appropriate program revisions to meet individuals' needs. During an interview on 1/20/16 from 11:05 - 11:20 a.m., the Program Manager and Clinical Director both stated problems with the former QIDP's review process were identified in early January 2016. At that time, the QIDP was given a 5 day time frame to get things in order. Rather than comply, the QIDP resigned. The Clinical Director stated QIDPs were expected to have the previous months data reviewed and summarized by the 10th of the current month in order to make program change decisions. The Clinical Director stated the facility completed "chart reviews," as part of the oversight process. Two charts were reviewed each week across the entire company, resulting in each individuals' chart being reviewed approximately once a year. The schedule for when each chart was to be reviewed was completed in advance for a year at a time. As such, the QIDP knew when each chart was scheduled for review and would ensure that chart was complete prior to the scheduled review, but was not maintaining the charts as required. When asked if the QIDP was performing appropriate monitoring an oversight, the Clinical	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 13 Director stated not in relation to individuals data. When asked about QIDP supervision, the Clinical Director stated he was responsible for supervision and oversight of the QIDPs. The facility failed to ensure the QIDP provided sufficient monitoring an oversight of individuals' programs. 2. Refer to W240 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP described relevant interventions to support independence.	W 159		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN 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 3 individuals (Individual #3) whose records were reviewed. This resulted in a lack of treatment provided related to an individual's psychosexual counseling needs. The findings include: 1. Individual #3's 7/6/15 IPP stated he was a 19 year old male whose diagnoses included mild intellectual disability, autism, and intermittent explosive disorder. During the entrance conference on 1/19/16 from 9:02 - 9:12 a.m., the Clinical Director stated Individual #3 had one-on-one male-only staffing	W 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G053		C 01/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240	Continued From page 14 due to recommendations from a psychosexual assessment. The Clinical Director stated they were having difficulty meeting Individual #3's needs in relation to the assessment, and were looking at alternative placement at a facility within the parent company that specialized in treating individuals with sexual issues. Individual #3's record included an assessment, dated 4/9/15, which stated Individual #3 needed "a sex offender treatment program with a provider that adheres to the ethical standards and treatment guidelines of the Association for the Treatment of Sexual Abusers. The provider should be certified by the SOMB [Sex Offender Management Board]. It is recommended that treatment is structured, addresses the examinees dynamic risk variables and focuses on community safety, honesty and compliance to treatment." However, Individual #3's IPP did not include objectives related to sex offender treatment or counseling. During a telephone interview on 1/22/16 from 10:36 - 10:40 a.m., the Clinical Director stated Individual #3 received weekly counseling at a behavioral health program, but the counselor did not meet the requirements outlined in the psychosexual assessment. The Clinical Director stated the facility had been unable to locate a provider that could meet Individual #3's needs. The facility failed to ensure Individual #3's program plan included interventions related to treatment needs as indicated by his psychosexual assessment.	W 240		

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
	13G053		C 01/21/2016

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - MILLIKEN

STREET ADDRESS, CITY, STATE, ZIP CODE: 7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint investigation conducted from 1/19/16 - 1/21/16. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000		
MM080	16.03.11100 Governing Body and Management The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W102.	MM080	RECEIVED FEB 08 2016 FACILITY STANDARDS	
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W149, W154 and W156.	MM134		
MM155	16.03.11300 Facility Staffing The requirements of Sections 300 through 399 of	MM155		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: KBuchanan | TITLE: program manager | (X6) DATE: 2-8-16

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
	13G053		C 01/21/2016

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - MILLIKEN

STREET ADDRESS, CITY, STATE, ZIP CODE: 7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM155	Continued From page 1 these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Rerfer to W159.	MM155		
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W240.	MM159		

ASPIRE
HUMAN SERVICES, LLC

RECEIVED
FEB 25 2016
FACILITY STANDARDS

RECEIVED
FEB 25 2016
FACILITY STANDARDS

2/25/16

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

RE: Milliken Heights, Provider #13G053

Dear Michael Case:

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

W104
Please refer to the response given under W149 as it relates to the Governing Body's failure to ensure policies and procedures for prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored.

Please refer to the response given under W159 as it relates to the Governing Body's failure to ensure the QIDP provided sufficient monitoring and oversight.

W149
Please refer to W154 as it relates to the facility's failure to ensure all allegations of abuse, neglect and mistreatment were thoroughly investigated.

Please refer to W156 as it relates to the facility's failure to ensure the results of all investigations were completed and reported as required within 5 working days.

W154

1. A thorough written Investigation has been completed and is on file in regards to Individual #1 being dropped off from school early. Individual #6 is no longer residing in the facility. He had moved out prior to the complaint survey. All of the current staff working in the home are not aware of any abuse, neglect or mistreatment occurring in the home. DSC B is no longer employed with Aspire Human Services. In addition, the staff in the home have reported that they have no concerns with the any of the current staff being aggravated while at work. There have been no reports of suspicious unknown injuries since the complaint investigation.
2. The staff currently working at the facility are being interviewed to verify that they have no concerns of abuse, neglect or mistreatment of any of the individuals in the home. If any

reports are made, the Program Manager will coordinate an investigation as outlined in company policy.

3. The Program Manager and Program Supervisor have received additional training in regards to the Abuse, Neglect and Mistreatment Policy and Procedure. Specifically focusing on the definitions of Abuse, Neglect and Mistreatment and the expectation that all investigations are completed within 5 working days. In addition, the Boise Aspire Team has a weekly meeting scheduled in which incident reports and investigations will be reviewed to verify thoroughness and timely completion of each report of abuse, neglect and mistreatment.
4. The Program Manager is currently signing and reviewing each investigation report on a weekly basis. The Program Manager will review the report for thoroughness and timely completion. Any identified errors will be immediately corrected before the reports are placed in the file.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director, QIDP & LPN.
6. Completion Date: 2/8/16

W156

1. Individual #6 is no longer residing in the facility. He had moved out prior to the complaint survey. All of the current staff working in the home are not aware of any abuse, neglect or mistreatment occurring in the home. There have been no reports of suspicious unknown injuries since the complaint investigation.
2. The staff currently working at the facility are being interviewed to verify that they have no concerns of abuse, neglect or mistreatment of any of the individuals in the home. If any reports are made, the Program Manager will coordinate an investigation as outlined in company policy.
3. The Program Manager and Program Supervisor have received additional training in regards to the Abuse, Neglect and Mistreatment Policy and Procedure. Specifically focusing on the definitions of Abuse, Neglect and Mistreatment and the expectation that all investigations are completed within 5 working days. In addition, the Boise Aspire Team has a weekly meeting scheduled in which incident reports and investigations will be reviewed to verify thoroughness and timely completion of each report of abuse, neglect and mistreatment.
4. The Program Manager is currently signing and reviewing each investigation report on a weekly basis. The Program Manager will review the report for thoroughness and timely completion. Any identified errors will be immediately corrected before the reports are placed in the file.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director, QIDP & LPN.
6. Completion Date: 2/8/16

W159

1. At the time of the complaint survey all program summaries were completed and filled in each individuals chart through the month of December 2015.
2. Currently the program summaries for the Month of January 2016 are completed and in each individuals chart. The program summaries were completed before February 10th 2016.
3. In addition to performing chart reviews, the Clinical Director has added an additional step to the Quality Assurance Procedures. This includes verifying that all Program Summaries are completed by the 10th of each month.

4. The Clinical Director will be responsible to document that the summaries have been completed on a monthly basis for each individual in the facility.
5. Person Responsible: Clinical Director & QIDP
6. Completion Date: 2/10/16

Please refer to W240 as it relates to the facility's failure to ensure the QIDP ensured an individual's IPP described relevant interventions to support independence.

W240

1. Individual #3 was assessed by a professional from the Aspire Human Services Pocatello area, he is certified as a Counselor, LPC & NCC. The professional interviewed individual #3 formally to gain a better understanding of his needs. In addition the professional did a thorough record review of Individual #3's past assessments and incidents. After the professional gained a better knowledge of Individual #3's needs he met with the team in Pocatello and they have determined that he would be appropriately served in the Fifth Street ICF/IID in Pocatello. Individual #3's parents/guardians are scheduled to visit the Fifth Street location on 2/28/16.
2. After Individual #3's parents/guardians visit the Fifth Street ICF/IID they have indicated that they will inform Aspire Human Services if they support their son living at the facility. If they support this move it has been identified that he would be able to move to the facility during the month of April 2016. If they do not support the move, Aspire Human Services will need to consider discharging Individual #3 to his parents/guardians.
3. Assessments for all other individuals residing in the facility have been reviewed and it has been verified that all other professional recommendations are being met.
4. Aspire Human Services is currently conducting chart reviews for all individuals at Milliken Heights. Each chart will be reviewed at least two times annually to verify all recommendations listed on professional assessments are being implemented.
5. The Clinical Director is responsible to schedule the chart reviews and help the treatment teams to obtain the appropriate services as recommended in each professional assessment.
6. Person Responsible: Program Manager, Clinical Director & QIDP
7. Completion Date: 3/10/16

MM080

Please see the response under W102 as it relates to Governing Body and Management.

MM134

Please see the responses under W149, W154 and W156 as they relate to Client Protections.

MM155

Please refer to W159 as it relates to Facility Staffing.

MM159

Please refer to W240 as it relates to Active Treatment Services.

Kristin Buchanan
Program Manager

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 27, 2016

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

Provider #13G053

Dear Ms. Young:

An unannounced on-site complaint investigation was conducted from January 19, 2016 to January 21, 2016 at Preferred Community Homes - Milliken. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007233

Allegation #1: The Qualified Intellectual Disabilities Professional (QIDP) does not provide sufficient monitoring and oversight of individuals' programs.

Findings #1: An unannounced, on-site complaint investigation was conducted from 1/19/16 to 1/21/16.

During that time, individuals' records were reviewed and staff interviews were conducted with the following results:

During the entrance conference on 1/19/16 from 9:02 - 9:12 a.m., the Clinical Director stated the QIDP quit "a couple weeks ago." The Clinical Director stated he was acting as the QIDP until a replacement could be found.

The facility utilized a Program Summaries form to monitor individuals' program progress. Three individuals' Program Summaries were reviewed and documented the following:

One individual's record included one Program Summaries form which stated it was for "October - December 2015." The form was signed by the Clinical Director on 1/18/16.

A second individual's record included a Program Summaries form for April 2015, dated 5/8/15 by the former QIDP. The next Program Summaries form stated it was for "May 2015 - December 2015" and was signed by the Clinical Director on 1/12/16.

A third individual's record included a Program Summaries form for August 2015, dated 9/5/15 by the former QIDP. The next Program Summaries form stated it was for "September and October 2015" and was signed by the Clinical Director on 1/8/16. A third Program Summaries form stated it was for "November and December 2015" and was signed by the Clinical Director on 1/8/16.

During an interview on 1/20/16 from 11:05 - 11:20 a.m., the Program Manager and Clinical Director both stated problems with the former QIDP's review process were identified in early January 2016. At that time, the QIDP was given a 5 day time frame to get things in order. Rather than comply, the QIDP resigned.

The Clinical Director stated QIDPs were expected to have the previous months data reviewed and summarized by the 10th of the current month in order to make program change decisions.

The Clinical Director stated the facility completed "chart reviews," as part of the oversight process. Two charts were reviewed each week across the entire company, resulting in each individuals' chart being reviewed approximately once a year. The schedule for when each chart was to be reviewed was completed in advance for a year at a time. As such, the QIDP knew when each chart was scheduled for review and would ensure that chart was complete prior to the scheduled review, but was not maintaining the charts as required.

When asked if the QIDP was performing appropriate monitoring an oversight, the Clinical Director stated not in relation to individuals data. When asked about QIDP supervision, the Clinical Director stated he was responsible for supervision and oversight of the QIDPs.

The governing body did not ensure the QIDP provided sufficient monitoring and oversight of individuals' programs. Therefore, the allegation was substantiated and deficient practice was identified at W104, W159, M080, and M155.

Conclusion #1: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: The facility does not have Registered Nurse (RN) oversight.

Findings #2: During the complaint investigation, staff interviews were conducted.

The Clinical Director was interviewed on 1/19/16 at 9:00 a.m. and stated in December 2015 the facility's RN had resigned and RN coverage was being provided by another RN within the company.

The RN from within the company was interviewed on 1/20/16 at 2:00 p.m. and stated she provided coverage on a regular basis for the facility and was on-call as needed.

It could not be determined, the facility did not have RN oversight. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals' supervision and treatment needs are not being met.

Findings #3: During the complaint investigation, observations and staff interviews were conducted, and individuals' records were reviewed with the following results:

Observations were conducted on 1/19/16 and 1/20/16 for a cumulative total of 2 hours and 53 minutes. Five individuals resided at the facility. Three individuals were provided with 1:1 staff supervision and the remaining 2 individuals shared a staff person. Throughout the observations, 7 Direct Care Staff (DCS) were interviewed. When asked what the supervision needs were for the individuals residing in the facility, all interviewed DCS were able to explain each individual's treatment needs including assistance with personal cares, such as toileting and supervision needs, including increased staffing due to elopement and psychosexual concerns.

During an observation, on 1/19/16 at 4:06 p.m., 4 personnel from a sister facility within the same parent company were at the facility. The Qualified Intellectual Disabilities Professional (QIDP) from the sister facility was interviewed during that time. The QIDP stated he and the other staff from the sister facility came to observe the individual with psychosexual needs to determine if the sister facility would be able to meet his needs.

The Clinical Director was interviewed on 1/19/16 at 9:00 a.m. and said the sister facility within the same parent company was being considered as a better placement option for the individual.

Three of the individuals' records were selected for review. Two individuals' records documented the individuals' needs and included evidence (e.g. comprehensive functional assessments, individual program plans, data collection, etc.) demonstrating individuals' needs were being met.

However, one individual's record included a psychosexual assessment, dated 4/9/15, which stated the individual needed "a sex offender treatment program with a provider that adheres to the ethical standards and treatment guidelines of the Association for the Treatment of Sexual Abusers. The provider should be certified by the SOMB {Sex Offender Management Board}. It is recommended that treatment is structured, addresses the examinees dynamic risk variables and focuses on community safety, honesty and compliance to treatment."

The individual's Individual Program Plan (IPP), dated 7/16/15, did not include objectives related to sex offender treatment or counseling.

During a telephone interview on 1/22/16 from 10:36 - 10:40 a.m., the Clinical Director stated the individual received weekly counseling at a behavioral health program, but the counselor did not meet the requirements outlined in the psychosexual assessment. The Clinical Director stated the facility had been unable to locate a provider that could meet the individual's needs.

The facility failed to ensure an individual's program plan included interventions related to treatment needs as indicated by his psychosexual assessment.

Therefore, the allegation was substantiated and the deficient practice was identified at W240 and M159.

Conclusion #3: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #4: Direct Care Staff (DCS) work without criminal background checks being completed.

Findings #4: During the complaint investigation, criminal background checks for 3 DCS hired within the past 6 months and the corresponding as-worked schedules were reviewed, and 7 DCS were interviewed with the following results:

The criminal background checks for 3 DCS hired within the past 6 months stated the 3 DCS had no disqualifying offenses that would prevent their employment at the facility.

The facility's as-worked schedules for the past 6 months documented the 3 DCS hired within the past 6 months did not work on a shift by themselves until their state criminal background checks were verified with no disqualifying offenses.

One of the 3 DCS hired within the last 6 months was no longer employed at the facility. Two of the DCS hired within the past 6 months were interviewed. Each DCS stated they were not permitted to work on a shift by themselves until their background checks were verified with no disqualifying offenses.

Five other DCS who were interviewed stated newly hired DCS were not permitted to work on a shift by themselves until the state criminal background checks were verified with no disqualifying offenses.

It could not be determined that DCS worked unsupervised without their criminal background checks being completed. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt