



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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March 11, 2016

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

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Ms. Buchanan:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Fieldstone, which was conducted on March 4, 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

Kristin Buchanan, Administrator
March 11, 2016
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 24, 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 March 24, 2016. If a request for informal dispute resolution is received after March 24, 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,

 for
MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - FIELDSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 2/29/16 - 3/4/16. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disability Professional	W 000	RECEIVED MAR 24 2016 FACILITY STANDARDS	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided privacy during care of personal needs. This failure directly impacted 2 of 6 individuals (Individuals #2 and #5) observed, and had the potential to impact 6 of 6 individuals (Individual #1 - #6) residing at the facility. This resulted in individuals' clothing being changed in view of others. The findings include: 1. Observations were conducted at the facility on 2/29/16 and 3/1/16. During those times, 2 sub-contractors were present in the facility	W 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>3/24/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	<p>Continued From page 1</p> <p>installing flooring. The sub-contractors were working in the hallway outside of the individuals' bedrooms. Individuals' privacy during care of personal needs was not protected, as follows:</p> <p>a. Individual #5's 2/18/16 IPP stated he was a 28 year old male whose diagnoses included severe intellectual disability and autism. He was non-verbal and required physical assistance to complete self-care tasks.</p> <p>An observation was conducted at the facility on 2/29/16 from 3:05 - 4:25 p.m. During that time, Individual #5 was prompted to go with staff to check his appearance.</p> <p>At 3:10 p.m., Individual #5 was in the bathroom located inside his bedroom. The bathroom door was ajar approximately 4 inches, and the bedroom door was fully open. While standing in the hallway, Individual #5's reflection could be seen in the mirror through the bathroom door. Individual #5 was observed to be standing naked in the bathroom as a direct care staff assisted him to change his incontinence brief.</p> <p>b. Individual #2's 1/21/16 IPP stated he was a 21 year old male whose diagnoses included mild intellectual disability and autistic disorder.</p> <p>An observation was conducted at the facility on 3/1/16 from 6:37 - 8:23 a.m. During that time, Individual #2 was prompted to change his pants.</p> <p>At 8:15 a.m., Individual #2 was in the bathroom located inside his bedroom. The bathroom door was ajar approximately 6 inches, and the bedroom door was fully open. The direct care staff working with Individual #2 was standing in</p>	W 130			

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

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FORM APPROVED
OMB NO. 0938-0391

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W 130	Continued From page 2 the bedroom. While standing in the hallway, Individual #2's reflection could be seen in the mirror through the bathroom door as Individual #2 stripped to his underwear and put on clean pants. During an interview on 3/3/16 from 2:50- 3:30 p.m., the QIDP stated bathroom and bedroom doors should have been closed in order to protect individuals' privacy during the care of personal needs. The facility failed to ensure Individual #2 and Individual #5's privacy was protected during care of personal needs.	W 130			
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 3 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual's blood pressure not being monitored as required. The findings include: 1. Individual #1's 7/17/15 IPP stated she was a 24 year old female whose diagnoses included severe intellectual disability and hypertension. Her Physician's Order, signed by the physician 1/13/16, stated she received lisinopril (an antihypertensive drug) 20 mg each morning.	W 322			

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W 322	<p>Continued From page 3</p> <p>The Nursing 2015 Drug Handbook listed nursing considerations for lisinopril that included "Monitor blood pressure frequently." However, Individual #1's record did not document consistent blood pressure monitoring, as follows:</p> <p>Individual #1's record included a letter from a physician, dated 7/1/15, which stated "Please check and record [Individual #1's] blood pressure twice weekly..." Her Physician's Orders, signed by the physician 7/1/15/15, included a handwritten change which stated her blood pressure was to be checked twice weekly and staff were to "contact nurse if systolic range is <90 or >140; diastolic <60 or >90. "</p> <p>Individual #1's blood pressure monitoring was reviewed and documented monitoring was missing, as follows:</p> <p>7/15 - missing 6 dates 8/15 - missing 7 dates 9/15 - missing 1 date 12/15 - missing 7 dates 1/16 - no documentation</p> <p>Additionally, Individual #1's blood pressure on 11/9/15 was documented as 148/112. However, no documentation the nurse had been contacted, as per the protocol, could be found.</p> <p>During an interview on 3/3/16 from 2:50 - 3:30 p.m., the LPN stated the missing blood pressure monitoring should have been caught during nursing reviews. The LPN stated the system for monitoring Individual #1's blood pressure needed to be revised.</p> <p>The facility failed to ensure Individual #1's blood</p>	W 322			

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W 322	Continued From page 4	W 322			
W 336	pressure was monitored as required. 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews were completed on a quarterly basis for 1 of 3 individuals (Individual #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: 1. Individual #3's IPP, dated 1/12/16, documented a 23 year old male whose diagnoses included moderate intellectual disability and autism. Individual #3's record included nursing assessments dated 2/2/15, 7/17/15, and 12/11/15. However, his record did not include a nursing assessment for the second quarter (April - June) of 2015. During an interview on 3/4/16 at approximately 10:00 a.m., the Clinical Director stated second quarter reviews had been missed due to turnover in nursing staff. The facility failed to ensure a nursing assessment was completed for the second quarter for Individual #3.	W 336			

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W 362	<p>483.460(j)(1) DRUG REGIMEN REVIEW</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the pharmacist conducted routine comprehensive drug regimen reviews for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in a lack of quarterly pharmacy reviews being completed. The findings include:</p> <p>1. Individuals #1 - #3's medical records were reviewed. Individuals #1 - #3's records included pharmacy reviews dated 3/27/15, 9/30/15, and 12/7/15. However, their records did not include reviews for the second quarter (April - June) of 2015.</p> <p>During an interview on 3/3/16 from 2:50 - 3:30 p.m., the Clinical Director stated second quarter reviews had not been completed as they had just changed pharmacies at that time.</p> <p>The facility failed to ensure quarterly comprehensive pharmacy reviews were completed for Individuals #1 - #3.</p>	W 362			
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by:</p>	W 369			

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W 369	<p>Continued From page 6</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 4 individuals (Individual #4) observed to take medications. This resulted in an individual's medication being improperly administered. The findings include:</p> <p>1. Individual #4's Physician's Order, signed 1/7/16, stated he was a 23 year old male. The order included alendronate (an antiosteoporotic drug) 70 mg every Tuesday. The order stated "Take with 8 [ounces] of water 30 [minutes] before eating, drinking or taking other meds."</p> <p>An observation was conducted at the facility on 3/1/16 from 6:37 - 8:23 a.m. During that time, Individual #4 was observed to participate in a medication administration program.</p> <p>At 7:48 a.m., Individual #4 entered the medication administration area. Individual #4 punched his medications from blister packs into a medication cup with verbal prompting, then took the medications. The medications included alendronate, Align (a Probiotic supplement drug), Caltrate (a calcium replacement drug), divalproex (an anticonvulsant drug), and guanfacine (an antihypertensive drug).</p> <p>When asked during the observation, the direct care staff assisting Individual #4 with the medication administration program stated she had not noticed the instructions related to taking the medication 30 minutes before other medications.</p> <p>During an interview on 3/3/16 from 2:50 - 3:30 p.m., the LPN stated the medication should have</p>	W 369			

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W 369	Continued From page 7 been given as directed.	W 369			
W 436	The facility failed to ensure Individual #4's alendronate was given as prescribed. 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. 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 taught to use and make informed decisions regarding adaptive equipment for 1 of 3 individuals reviewed (Individual #1). This resulted in an individual being without her hearing aids for an extended period of time, and a lack of appropriate plans to care for the hearing aids. The findings include: 1. Individual #1's 7/17/15 IPP stated she was a 24 year old female whose diagnoses included severe intellectual disability. Individual #1's record included an Audiologic Report, dated 12/1/14, which stated she had been fitted with binaural hearing aids due to "moderately-severe sensorineural hearing loss" in both ears. A subsequent Audiology Note, dated 7/7/15, stated "The lost hearing aid for the [right] ear is	W 436			

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W 436	<p>Continued From page 8</p> <p>still under original manufacturer's warranty. An impression was taken and the deductible costs and new earmold costs were explained to the caretaker and the patient."</p> <p>An Audiology Note, dated 10/15/15, stated Individual #1 was seen for "hearing aid pick-up" on 10/1/15.</p> <p>There was no clear documentation regarding the almost 3 months time it took from the audiology appointment fitting for replacement hearing aids to the pick-up on 10/1/15. Additionally, there was no clear information in Individual #1's record related to why the hearing aids required replacement.</p> <p>During an interview on 3/3/16 from 2:50 - 3:30 p.m., the QIDP stated Individual #1's hearing aids disappeared during a hospital visit in April 2015. When asked about the approximate 6 month time frame to get the hearing aids replaced, the QIDP stated it was due to paperwork. When asked about a training program for the care and use of the hearing aids, the QIDP stated the only program in place was to tolerate wearing hearing aids 15 minutes in the morning and in the evening. The QIDP stated the program needed to be replaced as Individual #1 wore her hearing aids on a consistent basis.</p> <p>The facility failed to ensure Individual #1 was provided with replacement hearing aids in a timely manner, and was provided appropriate training to care for the hearing aids.</p>	W 436			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the state licensure survey conducted from 2/29/16 - 3/4/16. The surveyors conducting your survey were: Michael Case, LSW, Team Lead Jim Troutfetter, QIDP	M 000		
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 W130.	MM134		
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W322, W336, W362 and W369.	MM166		
MM169	16.03.11700 Physical Environment The requirements of Sections 700 through 799 of these rules are modifications and additions to the	MM169		

RECEIVED
MAR 24 2016
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bochman</i>	TITLE <i>Program manager</i>	(X6) DATE <i>3/24/16</i>
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Bureau of Facility Standards

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MM169	Continued From page 1 requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W436.	MM169		
MM215	16.03.11711.01 Good Repair Each building used by the ICF/ID and its equipment must be in good repair. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 3/1/16 from 10:40 - 11:00 a.m. During that time, the following was noted: - The hall closet had a hole approximately one inch by one and a half inch. - The light switch in the laundry room was broken. - The toilet bolt covers in Individual #1's bathroom were missing. - The middle drawer of Individual #3's dresser	MM215		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2016
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - FIELDSTC		STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY 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
MM215	Continued From page 2 was missing. - There were two ceiling lights that did not work on the bed side of Individual #4's bedroom. - The light above the shower in Individual #5's bathroom did not work. - The ceiling light to the right of the bedroom door in Individual #5's room did not work. - There was a section of wall approximately two feet by two feet by Individual #6's bed that did not match the surrounding color of the wall. The facility failed to ensure environmental repairs were completed and maintained.	MM215		



3/21/2016

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

RECEIVED
MAR 24 2016
FACILITY STANDARDS

RE: Fieldstone, Provider #13G030

Dear Michael Case:

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

W130

1. An in-service training will be completed for the staff working at Fieldstone Meadows covering privacy during personal care needs while assisting the individuals; specifically individual #2 and #5.
2. By training all of the staff at Fieldstone Meadows it will help ensure privacy during personal care needs affecting all 6 individuals residing in the home.
3. The QIDP, LPN, and PS will continue to remind staff about privacy during their observations at Fieldstone Meadows.
4. The QIDP, LPN, and PS are in the homes daily. During their time at Fieldstone Meadows, they will observe to ensure all 6 individuals are provided privacy during their personal care needs.
5. Person Responsible: PS, QIDP, direct support professionals
Completion Date: 4/1/2016

W322

1. The Protocol for monitoring Individual #1's blood pressure monitoring is currently being revised by her IDT.
2. Nursing charts are being reviewed for each individual residing in the facility to verify that adequate blood pressure monitoring systems are in place. Any identified deficiencies will be corrected.
3. Training is scheduled for the Facility Nurses in relation to the creation and implementation of adequate blood pressure guidelines.
4. Currently each individual residing in the facility is scheduled to have a internal review completed at least 2 times annually. The chart review form is being revised to include assuring that adequate blood pressure guidelines are implemented when necessary.
5. Person Responsible: QIDP & Facility Nurse
6. Completion Date: 4/30/15

W336

1. Currently Individual #1 has nursing assessments scheduled to occur quarterly over the next 12 months.
2. All individuals residing in the facility have a nursing assessment to be completed at least quarterly.
3. A training has been scheduled for the nursing team. One of the training objectives is clarifying that each individual residing in the facility is to have a nursing assessment completed on a quarterly basis. In addition, the facility has contracted an RN to assist in administering and monitoring quarterly assessments. The RN is on site at least one day per week.
4. Currently each individual residing in the facility is scheduled to have a internal review completed at least 2 times annually. The chart review form includes monitoring to assure that each individual receives a quarterly assessment.
5. Person Responsible: QIDP & Facility Nurse
6. Completion Date: 4/30/15

W362

1. Aspire Human Services – Boise has recently obtained the services of a new local pharmacy to meet the needs of each individual being served.
2. Currently Pharmacy reviews are scheduled to occur quarterly for each individual living in the facility.
3. Training has been scheduled for all of the Facility Nurses to clarify that Pharmacy reviews are to occur at least quarterly for each individual being served.
4. Internal reviews are scheduled to occur at least two times annually for each individual residing in the facility. The chart review form includes verifying that quarterly pharmacy reviews have occurred. Any identified errors will be corrected immediately.
5. Person Responsible: Facility Nurse & QIDP
6. Completion Date: 4/30/16

W369

1. A staff meeting has been scheduled for the facility. One of the agenda items includes the Facility Nurse to provide additional training for all of the medication passers in the home on the importance of assuring individual #4's medications are given without error.
2. In addition to providing additional training in relation to Individual #4's medications, the Facility Nurse will also provide training as it relates to every individual residing in the facility to assure that all medications are administered without error.
3. The Facility Nurses are scheduled to provide additional training related to assuring that all medication sheets have clear instructions.
4. The Program Supervisor and Facility Nurse are scheduled to do at least one medication observations in the facility each month to assure that all medications are administered without error.
5. Person Responsible: Facility Nurse & Program Supervisor
6. Completion Date: 4/30/16

W436

1. Individual #1 currently has her hearing aids as ordered by her audiologist. The QIDP has scheduled a team meeting to discuss training options for individual #1 to assist her to utilize her hearing aids. After the meeting the QIDP will make revisions to individual #1's program plan based on team input.
2. All individuals residing in the facility are currently being provided with all equipment as recommended by members of the IDT.

3. A training has been scheduled for the Program Supervisor, QIDP and Facility nurse for the facility. The training will focus on the regulation W436 as it relates to assuring that all space and equipment is furnished, maintained and that each individual receives adequate training related to their equipment.
4. Internal reviews are scheduled to occur at least two times annually for each individual residing in the facility. The chart review form is being revised to include verifying that each individual is provided with and receives training related to their adaptive equipment.
5. Person Responsible: Facility Nurse & QIDP
6. Completion Date: 4/30/16

MM134

Please see response given under W130 as it relates to Client Protections.

MM166

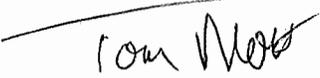
Please see the response given under W322, W336, W362, and W369 as they relate to Health Care Services.

MM169

Please see the responses given under W436 as it relates to Physical Environment.

MM215

1. Aspire Human Services has a monthly universal checklist. The form will be reviewed to ensure all environmental factors are inspected every month affecting all 6 individuals residing in the home.
2. All ICF's within Aspire Human Services complete the monthly universal check list. If there are revisions to the form all locations will be trained and the new form will be implanted the following month.
3. Aspire Human Services will be hiring a 2nd maintenance technician to ensure all facilities are in good repair.
4. The Program Manager and Maintenance Supervisor review the monthly universal checklist to ensure nothing falls through the cracks. In addition to the checklist, the program manager and maintenance supervisor will look for
5. Person Responsible: PS, QIDP, direct support professionals, maintenance supervisor
Completion Date: 4/1/2016


Tom Moss
Clinical Director


Kristin Buchanan
Program Manager