



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  
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P.O. Box 83720  
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March 11, 2016

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

RE: Preferred Community Homes - Vineyards, Provider #13G028

Dear Ms. Buchanan:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Vineyards, 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  
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **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](http://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,

  
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: 03/10/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/04/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - VINEYARDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2226 WEST SONOMA DRIVE MERIDIAN, ID 83642</b>	
(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 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: ABC - Antecedent Behavior Consequence DCS - Direct Care Staff HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse NA - Nursing Assistant QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure staff were provided initial and on-going training necessary to enable staff to perform their job duties effectively, efficiently, and competently for 1 of 4 individuals (Individual #4) observed to use a wheelchair for mobility purposes. This resulted in an individual being transported in a wheelchair improperly. The findings include:	W 189		

**RECEIVED**  
**MAR 24 2016**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Bachman* *Program Manager* *3/24/16*

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.

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W 189	<p>Continued From page 1</p> <p>1. Individual #4's 1/7/16 IPP stated she was a 58 year old female whose diagnoses included profound intellectual disability and mild right-side hemiparesis. She required staff assistance for ambulation, and the use of a wheelchair for walking long distances and to enter the facility van safely.</p> <p>An observation was conducted at the facility on 2/29/16 from 11:10 a.m. - 1:20 p.m. During that time, Individual #4 was observed to participate in community programming. At 11:20 a.m., DCS B was observed to assist Individual #4 into a wheelchair and wheel her outside to the facility van. The wheelchair was not observed to have foot rests.</p> <p>The van was equipped with a wheelchair lift mounted at the side doors. DCS B used the lift to move Individual #4 into the van where DCS A was waiting. Once in the van, DCS A positioned Individual #4's wheelchair behind the drivers seat and began to attach restraining straps to the chair.</p> <p>DCS A initially positioned the straps so they crossed each other in front of the wheelchair and attempted to tighten the straps. However, the straps then made contact with the back of Individual #4's feet and legs.</p> <p>DCS A released the straps and attempted to wrap them around the outside of the front wheels and attach them to the cross frame under the wheelchair seat. However, the straps still made contact with Individual #4's legs.</p> <p>DCS A released the straps and ran the strap</p>	W 189			

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W 189	<p>Continued From page 2</p> <p>through the caster fork of the front wheel and across to the opposite side of the wheelchair. This positioned the strap low across the floorboards.</p> <p>When asked how Individual #4's wheelchair was to be secured in the van, DCS A was unable to answer. When asked what training she had received regarding securing Individual #4's wheelchair, DCS A did not answer.</p> <p>An observation was conducted at the facility on 2/29/16 from 5:05 - 6:00 p.m. At the beginning of the observation, Individual #4 was on a community outing. At 5:25 p.m., Individual #4 returned in the facility van and was sitting in the back seat. Staff transferred Individual #4 from the back seat to a wheelchair, and exited the van using the lift.</p> <p>DCS C, who was assisting Individual #4 out of the van, stated the wheelchair was used only to get Individual #4 in and out of the van. DCS C stated Individual #4 was never transported in the van in her wheelchair and staff had not been trained to secure the wheelchair in the van. DCS C stated only Individual #3 was transported in a wheelchair. The Program Supervisor, who was present during the observation, confirmed Individual #4 was not to be transported in the wheelchair.</p> <p>During an interview on 3/3/16 from 2:00 - 2:50 p.m., the QIDP stated no staff training related to transporting individuals in wheelchairs had been completed.</p> <p>The facility failed to ensure staff received sufficient training related to transporting Individual</p>	W 189			

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W 189	Continued From page 3	W 189			
W 303	#4 in the facility van. 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 1 individual (Individual #1) 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 #1's 4/16/15 IPP stated she was a 67 year old female whose diagnoses included severe intellectual disability.  Individual #1's dental record, dated 7/29/15, documented "Caregiver helped hold hands [and] head." However, a record of the restraint (including description of the restraint, time in, time out, etc.) could not be found in Individual #1's record.  During an interview on 3/3/16 from 2:00 - 2:50 p.m., the QIDP stated the restraint should have been documented on an ABC form. The Clinical Director, who was present during the interview, stated it was not typical for Individual #1 to require restraint and the restraint would have been considered an emergency restraint and should have been documented.	W 303			

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W 303	Continued From page 4	W 303		
W 352	<p>The facility failed to ensure the use of physical restraint for Individual #1 was documented.</p> <p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE</p> <p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</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 annual dental examinations were completed for 2 of 4 individuals (Individuals #2 and #4) whose dental records were reviewed. This resulted in the potential for individuals' dental needs to go undetected. The findings include:</p> <p>1. Individuals #2 and #4's records were reviewed and documented Individual #2 had received a soft tissue oral screening from his primary care provider on 3/23/15, and Individual #4 had received a soft tissue oral screening from her primary care provider on 10/9/15.</p> <p>However, no documentation of a screening by a dental professional could be found in their records.</p> <p>During an interview on 3/3/16 from 2:00 - 2:50 p.m., the LPN stated Individuals #2 and #4 did not go to the dentist because they received soft tissue oral screenings from their primary care provider.</p> <p>The facility failed to ensure Individuals #2 and #4</p>	W 352		

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W 352	Continued From page 5 received dental screenings from a dental professional.	W 352			
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT  The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure comprehensive dental services were provided for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in a lack of thorough assessment of an individual's dental needs. The findings include:  1. Individual #1's 4/16/15 IPP stated she was a 67 year old female whose diagnoses included severe intellectual disability.  Individual #1's record included a dental note, dated 1/26/15, which stated "[Patient] difficult to work on. Doc referring her to [name of dentist] for [treatment]. Heavy plaque [and] debris."  A dental note, dated 7/29/15, stated "No [treatment] today...[patient] uncooperative. Heavy debris [and] plaque." The note stated the caregiver "requested a referral to [name of dentist] but they are full. Another referral was given."  Individual #1's record did not include information	W 356			

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W 356	Continued From page 6 regarding follow-up treatment being completed.  Additionally, Individual #1's record documented a tooth had been extracted on 12/22/11. Since that time, Individual #1 had returned for dental treatment on 7/17/12, 1/21/13, 7/22/13, in January 2014, and on 7/24/14. Each of the entries stated Individual #1 had heavy plaque and it was difficult to access most teeth. No additional information related to treatment being sought or provided, including x-rays, could be found in the record.  During an interview on 3/3/16 from 2:00 - 2:50 p.m., the NA and LPN both stated the dentist they were referred to on both 1/26/15 and 7/29/15 would not see Individual #1 due to her age. The NA stated an appointment had been made with a second dentist for 3/22/16. When asked what aggressive efforts had been made to obtain services for Individual #1, the NA stated there was nothing documented, but that 2 providers had been called (the one who refused and the one who was scheduled 3/22/16).  The facility failed to ensure aggressive efforts were made to obtain dental services to meet Individual #1's needs.	W 356		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW  A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the	W 362		

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W 362	Continued From page 7 pharmacist conducted routine comprehensive drug regimen reviews for 4 of 4 individuals (Individuals #1 - #4) whose medical records were reviewed. This resulted in a lack of quarterly pharmacy reviews being completed. The findings include:  1. Individuals #1 - #4's medical records were reviewed. Individuals #1 - #4'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.  During an interview on 3/3/16 from 2:00 - 2:50 p.m., the Clinical Director stated second quarter reviews had not been completed as they had just changed pharmacies at that time.  The facility failed to ensure quarterly comprehensive pharmacy reviews were completed for Individuals #1 - #4.	W 362			
W 369	483.460(k)(2) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 3 individuals (Individual #2) observed to take medications. This resulted in an individual's medication not being properly administered. The findings include:	W 369			

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W 369	Continued From page 8 1. Individual #2's IPP, dated 12/11/15, documented a 45 year old male whose diagnoses included profound intellectual disability.  His Physician's Order, dated 1/29/16, stated he received Docusate (a laxative drug) 20 ml twice a day.  However, during a medication administration observation on 3/1/16 from 7:11 - 8:10 a.m., the DCS was noted to pour 5 ml into a medication cup and mix it into a glass of polyethylene glycol (a laxative drug) which Individual #2 drank.  When asked, the DCS assisting Individual #2 with the medication administration stated she thought he was to receive 5 ml. The DCS then phoned the nurse for clarification and was directed to administer an additional 15 ml of Docusate.	W 369			
W 440	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas in the event of an emergency. The findings include:	W 440			

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W 440	<p>Continued From page 9</p> <p>1. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the night shift (10:00 p.m. - 6:00 a.m.) during the second quarter (April - June) of 2015.</p> <p>During an interview on 3/1/16 at approximately 10:30 a.m., the Program Manager stated the evacuation drill for the night shift had not been completed due to an oversight.</p> <p>The facility failed to ensure an evacuation drill was completed for the night shift during the second quarter of 2015.</p>	W 440			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  
**PREFERRED COMMUNITY HOMES - VINEYARI**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2226 WEST SONOMA DRIVE  
MERIDIAN, ID 83642**

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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		
MM155	16.03.11300 Facility Staffing  The requirements of Sections 300 through 399 of 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: Refer to W189.	MM155		
MM162	16.03.11500 Client Behavior and Facility Practices  The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W303.	MM162		
MM166	16.03.11600 Health Care Services  The requirements of Sections 600 through 699 of	MM166		

**RECEIVED**  
**MAR 24 2016**  
**FACILITY STANDARDS**

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Brennan*

*Program Manager*

*3/24/16*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/04/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - VINEYARI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2226 WEST SONOMA DRIVE MERIDIAN, ID 83642</b>
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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) COMPLETE DATE
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MM166	Continued From page 1  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 W352, W356, 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 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 W440.	MM169		



**RECEIVED**

**MAR 24 2016**

**FACILITY STANDARDS**

3/21/2016

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

RE: Vineyards, Provider #13G028

Dear Michael:

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

**W189**

1. All of the staff in the home are currently receiving training to clarify that Individual #1 uses her wheelchair only to get on the facility van and then transfers to a seat in the van during transport. In addition, the QIDP is writing a guideline to clarify how individual #1 is transported which will be included in her IPP.
2. The QIDP has scheduled an outside professional to assess each individual in the home and their needs related to transporting in the facility vehicle. Any recommendations made will be added to each individual's program plan and staff training will follow.
3. Quarterly each individual will be observed being transported in the facility van by the QIDP and Program Supervisor to verify that all guidelines are being followed as written.
4. The observations will be documented and any identified staff training will be provided at the time of the observations.
5. Person Responsible: Program Supervisor & QIDP
6. Completion Date: 4/30/16

**W303**

1. A team meeting has been scheduled to discuss the physical restraint utilized for individual #1 at her appointment on 7/29/15. Her team will discuss the need for a restraint moving forward. Any changes will be added to her Individual Program Plan with an addendum.
2. A team meeting has been scheduled to review restraint usage for each individual residing in the facility. At the meeting charts will be reviewed and discussed to verify each restraint over the past 12 months has been documented appropriately and the team respond appropriately to meet the needs of each individual.
3. A team meeting has been scheduled for each Monday. The QIDP, Facility Nurse and Program Supervisor are scheduled to attend each meeting. One of the agenda items is to review how each appointment went during the previous week. At this time the notes will be reviewed to verify that any restraints are documented as outlined in company policy.

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 a section for reviewing restraints utilized during medical appointments to assure company policies were followed. Any identified errors will be corrected immediately.
5. Person Responsible: Facility Nurse, QIDP & Program Supervisor
6. Completion Date: 4/30/16

#### **W352**

1. Individual's #2 and #4 have been scheduled to receive dental screenings from a dental professional.
2. All of the charts are being reviewed to assure that each individual residing in the facility has received dental screenings from a dental professional including soft tissue oral screenings.
3. Training has been scheduled for all of the Facility Nurses to clarify that all individuals are to receive dental screenings from a dental professional including individuals that require only soft tissue oral screenings.
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 all individuals receive dental screenings from a dental professional. Any identified errors will be corrected immediately.
5. Person Responsible: Facility Nurse, QIDP & Program Supervisor
6. Completion Date: 4/30/16

#### **W356**

1. Individual #1 currently has an appointment with a dental professional to meet her dental needs. The current provider is planning to provide treatment for her at her home in an effort to help her remain comfortable and set the occasion for aggressive dental treatment to be provided.
2. All of the charts are being reviewed to assure that each individual residing in the facility has received aggressive dental treatment.
3. Training has been scheduled for all of the Facility Nurses to clarify that aggressive efforts must be made to meet each individual's dental needs.
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 all individuals receive dental care. Any identified errors will be corrected immediately.
5. Person Responsible: Facility Nurse, QIDP & Program Supervisor
6. Completion Date: 4/30/16

#### **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 #2's Dosusate is administered without error.
2. In addition to providing additional training in relation to Individual #2'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 observation 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

**W440**

1. Direct Support Professionals will be trained on fire drills and how to complete a fire drill.
2. The Program Supervisor will be trained on fire drills and how to complete a fire drill within the quarter when missed.
3. The QIPD will review monthly data to ensure a fire drill is run monthly. In addition, the Program Supervisor will review the Fire Drill Report each month verifying completion with their signature.
4. Internal Reviews are completed each month by the QIPD's. During this process the QIDP's review the data and plan of care to ensure all needs are being met and all programs are being run. Each individual living at Vineyards has a fire drill service objective program. The Program Supervisor will review the fire drill book each month to ensure all drills are run and documented.
5. Person Responsible: Program Manager, Program Supervisor, Direct Support Professionals, Clinical Director, QIPD  
Completion Date: 4/15/2016

**MM155**

Please see W189 as it relates to Facility Staffing.

**MM162**

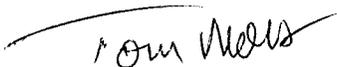
Please see W303 as it relates to Client Behavior and Facility Practices.

**MM166**

Please see W352, W356, W362, and W369 as it relates to Health Care Services.

**MM169**

Please see W440 as it relates to Physical Environment.



Tom Moss  
Clinical Director



Kristin Buchanan  
Program Manager