



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](mailto:fsb@dhw.idaho.gov)

March 16, 2016

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

RE: Preferred Community Homes - Bedford, Provider #13G039

Dear Ms. Buchanan:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Bedford, which was conducted on March 8, 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;

Kristin Buchanan, Administrator  
March 16, 2016  
Page 2 of 2

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 **March 29, 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 29, 2016. If a request for informal dispute resolution is received after March 29, 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,



KAREN MARSHALL  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

KM/pmt  
Enclosures

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

PRINTED: 03/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT 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 to 3/8/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD, Team Lead Trish O'Hara, RN  Common abbreviations used in this report are:  cm - centimeter CT - Computerized Tomography IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disability Professional	W 000			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a guardian was provided with comprehensive information necessary to make informed decisions for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in insufficient information being provided	W 124		<b>RECEIVED</b> <b>MAR 24 2016</b> <b>FACILITY STANDARDS</b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE **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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT 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 124	<p>Continued From page 1</p> <p>to a guardian on which to base consent decisions. The findings include:</p> <p>Individual #2's IPP, dated 3/19/15, documented a 41 year old female whose diagnoses included profound intellectual disability.</p> <p>Her record documented a CT scan was performed on 8/12/15 and revealed a 6 cm mass on her right breast and recommend a mammogram.</p> <p>A Nursing Progress Note, dated 8/24/15, documented the QIDP and LPN spoke with Individual #2's mother who agreed to an ultrasound and a biopsy if needed, but was opposed to a mammogram.</p> <p>An 8/27/15 Nursing Progress Note documented nursing was contacted by a local hospital's imagery department and informed that the radiologist would not perform an ultrasound unless a mammogram was also performed.</p> <p>Another Nursing Progress Note, dated 8/28/15, documented Individual #2's mother was to be informed of the situation.</p> <p>However, no further information related to informed consent of declining a mammogram could be found.</p> <p>When asked on 3/7/16 from 3:55 - 4:35 p.m., the QIDP stated she would address the informed consent with Individual #2's mother during her upcoming IPP meeting.</p> <p>The facility failed to ensure the guardian was fully informed of the benefits and risks of declining a</p>	W 124		

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

PRINTED: 03/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT 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 124	Continued From page 2	W 124			
W 334	mammogram for Individual #2. 483.460(c)(3)(i) 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 by a direct physical examination.  This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure quarterly health status reviews were conducted by direct physical examination for 1 of 3 individuals (Individuals #2) whose records were reviewed. This resulted in the potential for changes in health status to remain undetected and untreated without an actual physical examination. The findings include:  Individual #2's IPP, dated 3/19/15, documented a 41 year old female whose diagnoses included profound intellectual disability.  Her medical record documented a CT scan was performed on 8/12/15 revealing a 6 cm mass on her right breast and a mammogram was recommended.  A Nursing Quarterly Assessment, dated 9/15/15, did not address the presence of the breast mass. The area of the exam marked "BREAST" was left blank.  A Nursing Quarterly Assessment, dated 11/2/15, did not address the presence of the breast mass. The area of the exam marked "BREAST" was	W 334			

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

PRINTED: 03/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT 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 334	Continued From page 3 noted to be WNL (Within normal limits.)  In an interview on 3/8/16 at 3:15 p.m., the facility nurse confirmed the exam notes. She said the nurse who performed the exam was not aware of the breast mass.	W 334			
W 362	The facility did not provide nursing services needed by Individual #2. 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 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:  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.  During an interview on 3/7/16 from 3:55 - 4:35 p.m., the Clinical Director stated second quarter reviews had not been completed as they had just changed pharmacies at that time.	W 362			

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

PRINTED: 03/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT 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 362	Continued From page 4 The facility failed to ensure quarterly comprehensive pharmacy reviews were completed for Individuals #1 - #3.	W 362			
W 390	483.460(m)(2)(i) DRUG LABELING  The facility must remove from use outdated drugs.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all outdated drugs and biologicals were removed from use for 1 of 5 individuals (Individual #4) whose medications and biologicals were reviewed. This had the potential for an individual to receive an expired mouthwash. The findings include:  During an environmental review, on 3/1/16 from 12:00 - 12:40 p.m., one 16-ounce bottle of Peridex (a prescription strength mouthwash) with an expiration date of 1/19/16 was observed in the medication room cabinet. The prescription label contained Individual #4's name.  At that time, the Home Supervisor confirmed the mouthwash was expired, removed the expired mouthwash from the cabinet, and contacted the nursing staff.  The facility failed to ensure outdated/expired medications and biologicals were removed from use.	W 390			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/08/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT 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) COMPLETE DATE
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the state licensure survey conducted from 2/29/16 to 3/8/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD, Team Lead Trish O'Hara, RN	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 W124.	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 W334, W362, and W390.	MM166	<p><b>RECEIVED</b></p> <p><b>MAR 24 2016</b></p> <p><b>FACILITY STANDARDS</b></p>	

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



3/23/2016

Karen Marshall  
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 #13G039

Dear Karen Marshall:

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

**W124**

1. The IDT has scheduled a meeting with individual #2's guardian. During the meeting individual #2's guardian will be completely informed of the risk and benefits of her decision to decline a mammogram.
2. The Facility Nurse is currently reviewing the charts for each individual residing in the facility to assure that each guardian is informed of the risk and benefits of their choices as they relate to decisions.
3. A training has been scheduled for the Program Supervisor, QIDP and Facility Nurse at the facility. The training will focus on the importance of informing legal guardians of the risk and benefits of their choices as they relate to medical decisions.
4. Currently each individual residing in the facility is scheduled to have a internal review completed at least 2 times annually. The review form is being revised to include assuring that adequate documentation is on file that guardians have been informed of the risk and benefits of their medical decisions. Any identified discrepancies will be addressed with the IDT.
5. Person Responsible: Program Supervisor, QIDP & Facility Nurse
6. Completion Date: 4/30/15

**W331**

~~Please see responses given under W334, W362 & W390.~~

*Pen + ink change per Clinical Director  
3/28/16 @ 9:50 AM. — N. [Signature]*

**W334**

1. A revised nursing quarterly assessment has been completed for individual #2 which documents the presence of her breast mass.
2. The Facility Nurse is currently reviewing the charts for each individual residing in the facility to assure that each quarterly assessment is accurate.
3. The facility has recently contracted with an RN which is available at least one day per week. The RN is currently performing the nursing quarterly assessments.

4. Currently each individual residing in the facility is scheduled to have internal review completed at least 2 times annually. During the review process the nursing quarterly assessments are reviewed to assure they have been completed and are accurate. Any identified discrepancies will be addressed with the IDT.
5. Person Responsible: Program Supervisor, QIDP & Facility Nurse
6. Completion Date: 4/30/15
- 7.

**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 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

**W390**

1. Individual #4's expired mouthwash was removed from the facility on 3/1/16.
2. The Facility Nurse has gone through the medication cart and corresponding cabinets to assure and removed all identified expired medications from the cabinet.
3. A training has been scheduled for the Program Supervisors and Facility Nurses. The training will focus on the expectation that all expired medications (including mouthwash) will be immediately reported to the Facility Nurse or NOD so they can be removed from the facility.
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. One part of the observation will focus on assuring that all expired medications have been reported to the Facility Nurse or NOD so they can be removed from the facility.
5. Person Responsible: Facility Nurse & Program Supervisor
6. Completion Date: 4/30/16

**MM134**

Please see response given under W124 as it relates to Client Protections.

**MM166**

Please see response given under W334, W362 & W390 as it relates to Health Care Services.



Tom Moss  
Clinical Director



Kristin Buchanan  
Program Manager