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

CERTIFIED MAIL: 7012 3050 0001 2125 5853

March 21, 2016

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

RE: Preferred Community Homes - Cougar Creek, Provider #13G037

Dear Ms. Buchanant:

Based on the Medicaid/ Licensure survey completed at Preferred Community Homes - Cougar Creek on March 8, 2016, we have determined that Preferred Community Homes - Cougar Creek is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/ID) Conditions of Participation of **GOVERNING BODY AND MANAGEMENT (42 CFR 483.410), CLIENT PROTECTIONS (42 CFR 483.420), ACTIVE TREATMENT SERVICES (42 CFR 483.440) and CLIENT BEHAVIOR & FACILITY PRACTICES (42 CFR 483.450).** To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Preferred Community Homes - Cougar Creek to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/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.

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

Such corrections must be achieved and compliance verified by this office, before April 22, 2016. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than April 8, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 1, 2016**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Cougar Creek ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective March 8, 2016, through July 6, 2016. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **April 14, 2016**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT
Licensing and Certification Administration, DHW
PO Box 83720
Boise, ID 83720-0009
Phone: (208)334-6626
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 30, 2016**. If a request for informal dispute resolution is received after **March 30, 2016** the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,

Karen Marshall

KAREN MARHSALL
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures

April 6, 2016

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

RE: Cougar Creek, Provider #13G037

Dear Ms. Wisenor:

Aspire Human Services – Preferred Community Homes is requesting a formal extension to the full 90 days for the plan of correction for Cougar Creek.

We anticipate that the credible date will be within the first part of the extended 45 days.

Thank you for your time and consideration and if you have any further questions, please feel free to contact me at 208-972-5259.

Sincerely,

Shelly Brubaker

Shelly Brubaker
State Operations Manager

RECEIVED
APR 04 2016
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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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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: ABC - Antecedent Behavior Consequence ADLs - Activities of Daily Living BIP - Behavior Intervention Plan CFA - Comprehensive Functional Assessment DCS - Direct Care Staff h/o - history of H&P - History and Physical Examination Report HRC - Human Rights Committee IED - Intermittent Explosive Disorder IDT - Interdisciplinary Team IPP - Individual Program Plan LOS - Line of Sight LPN - Licensed Practice Nurse MARs - Medication Administration Records NOS - Not otherwise specified OCD - Obsessive Compulsive Disorder OT - Occupational Therapist/Therapy PCLP - Person Centered Lifestyle Plan Pt. - Patient PT - Physical Therapist/Therapy QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian SAM - Self-Administration of Medications SANE - Sexual Abuse Now Ended SI - Suicidal Ideation	W 000		

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

Jon Mills — Clinical Director — 4/4/16

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 000	Continued From page 1 SLP - Speech Language Pathologist WIC - Written Informed Consent	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, policy review, record review, staff interview and a review of the facility's compliance history and previous plans of correction, it was determined the facility failed to ensure the governing body provided sufficient oversight and direction over the facility. This resulted in the governing body's ability to identify and resolve systematic problems of a serious and recurrent nature being significantly impeded. The findings include: 1. Refer to W104 as it relates to the governing body's failure to ensure direction, monitoring and oversight was provided to the facility necessary to ensure policies were sufficiently developed, implemented and monitored and that compliance with regulatory requirements was achieved and sustained. The governing body was previously cited at W104 during a recertification survey dated 1/14/13 and a follow up survey dated 2/21/13. 2. Refer to W111 as it relates to the facility's failure to maintain a record keeping system that contained accurate information.	W 102		
W 104	483.410(a)(1) GOVERNING BODY	W 104		

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W 104	Continued From page 2 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility's governing body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. These failures directly impacted 6 of 6 individuals (Individuals #1 - #6) who had reside at the facility over the past year and resulted in a lack of protections being provided and a lack of adequate programming being implemented to meet individuals' active treatment and behavioral needs. The findings include: 1. The Governing Body failed to ensure the facility's Suicide Policy, revised 9/3/15, was sufficiently developed and implemented, as follows: a. The facility's Suicide Policy included a section titled "Procedures for Individual Suicide Guidelines." The section stated a team meeting was to be held and suicide guidelines would be implemented "...for any individual with a history of suicidal ideation." Individual #4's 3/24/15 PCLP stated he was a 45 year old male. His diagnoses included mild intellectual disability and Bi-polar I Disorder. A QIDP note documented the QIDP and Individual #4's guardian had a meeting on 2/4/15 from 11:00 a.m. to 12:00 p.m., prior to Individual	W 104		

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W 104	Continued From page 3 #4's admission to the facility on 2/25/15. The note documented Individual #4 had been receiving services in a residential habilitation program and had lost "a lot of skills." The note documented he was refusing to shower, isolating in his room, did not want to change his clothes, was very unmotivated, he did not want to leave his apartment, and he could not remember things. The note also documented he was refusing to eat and drink regularly, which had resulted in hospitalization. Individual #4's record included a corresponding report from the hospital, dated 7/30/14, which stated he had experienced lithium toxicity which was "likely caused by renal failure." When asked about Individual #4's admission, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4's mental health was unstable and the guardian was worried he might die if he stayed in his current placement. He had not been eating or drinking. When asked if Individual #4's failure to eat and drink was symptomatic of his depression or if he was actively suicidal, the QIDP stated she did not know. b. The facility's Suicide Policy stated for any individual with a history of suicidal ideation, "A QIDP will be responsible for conducting the team meeting and writing the guidelines using input from the team, as well as, assist in providing training for all staff with regard to the specific individual's suicide guidelines..." The facility's records included an incident report, dated 6/3/15, which stated Individual #4 had made a suicidal threat. An investigation into the incident was attached to the incident report.	W 104		

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W 104	Continued From page 4 Individual #4's record documented an objective was developed and an intervention plan was implemented specific to Individual #4's suicidal ideation, on 6/8/15. However, a comprehensive assessment of Individual #4's suicidal ideation, necessary to design appropriate intervention strategies, could not be found. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed and assessment had not been completed prior to the implementation of the programs. She also stated she had not completed an assessment for Individual #4's suicidal threats as it had only happened once so there was nothing to assess. However, the 6/3/15 investigation documentation and Individual #4's pre-admission documentation included current and historical information related to Individual #4's depressive symptoms, which included potential physically harmful behaviors such as suicide threats and attempts, eloping from the facility, drinking excessive amounts of water to self-induce vomiting, and refusing to eat, which had previously resulted in renal failure and hospitalization. The facility failed to comprehensively assess Individual #4's mental health needs prior to the implementation of the 6/8/15 intervention as follows: i. The investigation included the QIDP's written statement on an ABC sheet. The ABC sheet documented Individual #4 mowed the facility's lawn but refused to go back to work. At lunch he sat at the table for a much longer period of time than normal and stated he did not want to live at the facility anymore. The QIDP asked Individual #4 to come to her office to talk about what was happening and why he didn't finish work. The	W 104		

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W 104	Continued From page 5 QIDP documented Individual #4 stated "he hates living here, hates all of the staff and clients. He said he doesn't have any friends and wants to get a knife and stab himself. He stated he wants to die. He continued to state how much he hates it here, hates all the staff and me...I asked him if he really wanted to die and he said 'yes I want to get a knife and stab myself.' I let him know that I would be putting him on suicide watch and let his guardian know. [Individual #4] stood up, gave me a side hug and asked me to help him." A corresponding Suicide Risk Assessment was completed at 1:35 p.m. and stated "[Individual #4] is new to staff at Cougar Creek. He moved in on 2/25/15. He was struggling with depression in January. This is the first time he has made a suicide threat since his admission..." Attached to the investigation were staff statements dated 6/3/15, which included, but were not limited to, the following: - A staff wrote "[Individual #4] did not want to go to work today said [sic] he didn't feel good." - A staff wrote "[Individual #4] did not say any threatening remarks to me directly but throughout the day he did not act the same as usual. [Individual #4] did not want to shower like normal and after working half the day on work crew decided to stay back because he did not want to work at the next house. [Individual #4] was also quieter than normal and seemed less interested in what was going on around him." - A staff wrote "he has been acting weird in the last two weeks...more tierd [sic] or afraid to speak and I don't know whats [sic] triggering this."	W 104		

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W 104	Continued From page 6 No additional information was reviewed or garnered from staff related to the behaviors Individual #4 had displayed in order to assess and identify antecedent or triggering events prior to his suicidal threat. Additionally, no review or assessment of Individual #4's pre-admission information was completed in order to determine if his historical symptoms were consistent with his current symptoms. Further, no additional assessment information was present related to the implementation and efficacy of prior or current intervention strategies to address Individual #4's mental health needs prior to the implementation of the 6/8/15 intervention plan. ii. Attached to the investigation was a typed information sheet from the QIDP, dated 6/3/15, which stated Individual #4 was to be on suicide watch and remain under line of sight supervision at all times. The note stated staff did not need to sit inside his room but needed to see him while he was in bed and staff needed to maintain line of sight supervision when Individual #4 was in the bathroom. The note stated due to Individual #4 wanting to use a knife, he was to be restricted from the kitchen and all knives were to be removed from the house and placed in the garage. The QIDP note also stated Individual #4's guardian had been contacted. The guardian reported Individual #4 would try to drink excessively to make himself throw up. Drinking was to be restricted to 2-3 small cups at a time with a 30 minute wait until he could have more to drink. The note stated interactions were to be limited	W 104		

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W 104	Continued From page 7 and in the past Individual #4 had tried to talk about his parents, who were deceased, worrying about them. The note instructed staff to acknowledge Individual #4 with "I understand" and then stop interacting with him. The note also stated the guardian reported Individual #4 "has not acted upon any of his threats but this does not mean that he might not, If [Individual #4] attempts to hurt himself, block and redirect him. [Individual #4] does respond in the past and has stopped. The biggest concern for [guardian's name] is that he will drink excessively to make himself throw up and not eat. If this happens, do not react, have [Individual #4] clean up his mess. If he does not want to eat, it is OK [sic] at this time and I will continue to monitor this." No additional information was garnered, reviewed and assessed prior to the implementation of the 6/8/15 intervention plan (e.g. pre-admission information related to past major depressive episodes, Individual #4's previous binging and purging and assessment of the efficacy of intervention strategies implemented prior to his admission, prior statements regarding his parents, the frequency of suicidal threats which had been made prior to his admission, additional information regarding the types of treats made, the frequency of episodes in which Individual #4 had attempted to hurt himself requiring staff intervention, etc.). iii. The investigation documented a follow up suicide risk assessment was conducted the following day, on 6/4/15 at 12:45 p.m. The assessment documented he was "not back to baseline. He did not sleep last night which is very	W 104		

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W 104	Continued From page 8 unusual for him. He is not tired and appears to be nervous and fidgeting with his face..." The assessment documented he was to remain on suicide watch. Another suicide risk assessment was conducted on 6/5/15 at 3:45 p.m. The assessment documented Individual #4 had "not slept for the last 3 days. He continues to be very fidgety and told me he is not tired. He also stated that he 'doesn't feel right inside.' I took him to Primary Health to rule out medical..." The note documented Individual #4's psychiatric practitioner was contacted and increased his Risperdal (an antipsychotic drug), which had been decreased on 5/8/15 to .5 mg twice a day, back to 1 mg twice a day. The assessment documented if the medication reduction was what caused the unstable mental health, then he would be better in a couple of days. The assessment stated Individual #4 was to remain on suicide watch through the weekend and be re-assessed on Monday. No additional information was garnered from staff, reviewed or assessed prior to the implementation of the 6/8/15 intervention plan (e.g. previous sleep data correlations with an escalation of symptoms, if episodes of being "fidgety" had been previously observed, or if being fidgety was a new manifestation caused by sleep deprivation, if fidgeting was symptomatic of major depressive episodes, if fidgeting was indicative for his suicidal ideology, etc.). iv. A hand-written note by the QIDP, dated 6/4/15, stated "Due to history of trying to run away through his bedroom window, Graveyards please sit in his room by the window..."	W 104		

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W 104	Continued From page 9 When asked about the note, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had attempted to elope from the facility since his admission. The QIDP stated he had taken the screen to his bedroom window off. The Clinical Director, who was also present during the interview, stated Individual #4 would attempt to elope because he wanted to go see his parents, who were deceased and their grave sites were in another town. However, no additional information was garnered or assessed prior to the implementation of the 6/8/15 intervention plan (e.g. review of previous information related to how talking about his parents was indicative of his mental health status, a review of data to determine how many times Individual #4 had attempted to elope and if the incidents were all predicated by him talking about his parents, a review of data to assess how frequently Individual #4 had been talking about his parents, if the QIDP's instruction to limit interactions and acknowledge Individual #4's statements with "I understand," were being implemented consistently and what the efficacy of the intervention was, if elopements and attempted elopements were pre-indicators or associated with Individual #4's suicidal ideation, etc.). v. Staff notes, dated 6/5/15, were attached to the investigation. The notes documented Individual #4 seemed confused when deciding what to wear and changed his mind several times. Staff also documented his energy was extremely low and when doing familiar tasks he required direction in tasks such as dressing, showering, and picking out his clothes.	W 104		

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W 104	Continued From page 10 Another staff documented, on 6/5/15, that Individual #4 wanted to keep sleeping and went back to bed after taking his medications and eating breakfast. The note documented his hands and legs were fidgety and he was checking around the room to see if people were still watching. Staff documented they prompted him to watch a movie and sit outside. Other documented interventions included opening a window and "Turned Happy light on." No additional information was garnered from staff, reviewed or assessed prior to the implementation of the 6/8/15 intervention plan (e.g. what impacts line of sight supervision was having on his depressive symptoms, was his low energy and confusion related to his depressive symptoms, sleep deprivation or both, was staff prompting negatively impacting his symptoms, how long did staff allow Individual #4 to sleep during the day and did it result in a decrease in symptoms or impact his ability to sleep at night, were the interventions staff documented, such as the "happy light" appropriate, was the light left on for an appropriate amount of time, was the intervention attempted by other staff, what was the results of the interventions, did staff implement other interventions which were not documented and what was Individual #4's response, etc.). vi. Another suicide risk assessment was conducted on 6/6/15 at 11:50 (a.m. or p.m. not indicated). The assessment stated his fidgeting had decreased and his physical mannerisms had returned to normal. The assessment stated Individual #4 was smiling and laughing and talking to staff.	W 104		

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	13G037		03/08/2016

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W 104	Continued From page 11 A hand-written note by the Program Supervisor, dated 6/6/15, stated "After a follow up assessment, [QIDP's name] has determined that [Individual #4] can be moved off of line of sight & 1:1 at all times to 15 min checks when sleeping. Staffing can go back to normal. Staff has to remember to not only check on [Individual #4] physically but mentally & emotionally inquire how he is doing. Please call [QIDP's name] if there are any changes or questions. [Individual #4] has slept soundly the last 2 nights, has begun joining in socializing, however, he is still somewhat anxious through out [sic] the day." A suicide risk assessment, dated 6/8/15 at 6:00 a.m., was completed by the QIDP. The QIDP documented "After talking with [Individual #4] on the phone and with the information provided by the Program Supervisor, I took [Individual #4] off suicide watch but requested he continue to be line of sight until he was asleep then staff could do 15 minutes checks. [Individual #4] told me that he felt better with the increase of his Risperdal on Friday. He was sleeping, eating and socializing..." The form documented suicide precautions were discontinued on 6/7/15 at 11:45 a.m. The investigation was not consistent or clear in documenting when Individual #4's suicide precautions were discontinued (on 6/6/15 or 6/7/15). The facility's records included another incident report dated 6/7/15 which documented Individual #4 had eloped from the facility at 8:00 p.m. The investigation summary stated Individual #4 had taken his medications and went to his room at approximately 7:45 p.m. When staff went to check on him, he was not found. He was located at approximately 9:00 p.m. at a local gas station.	W 104		

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W 104	Continued From page 12 An investigation summary, dated 6/8/15 into the incident, completed by the Clinical Director stated "I talked to [Individual #4] when he arrived back at the home. [Individual #4] stated that he was feeling bad and that the [sic] wanted to go to [name of town] to see his parents gravesite [sic]..." Further, his 6/9/15 Medication Management Progress Note documented Individual #4 "reports he is 'not good.' He states 'I'm mad at life.' He doesn't like his living situation. He eloped last Sunday with the plan to go to [town that his parents' grave sites were at]. He attempted to leave again last night. He is now on LOS. Staff report that he had been doing well, but last Wednesday his mood changed abruptly. He has not been interested in doing anything, does not want to come out of his room to eat, has seemed more anxious and restless, and his sleep has been erratic. He has not slept the past two nights, but had slept well the two nights prior to that. He has not been working at his lawn mowing job or going for walk [sic] with staff. He denied SI, but was on 'suicide watch' last week." The note documented Individual #4's Mirtazapine (an antidepressant drug) would be increased from 30 mg to 45 mg each evening and Ativan (an anxiolytic drug) 1 mg was to be given each evening to assist Individual #4 with his sleep. However, no additional information was garnered, reviewed or assessed in order to address Individual #4's continued mental health symptoms (e.g. anxiousness, impacts of line of sight supervision, etc.) or how much sleep he required before sleeping was considered too little or excessive and indicative of mental instability.	W 104		

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W 104	Continued From page 13 Further no additional information was garnered, reviewed or assessed related to his elopement behavior behavior (e.g. review of previous information to determine how many times Individual #4 had attempted to elope and if the current elopement and attempted elopement had been predicated by Individual #4 talking about his parents, if elopements and attempts to elope were associated with his suicidal ideation, etc.). When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., if Individual #4's sleep had been assessed to determine what was adequate but not excessive or too little, the QIDP stated it had not been assessed. When asked if Individual #4's elopement behavior had been assessed, the QIDP stated it had not. The facility failed to comprehensively assess Individual #4's depressive symptoms, including the potential physically harmful behaviors of suicide, eloping from the facility, and drinking excessive amounts of water to self-induce vomiting and refusing to eat. The lack of comprehensive assessment resulted in the IDT's inability to design and implement intervention strategies necessary to minimize Individual #4's potential to engage in physical self-harm as a result of mental instability. c. The facility's Suicide Policy also included "Guidelines for individual's with History of Suicide Ideation" which stated individualized suicide guidelines were to include the following: "Information for staff members explaining the individual's history in regards to suicide attempts or threats...This would be information such as the frequency of attempts, items historically used for	W 104		

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W 104	Continued From page 14 suicide attempts...the types of threats the individual historically makes when threatening suicide. Included would be examples of suicidal ideation that the individual participated in historically." Individual #4's 6/8/15 Suicide Ideation program, revised 7/31/15 and 9/1/15, did not include comprehensive historical information. Further, the plan's instructions to staff stated if Individual #4 made a suicidal statement, staff were to "Follow suicide policy/guidelines. [Individual #4] will become line of sight while he is on suicide watch instead of arm's length." Comprehensive individualized information based on Individual #4's specific identified needs was not included in the plan. The plan did not include information garnered from the 6/8/15 incident (e.g.what behaviors Individual #4 had been demonstrating prior to the suicidal threat as reported by staff and the QIDP, implementation of restrictive interventions such as knife removal, not being allowed in the kitchen, water restrictions, staff being instructed to sit by his window to prevent elopement, not engaging in conversations about Individual #4's parents, etc.). Further, no additional information was garnered from the guardian based on the guardian's report that Individual #4 "has not acted upon any of his threats but this does not mean that he might not. If [Individual #4] attempts to hurt himself, block and redirect him. [Individual #4] does respond in the past and has stopped..." The facility failed to ensure Individual #4's suicidal guidelines contained comprehensive information, per facility policy.	W 104		

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W 104	Continued From page 15 d. Criteria for Individual #4's suicidal ideation objective was set at 0 incident of suicidal ideation for 6 consecutive months. Individual #4's record did not include information regarding how the criteria was established without a comprehensive assessment of his past suicidal ideology. Additionally, Individual #4's QIDP notes for January 2016 stated Individual #4 had met criteria on his suicidal ideation objective, therefore the objective would no longer be tracked. A corresponding hand-written note on Individual #4's 9/1/15 suicidal ideation plan stated "completed 2/8/16." When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed Individual #4's suicidal ideation plan had been discontinued. However, the facility's Suicide Policy did not include information related to when or if an individual's suicidal guidelines could be discontinued. The facility failed to ensure the facility's suicide policy was sufficiently developed and implemented. 2. Refer to W111 as it relates to the governing body's failure to ensure individuals' records contained complete, accurate information. 3. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they relate to the governing body's failure to ensure individual needs were not neglected and individual rights were upheld. a. Refer to W149 as it relates to the governing	W 104		

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W 104	Continued From page 16 body's failure to ensure policies and procedures related to the prevention and detection of abuse, neglect and mistreatment were adequately developed, implemented and monitored. b. Refer to W154 as it relates to the governing body's failure to ensure thorough investigations were conducted for all allegations of abuse, neglect and mistreatment. The facility was previously cited at W154 during a recertification survey dated 1/14/13. 4. Refer to W159 as it relates to the governing body's failure to ensure the QIDP provided coordination, monitoring and oversight of individuals' active treatment services necessary to ensure their identified needs were comprehensively addressed. The facility was previously cited at W159 during a recertification survey dated 1/14/13, a follow up survey dated 2/21/13, and a recertification survey dated 12/20/13. 5. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the governing body's failure to ensure individuals received comprehensive active treatment services based on their assessed needs. a. The facility was previously cited at W214 during an annual recertification survey dated 1/14/13, follow up surveys dated 2/21/13 and 4/4/13, an annual recertification survey dated 1/30/15 and a complaint survey dated 6/22/15. The facility submitted a plan of correction in response to the 6/22/15 complaint survey. The plan, signed by the Administrator on 7/14/15,	W 104		

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W 104	Continued From page 17 stated "All of the behavior assessments in the home are being reviewed and revised as necessary to include comprehensive information." The plan further stated the facility "is currently performing peer reviews. One element of the peer reviews is verifying that all behavior assessments are comprehensive." The plan's correction date was 8/15/15. However, the plan was not sufficiently implemented necessary to achieve and sustain compliance. Refer to W214 as it relates to the facility's failure to ensure individuals' behavior assessments included comprehensive information. b. Refer to W227 as it relates to the governing body's failure to ensure specific objectives were developed and implemented based on individuals' identified needs. The facility was previously cited at W227 during a recertification survey dated 1/14/13. c. Refer to W239 as it relates to the governing body's failure to ensure appropriate and functional replacement behaviors were developed. The facility was previously cited at W239 during an annual recertification survey dated 1/14/13 and a follow up survey dated 2/21/13. d. Refer to W252 as it relates to the governing body's failure to ensure data was collected in the form and frequency specified in individuals' plans. The facility was previously cited at W252 during an annual recertification survey dated 1/14/13. e. Refer to W206, W210, W214, W227, W234, W239, W249, W255, W258 W259, and W260 as they relate to the governing body's failure to ensure active treatment policies were	W 104		

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	13G037		03/08/2016

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W 104	Continued From page 18 implemented. 6. Refer to W266 Condition of Participation: Client Behavior and Facility Practices and associated standard level deficiencies as they relate to the governing body's failure to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. The facility was previously cited at W266 during a recertification survey dated 1/14/13 and a follow up survey dated 2/21/13. a. Refer to W278 as it relates to the facility's failure to ensure less restrictive interventions were tried and found to be ineffective prior to implementing restrictive interventions. The facility was previously cited at W278 during an annual recertification survey dated 1/14/13 and a follow up survey dated 2/21/13. b. Refer to W289 as it relates to the facility's failure to ensure interventions to manage individuals' inappropriate behavior were accurate, consistent and comprehensive. The facility was previously cited at W289 during an annual recertification survey dated 1/14/13, a follow up survey dated 2/21/13, and a recertification survey dated 1/30/15. c. Refer to W312 as it relates to the facility's failure to ensure individuals' medications to control maladaptive behavior were appropriately incorporated into a plan. The facility was previously cited at W312 during an annual recertification survey dated 1/14/13. d. Refer to W278, W289, W311, W312, W315, and W317 as they relate to the governing body's	W 104		

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	13G037		03/08/2016

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W 104	Continued From page 19 failure to ensure behavior management policies were implemented. The governing body failed to provide sufficient operating direction over the facility necessary to ensure regulatory compliance was achieved and sustained and that individuals' needs were met. The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet the individuals' health, safety, active treatment and behavioral needs.	W 104		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate information for 3 of 4 individuals (Individuals #1, #2, and #4) whose records were reviewed. This resulted in a lack of clear information being available regarding the individuals' experiences at the facility. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. He was admitted to the facility on 2/25/15. Individual #4's record did not include comprehensive, accurate information. Examples included, but were not limited to, the following:	W 111		

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	13G037		03/08/2016

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W 111	Continued From page 20 - His Medication Management Progress Notes, dated 7/8/15 through 2/10/16, all documented his intellectual disability as moderate. - His PCLP, dated 3/24/15, documented the nurse practitioner was his physician. - His Nutrition Assessment, dated 2/27/15, documented a 5/2/03 admission date. - His Social Service evaluation, dated 3/24/15 and revised on "1/28/15 [sic]" documented a 2/18/15 admission date and stated that he currently lived at Cougar Creek and would like to move back to Cougar Creek on 2/18/15. During an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director said the admission dates may have been an oversight and information regarding where he lived was a typo. 2. Individual #2's 5/26/15 IPP stated he was a 24 year old male whose diagnoses included moderate mental retardation. Individual #2's December 2015 Nursing Summary documented on 12/1/15 staff reported Individual #2 hit himself in the head several times during a behavior. The facility's Incident/Accident reports, dated 1/31/15 through 2/28/16, were reviewed and did not include an incident of Individual #2 hitting himself in the head several times. The Incident/Accident reports did include a 12/1/15 incident where another individual hit Individual #2 with a cup, which resulted in a scratch to the left side of Individual #2's head and neuro checks	W 111		

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W 111	Continued From page 21 were completed. When interviewed on 3/3/16 at 9:27 a.m., the LPN said the entry made on the December 2015 Nursing Summary was probably based on a call from staff and the neuro checklist that was initiated and completed on 12/1/15. 3. Individual #1's 2/16/16 IPP stated he was a 29 year old male whose diagnoses included mild intellectual disability. His BIP, dated 2/23/16, stated Individual #1 had eloped several times during the previous month and "had to be restrained in the parking lot due to being in imminent danger of getting hit by a car." The facility's Incident/Accident reports, dated 1/31/15 through 2/28/16, were reviewed and showed an elopement had occurred on 2/7/16. However, a statement by the staff involved in restraining Individual #1 said the restraint occurred inside a fast food restaurant rather than in a parking lot. The facility failed to maintain a record keeping system that contained accurate information.	W 111		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, policy review, record review, review of Incident/Accident Reports, and staff interview, it was determined the facility failed	W 122		

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W 122	Continued From page 22 to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented for 6 of 6 individuals (Individuals #1 - #6) who had resided at the facility within the past year. This failure resulted in a lack protections being in place to ensure individuals' rights were upheld and that their needs were not neglected. The findings include: 1. Refer to W123 as it relates to the facility's failure to ensure that prior to an individual's admission, each legal guardian was informed of the rules of the facility. 2. Refer to W125 as it relates to the facility's failure to ensure each individuals' rights were protected and promoted. 3. Refer to W128 as it relates to the facility's failure to ensure individuals were not subjected to drug use without appropriate justification. 4. Refer to W129 as it relates to the facility's failure to ensure each individual was provided with personal privacy. 5. Refer to W130 as it relates to the facility's failure to ensure each individual was provided with privacy during care of personal needs. 6. Refer to W144 as it relates to the facility's failure to ensure guardian communications were answered in a timely fashion. 7. Refer to W149 as it relates to the facility's failure to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently developed,	W 122		

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	13G037		03/08/2016

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W 122	Continued From page 23 implemented and monitored. 8. Refer to W154 as it relates to the facility's failure to ensure thorough investigations were conducted. 9. Refer to W155 as it relates to the facility's failure to ensure individuals were protected from potential abuse, neglect, and mistreatment while investigations were in process. 10. Refer to W157 as it relates to the facility's failure to ensure appropriate corrective action was taken in response to all investigations. The cumulative effect of these deficient practices resulted in individuals' rights being violated.	W 122		
W 123	483.420(a)(1) 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 rights and the rules of the facility. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure that prior to an individual's admission, the legal guardian was informed of the rules of the facility. This failure impacted 1 of 1 individual (Individual #4) admitted to the facility within the past year and resulted in the potential for an individual's rights to be infringed upon without due process. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a	W 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 123	Continued From page 24 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. He was admitted to the facility on 2/25/15. During observations conducted at the facility on 2/29/16 and 3/1/16, video cameras were observed in the dining room, living room, and hallway areas. Individual #4's record was reviewed and included a WIC, signed by Individual #4's guardian on 3/27/15, which documented the guardian did not give consent for the video cameras in the facility. However, Individual #4's record did not include documentation that the guardian had been informed of the camera use prior to Individual #4's admission, on 2/25/15. When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the Clinical Director stated guardians were typically informed of the camera use prior to admission. The QIDP, who was present during the interview, stated she had missed informing the guardian about the camera use during the admission process and the guardian had not been asked his opinion about the use of the video cameras prior to Individual #4 being admitted to the facility. The facility failed to ensure Individual #4's guardian was informed of the video camera use prior to Individual #4's admission to the facility.	W 123		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 125	Continued From page 25 of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' rights were promoted for 1 of 4 individuals (Individual #4) whose consents were reviewed. This resulted in a lack of information being available and a lack of due process being provided to an individual and his guardian. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. He was admitted to the facility on 2/25/15. a. Individual #4's 3/19/15 H&P included a recommendation for staff follow up with Individual #4's legal guardian to determine if he had a living will. However, his Social Service evaluation, dated 3/24/15 and revised on "1/28/15 [sic]," did not include information related to a living will. b. During observations conducted at the facility on 2/29/16 and 3/1/16, video cameras were observed in the dining room, living room, and hallway areas. Individual #4's record was reviewed and contained a WIC, signed by Individual #4's legal guardian on 3/27/15, which documented the guardian did not give consent for the video cameras in the facility. Attached to the WIC was an e-mail from the	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 125	Continued From page 26 guardian, dated 4/4/15. In the email, the legal guardian outlined several concerns with the WIC as well as basic rights issues of video cameras in the facility. Also attached to the WIC was a letter from the facility to the guardian, dated 2/17/16, which stated the facility maintained the right to continue to use the surveillance cameras in the event a parent/legal guardian did not give consent for the cameras. However, there was no corresponding documentation to the several concerns outlined by the guardian in the 4/4/15 e-mail. When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the Clinical Director confirmed the guardian's concerns had not been addressed. The facility failed to ensure Individual #4's guardian's right to due process was upheld.	W 125		
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. 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 not subjected to drug use without appropriate justification for 1 of 3 individuals (Individual #4) whose restrictive interventions were reviewed. This resulted in the potential for	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 128	Continued From page 27 an individual to be subjected to unnecessary drugs. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's records documented he had experienced multiple medications changes related to his diagnosis of Bi-polar I Disorder, as follows: - His psychiatric Medication Management Progress Note, dated 7/8/15, stated start Latuda (an anti-psychotic drug) 40 mg 1/2 qd [every day] x 1 week then 1/2-1 qd [every day]. Decrease Risperdal (an antipsychotic drug) 1 mg qhs x 1 week then d/c [discontinue]." - His psychiatric Medication Management Progress Note, dated 9/24/15, stated he was to receive Latuda 40 mg tablet 1 tablet by mouth once a day with meals and Ativan (an anxiolytic drug) was to be tapered and then discontinued. - His psychiatric Medication Management Progress Note, dated 10/13/15, stated "Increase Latuda to 60 mg qd. In two weeks, if mood not improved, increase to 80 mg qd." However, Individual #4's record did not include documentation of assessment or analysis of his Bi-polar I Disorder symptoms or other information related to an assessment of the medication use (e.g. documentation of desired effect and adverse consequences) in an effort to determine whether drug changes were warranted. When asked about the medication changes,	W 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 128	Continued From page 28 during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated she attend the meetings with the psychiatric practitioner and the guardian. She stated the psychiatric practitioner and the guardian made medication changes that the other members of the IDT did not always agree with. She stated at each meeting she presented data, but did not feel like it was taken into consideration. Individual #4's Depressive Symptoms plan, initiated on 6/8/15 and subsequently revised on 7/31/15, 9/1/15 and 2/16/16, was reviewed. The plan included depressive type symptoms and associated behaviors. However, the plan's definitions were not sufficiently developed to include observable behavior or to allow Individual #4 to express normal, appropriate human emotions. Examples included, but were not limited to, the following: - Symptom: "Irritable mood." Behavior: "Being agitated, angry. "No additional information related to observable behavior was included and no information related to Individual #4 becoming irritated and angry as a normal, appropriate human emotion was present. - Symptom: "Diminished interest in activities." Behavior: "Refusing to leave the house to participate in a community activity." The plan did not include information such as how many refusals were required to be considered symptomatic of his depression, if refusals to participate in known non-preferred activities were included in the definition, etc. - Symptom: "Change in sleep pattern." Behavior: "Not sleeping through the night or sleeping during	W 128		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 128	Continued From page 29 the day time (waking hours 7:30 AM - 8:30 PM)." The time frame given was equal to 11 hours of sleep. However, the status section of the plan gave his historical sleep average as 10 hours a night. The Depressive Symptoms plan did not include symptom criteria which was based on Individual #4's sleeping pattern history, or allow for any variation (e.g. sleeping 8 - 11 hours a night) depending on other factors such as the events of his day, prior night's ability to sleep, etc). - Symptom: "Fatigue or loss of energy." Behavior: "Having no energy to do an activity/task, being tired." The plan did not included information related to how Individual #4 was to be evaluated to determine normal amounts of fatigue (e.g. after increased amounts of physical exertion, when his was not feeling well, after a night in which he did not sleep well, etc.). - Symptom: "Laying on bed-isolating at odd times." Behavior: "During waking hours 7:30 AM - 8:30 PM." The plan did not include information related to when it was reasonable and appropriate for Individual #4 to be in his bedroom in private (e.g. separating himself from housemates who were being loud or creating an otherwise chaotic environment, separating himself to his bedroom when he was angry rather than assaulting others, etc.). Without appropriate data collection, it would not be possible for the IDT to make fully informed decisions regarding Individual #4's medication use. The facility failed to ensure appropriate data was collected, analyze and discussed by the IDT necessary to ensure Individual #4 was not	W 128		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 128	Continued From page 30 subjected to unnecessary drugs.	W 128		
W 129	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure personal privacy was not restricted without due process for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in an individual's right to privacy being violated. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. The facility's records included a 10/27/15 investigation report which documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet, dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the	W 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 129	Continued From page 31 bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. However, Individual #4's Functional Behavioral Assessment did not include information regarding sexual misconduct. Without such an assessment it would not be possible for the IDT, the guardian, and the HRC to comprehensively evaluate the need for the restrictive intervention, or ensure less restrictive alternates (e.g. implementing training programs to teach Individual #4 to respect the privacy of others, or programs to teach Individual #1 and others to protect their privacy by shutting the bathroom door) would not be effective. When asked during an interview on 3/7/16 from 2:05 to 4:35 p.m., the Clinical Director stated an assessment of Individual #4's alleged sexual misconduct had not been completed. The facility failed to ensure Individual #4's right to privacy was not restricted without due process. Further, interviews were conducted with 4 facility staff, on 3/1/16 from 11:05 - 11:15 a.m., regarding Individual #4's Line of Sight Guidelines. - One staff stated Individual #4 was to be in line of sight and staff were to be able to see him from head to toe at all times. When he wanted private time, staff were to stand by his closed bedroom door to make sure he did not leave his room.	W 129		

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	13G037		03/08/2016

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W 129	Continued From page 32 - Another staff stated if Individual #4 requested private time, the staff were to leave the door to his room open enough to see his arm or shoulder. - Another staff stated when Individual #4 wanted private time, the door to his bedroom was to be open so that part of his body was visible. - Another staff stated when Individual #4 wanted private time, staff were to sit in the hallway and leave the bedroom door open to be able to see part of his body. The facility failed to ensure the line of sight guidelines were consistently implemented necessary to ensure Individual #4's right to privacy was allowed to the maximum extent possible.	W 129		
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 record review and staff interview, it was determined the facility failed to ensure personal privacy during the care of personal needs was not restricted without due process for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in an individual's right to privacy during personal care tasks being violated. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 130	Continued From page 33 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. The facility's records included a 10/27/15 investigation report which documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet, dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. However, Individual #4's Functional Behavioral Assessment did not include information regarding sexual misconduct. Without such an assessment it would not be possible for the IDT, the guardian, and the HRC to comprehensively evaluate the need for the restrictive intervention or ensure less restrictive alternates (e.g. implementing training programs to teach Individual #4 to respect the privacy of others, or programs to teach Individual #1 and others to protect their privacy by shutting the bathroom door) would not be effective.	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 130	Continued From page 34 When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the Clinical Director stated an assessment of Individual #4's alleged sexual misconduct had not been completed. The facility failure to ensure Individual #4's right to privacy was not restricted without due process. Additionally, Individual #4's formal showering program stated he would wash his hair while showering with a non-specific verbal prompt. His individual support plan, dated 6/2/15, stated staff were to provide as much privacy as possible but remain in the area to ensure he washed all his body parts and hair. The plan did not include information related to how staff were to implement Individual #4's showering program and provide line of sight supervision. Further, Interviews were conducted with 4 facility staff on 3/1/16 from 11:05 - 11:15 a.m. regarding Individual #4's Line of Sight Guidelines. - One staff stated Individual #4 was to be in line of sight at all times and staff were to be able to see him from head to toe at all times. When he was in the shower or the bathroom, the door to the bathroom was to be open to make sure he did not leave the bathroom through the other bathroom door. - Another staff stated when Individual #4 was in the shower or bathroom, the bathroom door was to be open to make sure he was in the bathroom. When he was in the shower, the shower curtain would be opened in the shape of a window to ensure he was in the shower. - Another staff stated when Individual #4 was in	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 35 the bathroom, the door would be open so that Individual #4 could be visualized in the mirror. When he was in the shower, staff were to keep the bathroom door partially open. - Another staff stated when Individual #4 was in the bathroom, the door was to be open. When he was in the shower, the shower curtain would be opened in the shape of a window to ensure he was in the shower. The facility failed to ensure the line of sight guidelines were consistently implemented necessary to ensure Individual #4's right to privacy was allowed to the maximum extent possible.	W 130		
W 144	483.420(c)(2) COMMUNICATION WITH CLIENTS, PARENTS & The facility must answer communications from clients' families and friends promptly and appropriately. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure guardian communications were answered in a timely fashion for 1 of 4 individuals (Individual #4) whose WICs were reviewed. This resulted in the individual's guardian's concerns not being promptly addressed. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. He was admitted to the facility on 2/25/15.	W 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 144	Continued From page 36 During observations conducted at the facility on 2/29/16 and 3/1/16, video cameras were observed in the dining room, living room, and hallway areas. Individual #4's record was reviewed and included a WIC signed by Individual #4's legal guardian on 3/27/15 which documented the guardian did not give consent for the video cameras in the facility. Attached to the WIC was an e-mail from the guardian, dated 4/4/15. In the email, the legal guardian outlined several concerns with the WIC as well as basic rights issues of video cameras in the facility. Also attached to the WIC was a letter from the facility to the guardian, dated 2/17/16, which stated the facility maintained the right to continue to use the surveillance cameras in the event a parent/legal guardian did not give consent for the cameras. However, there was no corresponding documentation to the several concerns outlined by the guardian in the 4/4/15 e-mail. When asked during an interview on 3/7/16 from 2:00 - 4:35 p.m., the Clinical Director confirmed the guardian's concerns had not been addressed. The facility failed to promptly answer communications from Individual #4's legal guardian.	W 144		
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.	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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 149	Continued From page 37 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 developed, implemented and monitored for 6 of 6 individuals (Individuals #1 - #6) who had resided at the facility in the past year. This failure resulted in a lack of protection being provided to individuals. 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 anywhere [sic] or at any time." The policy was not sufficiently developed, implemented and monitored, as follows: 1. The facility's policy included multiple terms and definitions, which included financial exploitation. However, the policy did not include a definition of mistreatment or other types of exploitation, such as physical, sexual or criminal exploitation. When asked about the policy, on 3/4/16 at 11:30 a.m., the Clinical Director confirmed the other types of exploitation were not included in the policy. 2. The facility's Incident and Accident Reporting, policy revised 10/1/15, stated an Incident/Accident Report was to be completed for elopement, defined as "Any time an individual leaves the facility property in an attempt to run away or abscond from the facility or staff."	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
	13G037		03/08/2016

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W 149	Continued From page 38 Individual #1 was a 29 year old male with diagnoses including mild intellectual disability, Bipolar I Disorder, and Autism. His Elopement plan, dated 2/23/16, stated he had eloped 9 times from October 2015 through February 23, 2016. However, the facility's Incident/Accident Reports during the same time period showed only 1 reported elopement for Individual #1. When asked in an interview on 3/7/16 from 2:05 - 4:35 p.m., the QIDP said elopement data for Individual #1 was sometimes given to her verbally and sometimes it was found on ABC data sheets. She could not explain the lack of Incident/Accident Reports for Individual #1's elopements. The facility failed to ensure Incident/Accident Reports were completed per facility policy. 3. An Investigation was initiated on 3/25/15 due to concerns Individual #6 was sleeping on an "incontinent mattress." During the course of the investigation, 4 of the 11 direct care staff interviewed expressed concern about an individual residing at the facility being abusive towards a housemate. The Conclusion section of the Investigation stated "multiple staff expressed concern about [Individual #1], an individual residing at Cougar Creek, actions [sic] towards another house mate [sic]." The Investigation stated 3 Incident/Accident Reports documented incidents between Individual #1 and his housemates for the year. The Investigation stated a "chain lock" had been purchased to prevent Individual #1 from entering a housemate's room, and all staff had been	W 149		

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W 149	Continued From page 39 retrained, on 3/3/15, on body positioning to prevent future incidents. The Investigation stated Adult Protection was notified of the trend on 3/24/15. The Corrective Action section of the Investigation stated a meeting would be held to discuss the current plan for Individual #1 and that all staff of the facility would be retrained on the abuse, neglect, and mistreatment policy. The 3/25/15 Investigation did not indicate how the interventions would be monitored to see if they were effective or how the facility would ensure the trend did not continue. The facility's Incident/Accident Reports from 1/31/15 - 2/29/16 were reviewed. The reports documented Individual #1 continued to be abusive towards his housemates. Incidents included, but were not limited to, the following: - 9/13/15 at 1:50 p.m.: Individual #1 chased Individual #3 into the facility and hit him on the back. - 9/22/15 at 7:15 p.m.: Individual #1 was teasing Individual #3 and slapped him on the back. - 10/2/15 at 4:00 p.m.: Individual #1 grabbed Individual #2 by the hand and called him a name. - 10/22/15 at 3:00 p.m.: Individual #1 walked into Individual #2, then hit him in the shoulder. - 10/30/15 at 9:55 a.m.: Individual #1 pushed his shoulder into Individual #2's back. - 11/3/15 at 6:30 p.m.: Individual #1 pushed Individual #3 while in the community.	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 40 - 11/14/15 at 4:15 p.m.: Individual #1 hit Individual #2 in the shoulder with his arm. - 12/1 15 at 2:00 p.m.: Individual #1 hit Individual #2 on the left side of his head with a cup. - 12/15/15 at 9:55 a.m.: Individual #1 grabbed Individual #3 by both forearms. - 12/15/15 at 1:45 p.m.: Individual #1 grabbed Individual #3 by the wrists. However, there was no documentation indicating the continued patterns of abuse by Individual #1 towards his housemates had been identified or addressed. The facility's policy stated "The facility is responsible for tracking and trending significant incidents." However, the policy did not include information related to how frequently tracking and trending reviews were to be completed. When asked about the policy, on 3/4/16 at 11:30 a.m., the Clinical Director confirmed the frequency of tracking and trending reviews was not specified. The facility failed to ensure sufficient monitoring was provided to identify continuing trends of client to client abuse. 4. The facility's policy stated neglect "Is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." The policy was not implemented and monitored to ensure that Individual #4 was provided with sufficient supports and active treatment services necessary to ensure his mental health needs	W 149		

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W 149	Continued From page 41 were not neglected, as follows: Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. A QIDP note documented the QIDP and Individual #4's guardian had a meeting on 2/4/15 from 11:00 a.m. to 12:00 p.m., prior to Individual #4's admission to the facility on 2/25/15. The note documented Individual #4 had been receiving services in a residential habilitation program and had lost "a lot of skills." The note documented he was refusing to shower, isolating in his room, did not want to change his clothes, was very unmotivated, he did not want to leave his apartment, and he could not remember things. The note also documented he was refusing to eat and drink regularly, which had resulted in hospitalization. The note stated he began receiving Risperdal (an antipsychotic drug) while in the hospital. Individual #4's record included a corresponding hospital report dated 7/30/14 which documented Individual #4 was admitted to the hospital on 7/28/14 with lithium toxicity which was "likely caused by renal failure." The QIDP note stated the guardian would like to see Individual #4 re-learn skills he had forgotten and listed bathing, clean clothes, laundry, cooking, eating regularly, and going into the community. The note stated "would like him to move as soon as possible for health reasons and more training." When asked about Individual #4's admission, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4's mental	W 149		

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W 149	Continued From page 42 health was unstable and the guardian was worried he might die if he stayed in his current placement. He had not been eating or drinking. However, the facility failed to ensure his mental health needs were comprehensively assessed, that comprehensive interventions strategies were implemented, that sufficient data related to his mental health symptoms was collected, and that a comprehensive analysis was conducted and adjustments were made to ensure his mental health needs were met. The cumulative effect of these failures result in Individual #4's mental heath needs being neglected and the potential for Individual #4 to be subjected to unnecessary restrictive interventions, as follows: a. Individual #4's mental health needs were not comprehensively assessed. i. Individual #4's pre-admission records included a Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, which stated "Depending on [Individual #4's] mental health status, he can complete his ADL's independently. When his mental health is unstable, he will isolate and not want to do anything. This is one of the main reasons he is coming back to Cougar Creek." However, Individual #4's record did not include documentation that an IDT meeting had been held in order to evaluate the preliminary information and determine if Individual #4's needs could be met by the facility and what services and activities were essential to Individual #4's daily functioning upon admission. Further, Individual #4's record documented he	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 43 was admitted on 2/25/15. His record included 2/2015 data sheets for ADLs such as tooth brushing, applying deodorant, etc. but no information related to mental health monitoring and interventions was present. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated she had scheduled a meeting, prior to Individual #4's admission, but others failed to attend. The Clinical Director stated a copy of the 2/5/15 Preliminary Evaluation Form/Tentative Treatment Plan was at the facility and available to staff upon Individual #4's admission to the facility on 2/25/15. However, the Tentative Treatment plan did not include comprehensive information regarding how staff were to identify Individual #4's depressive symptoms or how they were to intervene if Individual #4 displayed depressive symptoms. Without such information, it would not be possible to ensure staff were able to consistently identify and intervene to assist Individual #4 in managing his mental health symptoms. ii. Individual #4's record included a Behavioral Assessment, dated 3/23/15, which stated he "has not displayed any maladaptive behaviors since his admission..." The "Impact on Daily Living" section of the assessment stated "When [Individual #4's] mental health is poor he will isolate and refuse to eat or drink. This has caused him to be hospitalized in the past." The assessment also stated he had an individualized, structured reinforcement plan and received Risperidone (an antipsychotic drug) and	W 149		

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W 149	Continued From page 44 Mirtazapine (an antidepressant drug) to assist with his mood stabilization. The assessment did not include additional information regarding what his "structured reinforcement plan" was. His record did include a point card exchange sheet, but no additional assessment information was present to determine how the point exchange had been established (e.g. how it was determined what items were reinforcing to Individual #4, how frequently and for what tasks points needed to be earned, and how many points were needed and how frequently exchanges were to be made in order for the reinforcement to be meaningful, etc.). Further, the assessment did not include any other information related to Individual #4's mood, what signs and symptoms were being monitored to evaluate his mental health status, interventions which were to be implemented to assist Individual #4 to manage his mental health symptoms, how his medications were being monitored for desired effect and adverse consequences, what if any, impacts the psychotropic medications were having on Individual #4's kidneys, etc. When asked about the assessment, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated since Individual #4 had not displayed any maladaptive behaviors while at the facility that there was nothing to assess. The Clinical Director, who was also present during the interview, stated Individual #4 was new to the facility and they were not sure how the new environment would impact him so they were establishing baseline information. The QIDP stated they were monitoring Individual #4 mental	W 149		

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W 149	Continued From page 45 health using the same signs and symptoms that had been used at his previous residential habilitation placement. The QIDP stated monitoring had begun in March 2015, but the data sheet could not be found. Without comprehensive assessment information, and comparative analysis between past and current behaviors, it would not be possible for the IDT to identify if or how Individual #4's new environment would impact him. iii. Individual #4's QIDP data summaries documented he had engaged in depressive symptoms at the following rates: April 2015: 41 May 2015: 30 June 2015: 46 Additionally, June data documented Individual #4 had engaged in suicidal ideation and had eloped from the facility. However, updates to Individual #4's behavior assessment were not evident until 7/28/15. When asked about Individual #4's Behavior Assessment, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed the Behavior Assessment was not updated until 7/28/15. iv. Individual #4's Functional Behavioral Assessment, dated 7/28/15, and revised 12/9/15 and 2/16/16, did not include comprehensive information based on depressive symptoms and maladaptive behaviors he had demonstrated while residing at the facility. Examples included, but were not limited to, the following:	W 149		

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W 149	Continued From page 46 - Individual #4's records documented he had eloped and attempted to elope from the facility on 6/7/15 and 6/8/15. Further, the facility's records included an investigation related to a suicide threat Individual #4 had made on 6/3/15. The investigation included a hand-written note by the QIDP, dated 6/4/15, which stated "Due to history of trying to run away through his bedroom window, Graveyards please sit in his room by the window..." When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had attempted to elope from the facility since his admission to the facility. The QIDP stated he had taken the screen to his bedroom window off. The Clinical Director, who was also present during the interview, stated Individual #4 would attempt to elope because he wanted to go see his parents, who were deceased and their grave sites were in another town. Further, an ABC log dated 1/11/16 at 7:00 a.m., documented he was refusing all tasks and stated he did not care about going to another town and seeing his parents, and a "Staff Statement" sheet, dated 10/16/15, stated "Please watch for [Individual #4's] window when it is open. I noticed today that the screen was push [sic] out and broken. He was laying on bed stairing [sic] at open window. I took screen [sic] off front of house & placed in [Individual #4's] window." However, comprehensive information related to Individual #4's elopements was not present in his assessment and no objective or program plans addressing the behavior had been developed.	W 149		

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W 149	Continued From page 47 When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed Individual #4's elopement behavior had not been assessed. The facility failed to ensure Individual #4's Functional Behavioral Assessment included comprehensive information regarding his elopements and attempts to elope. - Individual #4's ABC Logs documented he had continued to attempted to self induce vomiting. Examples included, but were not limited to ABC logs completed on 6/20/15, 7/8/15, 7/22/15, 10/11/15, 10/13/15 and 10/16/15. However, Individual #4's Functional Behavior Assessment did not included comprehensive information related to self-induced vomiting. When asked, during an interview on 3/4/16 from 2:00 p.m. - 4:35 p.m., if Individual #4's self-induced vomiting had been assessed, the QIDP stated it had not been. The facility failed to ensure Individual #4's self-induced vomiting was comprehensively assessed. - A 10/27/15 investigation report documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet, dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day,	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 48 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. Individual #4's Functional Behavioral Assessment did not include additional information regarding sexual misconduct or the impacts that line of sight supervision had on Individual #4. However, his PCLP included an "Addendum", dated 2/4/16, which stated he was to see a neurologist "to rule out early onset dementia and/or Parkinson's disease and would be "scheduled for a sexual assessment as soon as all medical issues are ruled out." When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., about ruling out medical issues prior to conducting a sexual assessment, the Clinical Director stated that was a judgement error. The facility failed to ensure Individual #4's sexual behaviors were comprehensively assessed prior to implementing restrictive interventions. - Individual #4's Functional Behavior Assessment stated "[Individual #4] will become irritated and if asked to [sic] frequently, he has physically assaulted staff which is uncharacteristic of his typical behavior." The assessment did not include additional information related to what observable behaviors constituted "irritated" prior	W 149		

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W 149	Continued From page 49 to Individual #4 becoming physically assaultive. No information was present regarding how Individual #4 was assaultive (e.g. hitting, kicking, biting, throwing objects, etc.). Individual #4's pre-admission information, dated 2/5/15, stated he disliked "being over cued" and "people getting into his business." Additionally, his 3/24/15 PCLP stated Individual #4 did not like over-cuing, he "gets angry" when he is told what to do and he did not like people helping him when they "tell him what to do." Further, a Medication Management Progress Note, dated 9/24/15, stated "Staff report that pt. needs repeated prompting to shower. Pt. reports it irritates him to be prompted and would like to do it on his own..." Individual #4's ABC logs documented multiple incidents of aggression and other potential precursory statements in response to staff prompting. Examples included, but were not limited to, ABC logs completed on 8/9/15, 9/1/15, 10/2/15, 10/19/15, 11/28/15, 12/24/15. Further, staff documented, on 1/18/16 at 1:15 p.m., Individual #4 became "agitated at staff cues to complete responsibilities & a shower. He kept saying 'No' or 'I don't know' after a couple more prompts [Individual #4] became really angry & got up, yelled 'no, no, no' and attacked [staff's name]. He backed her into the kitchen punching her 7x. He then stopped & went back & sat on the couch." The staff documented "The police were called (non-emergency) & are coming to speak with [Individual #4]." However, Individual #4's Functional Behavioral Assessment did not include any assessment information related to his aggression.	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
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PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 149	Continued From page 50 Further, the "Recommended refusal guidelines" section of the assessment stated when Individual #4 does not engage in a task, "prompt him again in 15 minutes by following the prompt hierarchy, up to light physical..." The assessment did not include information regarding how the 15 minute timeframe was established or how it was determined prompting every 15 minutes was not too frequent. Additionally, the 15 minute recommendations was not consistent with Individual #4's Visual Calendar plan (which was identified as his replacement behavior programming on his Functional Behavioral Assessment) or his ADL programs. Individual #4's 8/1/15 Visual Calendar plan stated staff were to follow the prompt hierarchy up to a light physical prompt to assist Individual #4 to schedule the tasks he needed to do during the morning and evening shifts. The plan stated staff were to "allow at least 10 seconds between prompts." As stated Individual #4 was given an initial prompt, then 4 additional prompts within 40 seconds. The plan also stated if Individual #4 refused all prompting, staff were to "re-cue in 5 minutes by following the prompt hierarchy." The plan was not consistent with the Functional Behavioral Assessment's 15 minute recommendation. Individual #4's ADL programs were reviewed. Individual #4's ADL programs stated staff were to follow the prompt hierarchy in order to assist him to complete the tasks identified in the objectives. However, the programs were not consistent in providing direction to staff regarding how long to wait between prompts when following the prompt	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
	13G037		03/08/2016

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W 149	Continued From page 51 hierarchy. Examples included, but were not limited to, the following: Individual #4's hygiene program, revised 9/10/15, stated staff were to wait at least 5 seconds between prompts. Individual #4's hand washing program, revised 6/2/15, stated staff were to wait at least 15 seconds between prompts. Individual #4's showering program, revised 6/2/15, did not specify the amount of time to wait between prompts. Additionally, the status section of Individual #4's vocational program for following 2 step directions, revised 10/2/15, stated "[Individual #4] can follow directions with verbal, gestural and physical prompts. [Individual #4] will comply with a request in 30 seconds..." However, Individual #4's Functional Behavioral Assessment did not include information related to adjusting prompt frequency based on his mental health status. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed prompting time frames had not been assessed. The facility failed to ensure Individual #4's mental health needs and associated behaviors were comprehensively addressed necessary to ensure his chronic and emerging needs were not neglected. b. Individual #4's 2/16/16 depressive symptom plans were not sufficiently designed and	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
	13G037		03/08/2016

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W 149	Continued From page 52 implemented necessary to ensure his individualized mental health needs were not neglected. i. Individual #4's depressive symptoms plan listed depressive type symptoms and associated behaviors. However, the program definitions were not sufficiently developed to include observable behavior or to allow Individual #4 to express normal, appropriate emotions. Examples included, but were not limited to, the following: - Symptom: "Irritable mood." Behavior: "Being agitated, angry." No additional information related to observable behavior was included and no information related to Individual #4 becoming irritated and angry as a normal, human emotion (e.g. due to staff over-cueing, etc.) was present. - Symptom: "Diminished interest in activities." Behavior: "Refusing to leave the house to participate in a community activity." The plan did not include information such as how many refusals were required to be considered symptomatic of his depression, if refusals to participate in known non-preferred activities were included in the definition, etc. - Symptom: "Increase in appetite." Behavior: "Stealing others food, eating food out of the pantry or refrigerator that is not part of the meal." Information related to drinking excessive amounts of fluids and self-induced vomiting was not included. - Symptom: "Decrease in appetite." Behavior: "Refusing to eat or drink." Information related to what constituted a refusal (e.g. not eating one meal, only eating half of a meal, refusing liquids	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 53 once when offered, etc.) was not included. - Symptom: "Change in sleep pattern." Behavior: "Not sleeping through the night or sleeping during the day time (waking hours 7:30 AM - 8:30 PM)." The time frame given was equal to 11 hours of sleep. However, the status section of the plan gave his historical sleep average as 10 hours a night and the criteria established to reduce his Ativan (an anxiolytic drug) use was set at 8 hours each night per his 7/8/15 Medication Plan. The Depressive Symptoms plan did not include symptom criteria which was based on Individual #4's sleeping pattern history, or allow for any variation (e.g. sleeping 8 - 11 hours a night) depending on other factors such as the events of his day, prior night's ability to sleep, etc. - Symptom: "Fatigue or loss of energy." Behavior: "Having no energy to do an activity/task, being tired." The plan did not included information related to how Individual #4 was to be evaluated to determine normal amounts of fatigue (e.g. after increased amounts of physical exertion, when his was not feeling well, an a night in which he did not sleep well, etc.). - Symptom: "Laying on bed-isolating at odd times." Behavior: "During waking hours 7:30 AM - 8:30 PM." The plan did not include information related to when it was reasonable and appropriate for Individual #4 to be in his bedroom in private (e.g. separating himself from housemates who were being loud or creating an otherwise chaotic environment, separating himself to his bedroom when he was angry rather than assaulting others, etc.).	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 54 The depressive symptoms plan stated as soon as staff noticed Individual #4 displaying depressive type symptoms, they were to ask him to participate in an activity or task. How many times Individual #4 was to be prompted or the frequency of prompts was not included in the plan. Staff were to also let Individual #4 know they were there to talk with him, if he would "like to talk about how he is feeling." However, Individual #4's records included typed information from the QIDP, dated 6/3/15, which were completed in response to a suicide threat made by Individual #4. The note stated interactions were to be limited and in the past Individual #4 had tried to talk about his parents, who were deceased, worrying about them. The note instructed staff to acknowledge Individual #4 with "I understand" and then stop interacting with him. The depressive symptoms plan did not include information related to whether staff were to engage in conversations with Individual #4 regarding his parents. The facility failed to ensure Individual #4's Depressive symptoms plan was sufficiently developed to ensure his mental heath needs were not neglected and he was allowed appropriate expressions of normal human emotion. ii. Individual #4's ABC logs documented multiple interventions which had been attempted but were not defined, incorporated into his plans, consistently applied or evaluated for efficacy. Examples included, but were not limited to, the following:	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 55 6/16/15: Individual #4 was "overeating" and staff asked him to use "coping skills." On 9/21/15 at 7:10 p.m., Individual #4 "charged" at staff. Staff documented "Tried getting him to use coping skills." No information was present regarding what Individual #4's "coping skills" were. - 9/1/15 at 7:56 p.m.: Staff documented the used "first this, then this" interventions and giving choices. No information was present regarding what was offered first or if the intervention was appropriate. - 10/2/15 from 4:00 - 4:15 p.m.: Staff documented Individual #4 was being prompted to participate and talked to about his deal with the QIDP to get out of the house once per day. No information was present regarding what the "deal" was or how long it was in effect. - 1/18/16 at 1:15 p.m.: Staff documented Individual #4 became "agitated at staff cues to complete responsibilities & a shower. He kept saying 'No' or 'I don't know' after a couple more prompts [Individual #4] became really angry & go up [sic], yelled 'no, no, no' and attacked [staff's name]. He backed her into the kitchen punching her 7x. He then stopped & went back & sat on the couch." The staff documented "The police were called (non-emergency) & are coming to speak with [Individual #4]." No additional information was present on the ABC log which indicated if or when the police spoke to Individual #4 and what the outcome was. No additional information related to Individual #4's coping skills, first this, then this, QIDP deal, or contacting the police was present on the ABC	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 56 logs, Individual #4's Functional Behavioral Assessment, or his Depressive Symptoms Plan. Further, Individual #4's ABC logs documented "happy light" use on 4/9/15 at 9:00 - 9:30 a.m. However, no additional information related to the light was present on the ABC logs, Individual #4's Functional Behavioral Assessment, or his Depressive Symptoms Plan. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had a full spectrum light and confirmed its use had not been assessed or incorporated into a plan but it probably should have been. The facility failed to ensure the interventions used to address Individual #4's mental health symptoms were consistently applied and evaluated for efficacy, necessary to ensure his mental health needs were not neglected. c. Other factors which impacted Individual #4's mental health were not sufficiently monitored, assessed and/or re-assessed and adjusted. Examples included, but were not limited to, the following: i. Individual #4's Functional Behavioral Assessment stated he had started counseling on 6/15/15 and stopped on 7/8/15 due to "[Individual #4] not being able to discuss his issues." However, Individual #4's pre-admission information included a 2/11/13 Comprehensive Diagnostic Assessment from a mental health provider. The report documented Individual #4 had limited insight and that his "ability to recognize and report symptoms is fair, but he	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 57 does require some coaching to articulate symptoms and the impact they have on his stability and functioning. [Individual #4] states that when he feels depressed he gets sad, lonely, and worries a lot. He has trouble recognizing triggers for his symptoms. Stressful situations can lead to him getting more depressed. He states he has some mood swings. [Individual #4] required some assistance in recognizing symptoms of low motivation, isolation and anger." The Assessment stated Individual #4 was to be seen for counseling to address symptoms of depression, guilt, and bipolar mood swings to develop coping strategies, process emotions and feelings and increase his self-esteem. No additional information related to his past counseling and his ability to identify and use coping skills to manage his depressive symptoms was present in the Functional Behavioral Assessment. Further, the assessment did not include an analysis related to why the 6/15/15 counseling attempt was unsuccessful (e.g. Individual #4 did not like the counselor, Individual #4 was experiencing severe depressive symptoms which interfered with his ability to express himself, not enough time was provided for Individual #4 to build rapport with the counselor, etc.). ii. Individual #4's pre-admission information stated Individual #4 had a job but was fired due to poor attendance and "He currently does not want to work but this could be due to his unstable mental health." The preliminary information further stated "It is hoped that he will have interest when he moves back to Cougar Creek." Additionally, Individual #4's 2/26/15 OT Report,	W 149		

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	13G037		03/08/2016

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W 149	Continued From page 58 completed after he was admitted to the facility, stated in the past Individual #4 had worked at a gas station and "states he would like to work there again. This was a big motivator for [Individual #4] to get out of bed compared to prior vocational training activities." The assessment also stated Individual #4 would "like to maximize outings including: eating out, movies, park, fishing, basketball at the YMCA, swimming and baseball." The assessment included a recommendation to "Inquire with potential employers to obtain work if appropriate." However, Individual #4's Functional Behavioral Assessment did not include information related to how not having a job and not participating in community activities either impacted or were symptomatic of his mental health status. iii. Individual #4's 2/5/15 pre-admission Preliminary Evaluation Form/Tentative Treatment Plan stated "New staff are hard for [Individual #4] to learn to build rapport with them." Further, Individual #4's Medication Management Progress Note, dated 7/30/15, stated the QIDP "reports that there has been many staff changes over the past month and that is most likely why pt. has exhibited an increase in symptoms." However, Individual #4's Functional Behavioral Assessment did not include information related to how staff changes impacted his behavior and his mental stability. iv. Individual #4's records included a "Comprehensive Diagnostic Assessment," dated 2/4/16, from his mental health medication management agency. The assessment stated in the 2016 update section that "Individual #4 had	W 149		

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W 149	Continued From page 59 minimal to report and allowed others to contribute for him. His team reports he experienced a major depressive episode in July and is still getting back to baseline; though he has shown a few 'manic behaviors' in the past few days." No information related to what baseline was or what "manic behaviors" Individual #4 had demonstrated was present in the assessment. The assessment stated "The team reports 'A tough year with positive moments' and multiple 'not so good days' in which the client does not leave his room or couch, attend to personal hygiene, does not eat, and refuses to get his blood sugar levels checked. Client has had a few instances of getting physically aggressive with staff when he is angry. The team also reports some concerns about Parkinson's or dementia as some of his skills have been diminishing and he has severe hand tremors; an appointment has been scheduled with his medical doctor. Client was in a positive mood and reported liking where he currently resides." Additionally, Individual #4's PCLP included an "Addendum," dated 2/4/16, and signed by the QIDP, which stated the following: "Despite multiple positive reinforcements/interventions, [Individual #4] still continues to refuse to participate in his active treatment program. He continues to struggle with depressive type symptoms and is seen regularly by his med manager." "It is the team's consensus that [Individual #4] has lost many skills that he used to have in his ADL's and ability to think. [Individual #4] exhibits	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
	13G037		03/08/2016

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W 149	Continued From page 60 many signs of dementia/Parkinson's disease. [Individual #4] has been referred top his primary physician for a referral for a brain scan and possible referral to a neurologist to rule out early onset dementia and/or Parkinson's disease. Therefore, until it is confirmed or denied, no changes will be made in [Individual#4's] programming. Staff will continue to document every 1/2 hour the activities/tasks that are offered to [Individual #4] and his response. 1 hour documentation will be done on the graveyards..." When asked, during an interview on 3/7/16 from 2:05 - 4:35 p.m., about the signs of Dementia Individual #4 was displaying, the QIDP and the Administrator stated he would become confused, such as not being able to remember how to put on his shirt. However, Individual #4's 9/1/15 Depressive Symptoms plan included "Decreased ability to think" as a depressive symptom, until the plan was revised on 2/16/16. The 9/1/15 plan included the following: - Symptom: "Decreased ability to think." Behavior: "Being confused as to what to wear, what the next step of a task is that [Individual #4] knows, standing in front of an item i.e. dresser and doesn't know what he needs." QIDP summaries documented he had demonstrated a "decreased ability to think" at the following rates: April 2015: 1 May 2015: 0 June 2015: 4 July 2015: 3	W 149		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 61 August 2015: 1 September 2015: 0 October 2015: 0 November 2015: 0 December 2015: 0 January 2016: 0 When asked, during an interview on 3/7/16 from 2:05 - 4:35 p.m., the QIDP and the Administrator could not differentiate confusion when Individual #4 was depressed or how it was determined confusion was not an adverse side effect of his psychotropic medications. When asked what other symptoms Individual #4 demonstrated, the QIDP stated the nurse would need to be asked. When asked what symptoms of Parkinson's Individual #4 was demonstrating, the QIDP stated he had hand tremors. However, Individual #4's Social Evaluation, revised 1/28/15, stated Individual #4 had been on Propranolol, but the medication was discontinued in 2007 or 2008 to "monitor for reduced hand tremor" and his 3/20/15 Annual Nursing Assessment documented "his physician had recommended discontinuation of Depakote (an anticonvulsant drug) due to persistent hand tremors some time between 2007 and 2008. No information was present to differentiate when hand tremors a known, normal occurrence or when they were an adverse side effect of his psychotropic medications. When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., what other symptoms of Parkinson's Individual #4 was demonstrating, the QIDP stated the nurse would need to be asked. The facility failed to ensure Individual #4's mental health needs were comprehensively assessed,	W 149		

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W 149	Continued From page 62 that comprehensive interventions strategies were implemented, that sufficient data related to his mental health symptoms was collected, and that a comprehensive analysis was conducted and adjustments were made to ensure his mental health needs were met and that he was not subjected to unnecessary restrictive interventions. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., if the facility's failure to provide Individual #4 with comprehensive programming necessary to address his mental health needs met the facility's definition of neglect as stated in policy (e.g. the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness), the Administrator stated it could. The facility failed to ensure Individual #4's mental heath needs were not neglected. 5. Refer to W154 as it relates to the facility's failure to ensure thorough investigations were conducted for all allegations of abuse, neglect and mistreatment. 6. Refer to W155 as it relates to the facility's failure to ensure individuals were protected while investigations were being conducted. 7. Refer to W157 as it relates to the facility's failure to ensure appropriate corrective action was taken in response to all investigations.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are 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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 154	Continued From page 63 This STANDARD is not met as evidenced by: Based on review of the facility's policies, review of Abuse Investigations and Incident/Accident reports, and staff interview, it was determined the facility failed to ensure thorough investigations were conducted. That failure directly impacted 6 of 6 individuals (Individuals #1 - #6) who had resided at the facility over the past year. This resulted in a lack of sufficient information being collected on which to base corrective action decisions. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 10/12/15, stated the Company and/or Administrator "will ensure that all allegations of Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source are thoroughly investigated." The definitions section of the policy stated "Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The policy stated "The Administrator, Administrator Designee, A.O.D. [administrator on duty] or State Operations Manager will establish evidence and documentation that all allegations have been thoroughly investigated." a. On 3/25/15, an Abuse Investigation documented that Individual #6 (an individual who had resided at the facility during the past year) had been sleeping on an incontinent mattress and the incontinent mattress had not been addressed within a timely manner. Individual #6 was provided with a new mattress and a water proof cover on 3/25/15.	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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 64 The Clinical Director and Program Manager interviewed 13 staff to rule out abuse, neglect, mistreatment, or favoritism. The conclusion section documented no abuse, neglect, or mistreatment was occurring and the employees stated individuals' needs were addressed within a timely manner. However, during the course of the investigation, 4 of the 11 direct care staff interviewed expressed concern about an individual residing at the facility being abusive towards a housemate. The conclusion section of the investigation stated "multiple staff expressed concern about [Individual #1], an individual residing at Cougar Creek, actions [sic] towards another house mate [sic]." The investigation stated 3 Incident/Accident Reports documented incidents between Individual #1 and his housemates for the year. Adult Protection was notified and visited the facility and interviewed the victim of the incidents on 3/31/15. However, the investigation did not include interviews with the individuals who resided at the facility at that time to rule out neglect or mistreatment. In addition, the investigation did not include an interview with Individual #2 to determine if he was fearful of, or how he felt, about the actions of Individual #1. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director and the QIDP said they did not interview the individuals who resided at the facility at that time. The facility failed to ensure all allegations of potential abuse, neglect and mistreatment were	W 154		

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W 154	Continued From page 65 thoroughly investigated. 2. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability, and Bi-polar I Disorder. He was admitted to the facility on 2/25/15. a. On 10/3/15 at 3:20 p.m., an Incident/Accident Report documented Individual #4 engaged in self-induced vomiting. The Witness Statements Summary section documented two staff reported Individual #4 was observed drinking water and juice and then he went into the medication room. The staff reported that Individual #4 vomited while in the medication room and about 1/4th of a bottle of mouthwash was missing. However, the staff statements did not include who, if anyone, observed Individual #4 vomiting or drinking the mouthwash. Individual #4 was not interviewed about drinking the mouthwash, vomiting, or self-inducing vomiting. Individual #4's record contained documentation which included current and historical information related to self-induced vomiting. Examples included but were not limited to, the following: - Individual #4's 2/5/15 Preliminary Evaluation Form/Tentative Treatment Plan documented Individual #4 "may binge and purge." - A note typed by the QIDP on 6/3/15, stated Individual #4's guardian had been contacted. The guardian reported Individual #4 would try to drink excessively to make himself throw up. Drinking was to be restricted to 2-3 small cups at a time with a 30 minute wait until he could have more to drink.	W 154		

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W 154	Continued From page 66 However, the Record Review Summary section stated "this is the first incident of this kind." No additional information related to past incidents of self-induced vomiting was garnered or reviewed. During an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director stated the Record Review Summary section of an investigation included only the review of prior Incident/Accident Reports and did not include review of any other information included in an individual's record. Without a review of Individual #4's records, it would not be possible to determine it the behavior was a result of inadequate programming. The facility failed to ensure the incident was thoroughly investigated. b. On 10/22/15 at 12:45 p.m., an Incident/Accident Report documented Individual #1 was in a bathroom conjoining two bedrooms. Individual #4 was in his bedroom and the door to the bathroom was open. Individual #4 pulled down his pants and showed Individual #1 his private area. The Witness Statements Summary section documented Individual #1 reported to a staff that Individual #4 had exposed himself. The Investigation Report staff statements did not include any staff observation of Individual #4 exposing himself. In addition, Individual #4 was not interviewed about exposing his private area to Individual #1. When asked during an interview on 3/2/16 at 1:35	W 154		

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W 154	Continued From page 67 p.m., the QIDP stated it was reported that this type of incident had happened one other time, prior to 10/22/15, but she could not remember the exact date. The first incident was not observed by anyone except Individual #1. At that time, Individual #1 said that Individual #4 opened his pants and exposed himself to him, however an Incident/Accident Report was not completed. Additionally, Individual #4's record contained documentation which included current and historical information related to Individual #4's sexual misconduct. For example, his Social Evaluation, revised 1/28/15, documented he "has attended SANE classes in the past due to sexually inappropriate behavior..." However, the Record Review Summary section documented, "record reviews this is the first of this kind." No additional information related to past incidents of sexual misconduct was garnered or reviewed. During an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director stated the Record Review Summary section of the investigation included only the review of prior Incident/Accident Reports and did not include review of any other information included in an individual's record. Without a review of Individual #4's records, it would not be possible to determine it the behavior was a result of inadequate programing. The facility failed to ensure the incident was thoroughly investigated. c. On 6/3/15 at 1:35 p.m., an Incident/Accident Report documented Individual #4 told the QIDP	W 154		

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W 154	Continued From page 68 that he did not want to live at the facility, hated all the staff and clients, and wanted to get a knife and kill himself. The Report documented the QIDP completed an assessment and Individual #4 was placed under line of sight supervision and all knives were removed from the kitchen. Individual #4 remained on line of sight supervision until 6/7/15. Individual #4's record contained documentation which included current and historical information related to Individual #4's depressive symptoms, which included potential physically harmful behaviors such as suicide threats and attempts, eloping from the facility, drinking excessive amounts of water to self-induce vomiting and refusing to eat which had previously resulted in renal failure and hospitalization. Examples included, but were not limited to, the following: - A note typed by the QIDP on 6/3/15, referred to Individual #4's past history of suicidal ideation. The note stated "Per [guardian's name], [Individual #4] has not acted upon any of his threats but this does not mean that he might not. If [Individual #4] attempts to hurt himself, block and redirect him. [Individual #4] does respond in the past and has stopped." The QIDP note also stated Individual #4's guardian had been contacted. The guardian reported Individual #4 would try to drink excessively to make himself throw up. Drinking was to be restricted to 2-3 small cups at a time with a 30 minute wait until he could have more to drink. - A hand-written note by the QIDP, dated 6/4/15, stated "Due to history of trying to run away	W 154		

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	13G037		03/08/2016

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W 154	Continued From page 69 through his bedroom window, Graveyards please sit in his room by the window..." However, the Record Review Summary documented "this is the first time [Individual #4] has made a comment of this nature since living at Cougar Creek." No additional information related to past suicidal threats was garnered or reviewed. During an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director stated the Record Review Summary section of an investigation included only the review of prior Incident/Accident Reports and did not include review of any other information included in an individual's record. Without a review of Individual #4's records, it would not be possible to determine it the behavior was a result of inadequate programing. The facility failed to ensure the incident was thoroughly investigated. d. On 6/7/15 at 8:00 p.m., an Incident/Accident Report documented that Individual #4 jumped over the fence in the backyard of the facility and eloped. The facility contacted the local police department and, at 9:00 p.m., Individual #4 was found at a gas station and returned to the facility. When he returned to the facility, Individual #4 stated he "was feeling bad and that he wanted to go to [name of another town] to see his parents gravesite." Individual #4's record included a hand-written note by the QIDP, dated 6/4/15, which stated "Due to history of trying to run away through his bedroom window, Graveyards please sit in his	W 154		

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W 154	Continued From page 70 room by the window..." When asked about the note, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had attempted to elope from the facility since his admission. The QIDP stated he had taken the screen to his bedroom window off. The Clinical Director, who was also present during the interview, stated Individual #4 would attempt to elope because he wanted to go see his parents, who were deceased and their grave sites were in another town. However, the Record Review Summary documented "this is the first time [Individual #4] has made a comment of this nature since living at Cougar Creek." No additional information related Individual #4's previous attempts to elope was garnered or reviewed. During an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director stated the Record Review Summary section of an investigation included only the review of prior Incident/Accident Reports and did not include review of any other information included in an individual's record. Without a review of Individual #4's records, it would not be possible to determine it the behavior was a result of inadequate programing. The facility failed to ensure the incident was thoroughly investigated.	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse	W 155		

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W 155	Continued From page 71 while the investigation is in progress. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, and staff interview it was determined the facility failed to ensure an individual was protected from potential abuse, neglect, and mistreatment while an investigation was in process. This failure directly impacted 1 of 5 individuals (Individual #1) and had the potential to impact all individuals (Individuals #1 - #5) residing at the facility. This resulted in the potential for individuals being subjected to potential abuse and neglect during the course of investigations. The findings include: 1. The facility's Abuse policy, revised 10/12/15, defined physical abuse as "Any physical motion or action by which bodily pain, harm, or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive or intrusive procedures to control inappropriate behavior for purposes of punishment." The policy also stated "If after an initial assessment, the Administrator, Administer Designee, A.O.D., or State Operations Manager has reasonable cause to believe that an employee could be guilty of Abuse, Neglect, or Mistreatment then the employee will be placed on suspension immediately. The suspension will be in effect until a full investigation is completed." However, the individual was not protected during the course of investigation, as follows: An Incident/Accident Report, dated 5/6/15, was reviewed. It showed Individual #1's shirt had	W 155		

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W 155	Continued From page 72 been torn by a staff member. Staff A's statement said Individual #1 had taken the TV remote control while another individual was watching TV. Staff A said "I tried to get the remote but because he [Individual #1] was moving around I grabed [sic] his shirt and it tore a small hole." The report stated Individual #1 got upset and threw the remote across the room. Individual #1 then ran outside and was throwing rocks at the door where Staff A was standing. Staff B reported he put his body between Staff A and Individual #1 "to prevent additional incidents." An investigation was conducted the same day. However, there was no documentation showing Staff A had been removed to protect Individual #1 from abuse during the investigation. The investigation stated after Individual #1 de-escalated, Staff A and Individual #1 spent the rest of the shift together without any issues. In an interview on 3/7/16 from 2:05 - 4:35 p.m., the Administrator said he did not determine suspension was needed. The facility failed to ensure Individual #1 was immediately protected after an allegation of abuse was filed.	W 155		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of investigations and staff interview, it was determined the facility failed to ensure appropriate corrective action was taken in	W 157		

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W 157	Continued From page 73 response to all investigations. That failure directly impacted 1 of 4 individuals (Individual #4) whose records were reviewed, and had the potential to impact all individuals (Individuals #1 - #5) residing in the facility. This resulted in a lack of sufficient corrective action being identified and implemented. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. a. On 6/3/15 at 1:35 p.m., an Incident/Accident Report documented Individual #4 told the QIDP that he did not want to live at the facility, hated all the staff and clients, and wanted to get a knife and kill himself. The Report documented the QIDP completed an assessment and Individual #4 was placed under line of sight supervision and all knives were removed from the kitchen. Individual #4 remained on line of sight supervision until 6/7/15. Individual #4's record contained documentation included in current and historical information related to Individual #4's depressive symptoms, which included potential physically harmful behaviors such as suicide threats and attempts, eloping from the facility, drinking excessive amounts of water to self-induce vomiting and refusing to eat which had previously resulted in renal failure and hospitalization. Examples included, but were not limited to, the following: - A note typed by the QIDP on 6/3/15 referred to Individual #4's past history of suicidal ideation. The note stated "Per [guardian's name], [Individual #4] has not acted upon any of his threats but this does not mean that he might not.	W 157		

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W 157	Continued From page 74 If [Individual #4] attempts to hurt himself, block and redirect him. [Individual #4] does respond in the past and has stopped." The Corrective Action Taken section of the investigation documented that staff would receive additional training in relation to what line of sight supervision was, that all future suicide assessments would be completed by the QIDP, that Individual #4 would meet with his medication manager to assess his medication, that Individual #4's bedroom would be moved closer to the living area for better monitoring, and the home would look into purchasing a basketball hoop for Individual #4's use. The corrective action did not recommend a review of Individual #4's active treatment program to ensure his needs were being met. Further, the facility implemented a Depressive Symptoms plan and a Suicidal Ideation plan, which were implemented on 6/8/15. However, Individual #4's depressive symptoms and suicidal ideation was not comprehensively assessed prior to the implementation of the plans. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated the behaviors were not assessed prior to the implementation of the plans. The facility failed to ensure appropriate corrective action taken in response to the incident. b. On 6/7/15 at 8:00 p.m., an Incident/Accident Report documented that Individual #4 jumped over the fence in the backyard of the facility and eloped. The facility contacted the local police	W 157		

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	13G037		03/08/2016

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W 157	Continued From page 75 department and, at 9:00 p.m., Individual #4 was found at a gas station and returned to the facility. When he returned to the facility Individual #4 stated he "was feeling bad and that he wanted to go to [name of another town] to see his parents gravesite." Individual #4's record included a hand-written note by the QIDP dated 6/4/15 which stated "Due to history of trying to run away through his bedroom window, Graveyards please sit in his room by the window..." When asked about the note, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had attempted to elope from the facility since his admission. The QIDP stated he had taken the screen to his bedroom window off. The Clinical Director, who was also present during the interview, stated Individual #4 would attempt to elope because he wanted to go see his parents, who were deceased and their grave sites were in another town. The Corrective Action Taken section of the investigation documented actions taken included staff receiving additional training in relation to what line of sight supervision was, all future suicide assessments would be handled by the QIDP, an appointment with Individual #4's medication manager, purchasing a basketball hoop, and moving Individual #4's bedroom closer to the living area for better supervision. Additionally, staffing was increased on the AM and PM shifts and a visit to Individual #4's parents gravesite was scheduled. The corrective action did not recommend a review of Individual #4's active treatment program	W 157		

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W 157	Continued From page 76 to ensure his needs were being met and no plans related to Individual #4's elopements and attempts to elope were present in his 7/28/15 Functional Behavioral Assessment. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated programming for elopement was not implemented. The facility failed to ensure appropriate corrective action was taken in response to the incident. c. On 10/22/15 at 12:45 p.m., an Incident/Accident Report documented Individual #1 was in a bathroom conjoining two bedrooms. Individual #4 was in his bedroom and the door to the bathroom was open. Individual #4 pulled down his pants and showed Individual #1 his private area. The Witness Statements Summary section documented Individual #1 reported to a staff that Individual #4 had exposed himself. The Investigation Report staff statements did not include any staff observation of Individual #4 exposing himself. In addition, Individual #4 was not interviewed about exposing his private area to Individual #1. Individual #4's record contained documentation which included current and historical information related to Individual #4's sexual misconduct. For example, his Social Evaluation, revised 1/28/15, documented he "has attended SANE classes in the past due to sexually inappropriate behavior..." The Conclusion section of the investigation documented Individual #4 "did expose himself from his bedroom" and the Corrective Action	W 157		

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W 157	Continued From page 77 Taken section of the investigation showed Individual #4 was placed on Line of Sight 24/7 Guidelines. However, no corrective action was taken to address Individual #4's or Individual #1's need for assistance in protecting their own personal privacy, or the privacy of others, and the corrective action did not recommend a review of Individual #4's active treatment program to ensure his needs were being met. When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the Clinical Director stated an assessment of Individual #4's alleged sexual misconduct had not been completed. The facility failed to ensure appropriate corrective action taken in response to the incident.	W 157		
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 6 of 6 individuals (Individuals #1 - #6) who had resided at the facility in the past year. This failure resulted in a lack of sufficient QIDP coordination, monitoring and oversight necessary to ensure individuals' rights were protected and their active treatment and behavioral needs were met. The findings include: 1. Refer to W122 Condition of Participation:	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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 159	Continued From page 78 Client Protections and associated standard level deficiencies as they relate to the facility's failure to ensure individual needs were not neglected and individual rights were upheld. 2. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the facility's failure to ensure individuals received comprehensive active treatment services based on their assessed needs. 3. Refer to W266 Condition of Participation: Client Behavior and Facility Practices and associated standard level deficiencies as they relate to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. The cumulative effect of these deficient practices significantly impeded the facility's ability to ensure the QIDP provided sufficient coordination, monitoring and oversight necessary to ensure individuals' active treatment and behavioral needs were met, and their rights were protected.	W 159		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's	W 195		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 195	Continued From page 79 program. This resulted in a lack of necessary services and supports being provided to individuals in order to adequately address their individualized needs. The findings include: 1. Refer to W196 as it relates to the facility's failure to ensure each individual was provided with continuous and consistent active treatment services in accordance with their assessed needs.	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals were provided specialized and generic training based on their assessed needs for 2 of 4 individuals (Individuals #1 and #4) whose active treatment programs were reviewed. That failure resulted in individuals not being provided with continuous active treatment. The findings include: 1. Refer to W199 as it relates to the facility's failure to ensure the IDT reviewed current	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 196	Continued From page 80 evaluation information prior to an individual being admitted to the facility. 2. Refer to W206 as it relates to the facility's failure to ensure appropriate professionals were utilized in the development of an individual's PCLP. 3. Refer to W210 as it relates to the facility's failure to ensure accurate assessments were conducted within 30 days of admission. 4. Refer to W212 as it relates to the facility's failure to ensure that evaluation data was available to support individuals' diagnoses. 5. Refer to W214 as it relates to the facility's failure to ensure behavior assessments contained comprehensive information. 6. Refer to W216 as it relates to the facility's failure to ensure individuals' CFAs included comprehensive health information. 7. Refer to W217 as it relates to the facility's failure to ensure dietary assessments contained comprehensive information. 8. Refer to W219 as it relates to the facility's failure to ensure an individual's affective development was comprehensively assessed. 9. Refer to W222 as it relates to to the facility's failure to ensure an individual's cognitive development was adequately assessed. 10. Refer to W223 as it relates to the facility's failure to ensure an individual's CFA include comprehensive social information.	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 196	Continued From page 81 11. Refer to W227 as it relates to the facility's failure to ensure an individual's PCLP included objectives to meet the identified needs. 12. Refer to W234 as it relates to the facility's failure to ensure clear, consistent direction to staff was provided in each written training program. 13. Refer to W238 as it relates to the facility's failure to ensure training programs specified behaviors which interfered with functional abilities. 14. Refer to W239 as it relates to the facility's failure to ensure replacement behavior training was appropriate to address individuals' maladaptive behaviors. 15. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with identified needs and program plans. 16. Refer to W252 as it relates to the facility's failure to ensure sufficient data was collected to determine the efficacy of intervention strategies. 17. Refer to W255 as it relates to the facility's failure to ensure PCLPs were revised when objectives were successfully completed. 18. Refer to W256 as it relates to the facility's failure to ensure PCLPs were revised to reflect regression of skills. 19. Refer to W258 as it relates to the facility's failure to ensure the IDT considered training towards new objectives based on individual	W 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 196	Continued From page 82 performance. 20. Refer to W259 as it relates to the facility's failure to ensure comprehensive functional assessments were updated annually, or as needed, to accurately reflect the current status/needs for individuals. 21. Refer to W260 as it relates to the facility's failure to ensure PCLPs were revised to accurately reflect and respond to an individual's current needs and functional changes. The cumulative effect of these systemic deficient practices significantly impeded the facility's ability to meet the individuals' active treatment needs.	W 196		
W 199	483.440(b)(2) ADMISSIONS, TRANSFERS, DISCHARGE Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the IDT reviewed current evaluation information prior to individuals being admitted to the facility for 1 of 1 individual (Individual #4) admitted to the facility within the past year. This failure resulted in potential for an individual to be admitted without indications the facility could meet his needs. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on	W 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 199	Continued From page 83 2/25/15. His diagnoses included Mild Intellectual Disability and Bi-polar I Disorder. A QIDP note documented the QIDP and Individual #4's guardian had a meeting on 2/4/15 from 11:00 a.m. to 12:00 p.m., prior to Individual #4's admission to the facility on 2/25/15. The note documented Individual #4 had been receiving services in a residential habilitation program and had lost "a lot of skills." The note documented he was refusing to shower, isolating in his room, did not want to change his clothes, was very unmotivated, he did not want to leave his apartment, and he could not remember things. The note also documented he was refusing to eat and drink regularly, which had resulted in hospitalization. The note stated he began receiving Risperdal (an antipsychotic drug) while in the hospital. Individual #4's record included a corresponding hospital report dated 7/30/14 which documented Individual #4 was admitted to the hospital on 7/28/14 with lithium toxicity and acute renal failure. The QIDP note stated the guardian would like to see Individual #4 re-learn skills he had forgotten and listed bathing, clean clothes, laundry, cooking, eating regularly, and going into the community. The note stated "would like him to move as soon as possible for health reasons and more training." When asked about Individual #4's admission, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4's mental health was unstable and the guardian was worried he might die if he stayed in his current placement. He had not been eating or drinking. When asked if Individual #4's failure to eat and drink was symptomatic of his depression or if he was actively suicidal, the QIDP stated she did not	W 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 199	Continued From page 84 know. Individual #4's record included pre-admission information garnered from staff at his residential habilitation placement on 2/5/15. However, Individual #4's record did not include documentation that an IDT meeting had been held in order to evaluate the preliminary information and determine if Individual #4's needs could be met by the facility. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated she had scheduled a meeting prior to Individual #4's admission, however, others failed to attend. The facility failed to ensure the IDT reviewed evaluation information prior to Individual #4's admission to the facility.	W 199		
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on policy and record review, and staff interview, it was determined the facility failed to ensure appropriate professionals were utilized in the development of the PCLP for 1 of 1 individual	W 206		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 206	Continued From page 85 (Individual #4) admitted to the facility within the past year. This resulted in a lack of programs being implemented necessary to meet an individual's needs. The findings include: 1. The facility's "Active Treatment/Growth and Development" policy, revised 9/23/15, stated in the assessment section that "When a new individual moves into one of the group homes, a team of professionals (Physician, Social Worker, QIDP, Dietician, Guardian, etc.) spends the first 30 days assessing the strengths and needs of the individual. This team is called the interdisciplinary team." The policy stated "The strengths and needs of the individual are then reviewed and prioritized into goals and objectives by the interdisciplinary team, the individual being served, and/or the legal guardian...." Further, the facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 9/23/15, documented on admission, the facility would make a determination of whether a safety plan needed to be implemented while further assessments were being completed. The factors to be considered included, but were not limited to: - "Historical maladaptive behavior - the risk of harm to self and/or others past behaviors will be the indicator that the need of a safety plan must be in place prior to admission. The safety plan will be in effect for a minimum of the first 30 days after admission, while further assessments are being completed." - "Potential environmental and medical factors that may contribute to the maladaptive behavior."	W 206		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 206	Continued From page 86 However, the "Active Treatment/Growth and Development" policy and the "Behavior Support Method Hierarchy & Definitions" policy was not implemented, as follows: Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's pre-admission records also included a Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, which stated "Depending on [Individual #4's] mental health status, he can complete his ADL's [sic] independently. When his mental health is unstable, he will isolate and not want to do anything. This is one of the main reasons he is coming back to Cougar Creek." Individual #4's record included a Meeting and In-Service signature sheet which documented his initial PCLP meeting was held on 3/17/15 from 1:00 - 1:30 p.m. The meeting was attended by Individual #4, Individual #4's guardian, the facility LPN, Program Supervisor, and the QIDP. Assessment information and recommendations from the PT, OT, SLP, and RD as well as a list of proposed Formal Programs and proposed Service Objectives was attached to the signature sheet. No other assessment information was present and no documentation of discussion regarding Individual #4's priority needs or programs was included. Additionally, Individual #4's record included a "Medication Management Progress Note," dated	W 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 206	Continued From page 87 3/13/15, which documented he was receiving Mirtazapine (an antidepressant drug) 30 mg each evening and Risperdal (an anti-psychotic drug) 1 mg twice a day. However, no assessment, defined signs and symptoms, proposed objectives, or discussion related to Individual #4's mental health was present in the 3/17/15 PCLP meeting minutes. Further, no information was present related to the drug use, how the drugs were to be monitored for desired response and adverse consequences, or how the drug use may change in relation to Individual #4's mental stability. When asked, during an interview on 3/4/16 from 2:00 to 4:35 p.m., the QIDP stated the facility was focused on Individual #4's ADLs for independence. The facility failed to ensure programs were implemented to meet identified mental health needs for Individual #4. Individual #4's record also included initial assessments, that were completed after the 3/17/15 PCLP meeting, as follows: - Individual #4's H&P Examination was completed on 3/19/15. - Individual #4's Nursing Evaluation was completed on 3/20/15. - Individual #4's Behavior Assessment was completed on 3/23/15. - Individual #4's Social Services Evaluation was completed on 3/24/15, which was also his PCLP implementation date. Without comprehensive assessment information, it would not be possible for the IDT to identify	W 206		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 206	Continued From page 88 Individual #4's priority needs necessary to establish objectives and design an effective active treatment program. During an interview on 3/7/16 from 2:05 - 4:35 p.m., the Clinical Director reviewed Individual #4's records but could not explain why the PCLP meeting was held prior to Individual #4's assessments being completed. The facility failed to ensure appropriate professionals were utilized in the development of Individual #4's PCLP.	W 206		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on policy and record review, and staff interview, it was determined the facility failed to ensure accurate assessments were conducted within 30 days for 1 of 1 individual (Individual #4) who was admitted to the facility within the last year. This resulted in a lack of information being available on which to base program intervention decisions. The findings include: 1. The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "When a new individual moves into one of the group homes, a team of professionals (Physician, Social Worker, QIDP, Dietician, Guardian, etc.)	W 210		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 210	Continued From page 89 spends the first 30 days assessing the strengths and needs of the individual." The policy was not implemented, as follows: Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. When asked about Individual #4's admission, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4's mental health was unstable and the guardian was worried he might die if he stayed in his current placement. He had not been eating or drinking. Individual #4's record included a Behavioral Assessment, dated 3/23/15, which stated he "has not displayed any maladaptive behaviors since his admission..." The "Impact on Daily Living" section of the assessment stated "When [Individual #4's] mental health is poor he will isolate and refuse to eat or drink. This has caused him to be hospitalized in the past." The assessment also stated he had an individualized, structured reinforcement plan and received Risperidone (an antipsychotic drug) and Mirtazapine (an antidepressant drug) to assist with his mood stabilization. The assessment did not include additional information regarding what his "structured reinforcement plan" was. His record did not include a point card exchange sheet, but no additional assessment information was present to determine how the point exchange had been established (e.g. how it was determined what	W 210		

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	13G037		03/08/2016

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W 210	Continued From page 90 items were reinforcing to Individual #4, how frequently and for what tasks points needed to be earned, and how many points were needed and how frequently exchanges were to be made in order for the reinforcement to be meaningful, etc.). Further, the assessment did not include any other information related to Individual #4's mood, what signs and symptoms were being monitored to evaluate his mental health status, interventions which were to be implemented to assist Individual #4 to manage his mental health symptoms, how his medications were being monitored for desired effect and adverse consequences, etc. When asked about the assessment, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated since Individual #4 had not displayed any maladaptive behaviors while at the facility that there was nothing to assess. The Clinical Director, who was also present during the interview, stated Individual #4 was new to the facility and they were not sure how the new environment would impact him so they were establishing baseline information. The QIDP stated they were monitoring Individual #4 mental health using the same signs and symptoms that had been used at his previous residential habilitation placement. The QIDP stated monitoring had begun in March 2015, but the data sheet could not be found. Without comprehensive assessment information, and comparative analysis between past and current behaviors, it would not be possible for the IDT to identify if or how Individual #4's new environment would impact him.	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 210	Continued From page 91 The facility failed to ensure comprehensive assessments were conducted within 30 days of Individual #4's admission.	W 210		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evaluation data was available to support the diagnoses for 2 of 4 individuals (Individuals #1 and #4) whose assessments were reviewed. This resulted in the potential for individuals to receive unnecessary interventions based on inaccurate evaluation data. The findings include: 1. Individual #1 was a 29 year old male admitted to the facility on 8/13/07. a. A PCLP, dated 3/10/15, showed diagnoses of Bipolar Disorder, IED, Impulsive Disorder, Pervasive Developmental Disorder/Asperger's Syndrome, Seizure Disorder - Partial, and mild intellectual disability. A subsequent PCLP, dated 2/4/16, showed diagnoses of Bipolar Disorder, OCD, Autism, Seizure disorder - Partial, IED and mild intellectual disability. Impulsive Disorder and Pervasive Developmental Disorder/Asperger's Syndrome were not included. An initial psychiatric clinic visit note by a new provider, dated 9/22/15, stated Individual #1 had	W 212		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 212	Continued From page 92 a history of Autism, OCD, and Tourette's Disorder. It also noted a "History of Bipolar Disorder, but unclear what constituted this diagnosis." b. A BIP, dated 3/17/14, attributed Individual #1's maladaptive behavior of verbal aggression to "Bipolar Disorder NOS" and an active treatment program was in place to decrease the behavior, stating the presumed function of the behavior was attention seeking. A BIP, dated 8/5/15, attributed the behavior to "Bipolar Disorder NOS, Pervasive Developmental Disorder, and Asperger's Syndrome." A BIP, dated 11/23/15, attributed the behavior to "OCD, Tourette's and Bipolar Disorder (by history)." A Functional Behavioral Assessment, dated 2/23/16, attributed the behavior to "Bipolar 1 Disorder, OCD, Autism, and IED." Individual #1's record did not include consistent information regarding what diagnosis contributed to his maladaptive behavior and no program changes were made when the causative diagnosis was changed. c. A BIP, dated 8/5/15, attributed Individual #1's maladaptive behavior of physical aggression to "Bipolar Disorder NOS." An active treatment program was in place to decrease the behavior, stating the presumed function of the behavior was attention seeking. BIPs, dated 11/19/15 and 2/23/16, said the behavior was due to "Autism."	W 212		

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W 212	Continued From page 93 It was unclear what diagnosis contributed to the maladaptive behavior and no program changes were made when the causative diagnosis was changed. When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the QIDP said the causative diagnoses were changed by the psychiatric care provider and were not questioned or discussed by the IDT. She said data was not collected to support the diagnosis changes. The facility failed to ensure there was supporting information for each diagnosis, and failed to ensure evaluations were completed for use in developing active treatment programs for Individual #1. 2. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability, Bi-polar I Disorder, hand tremors, diabetes mellitus type II, and hyperlipidemia. Individual #4's record was reviewed and included varying diagnoses which included, but were not limited to, the following: - A 3/19/15 H&P which documented a history of deviant sexual behavior and no major depressive disorder. - A 2/9/16 H&P which stated severe episodes of recurrent major depressive disorder. - A 3/16/15 CFA and 3/24/15 PCLP did not include deviant sexual behaviors and stated his level of intellectual disability was mild.	W 212		

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	13G037		03/08/2016

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W 212	Continued From page 94 - Psychiatric medication management progress notes from 7/8/15 - 2/10/16 stated his level of intellectual disability was moderate. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4's level of intellectual disability was mild. The facility failed to Individual #4's record contained consistent diagnostic information.	W 212		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior assessments contained comprehensive information for 2 of 3 individuals (Individuals #1 and #4) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: The facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 9/23/15, stated when an individual was being admitted, the facility would consider "Historical maladaptive behavior - the risk of harm to self and/or others past behaviors will be the indicator that the need of a safety plan must be in place prior to admission." Additionally, the policy stated the following information would be considered when	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 95 determining the need for a formal behavioral support program: "Baseline data of maladaptive behavior..." "Analysis of potential causes; for example, A [sic] retrospective analysis will occur investigating historical maladaptive behavior and experiences, Potential [sic] environmental and medical factors/physiological conditions for the maladaptive behavior, Lack [sic] of exposure to positive models and teaching strategies, Lack [sic] of ability to communicate needs and desire, Lack [sic] of success experiences, or other conditions which may elicit or sustain a behavior." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's record included a Behavioral Assessment, dated 3/23/15, which stated he "has not displayed any maladaptive behaviors since his admission..." The "Impact on Daily Living" section of the assessment stated "When [Individual #4's] mental health is poor he will isolate and refuse to eat or drink. This has caused him to be hospitalized in the past." The assessment also stated he had an individualized, structured reinforcement plan and received Risperidone (an antipsychotic drug) and Mirtazapine (an antidepressant drug) to assist with his mood stabilization. The assessment did not include any other	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 96 information related to Individual #4's mood, what signs and symptoms were being monitored to evaluate his mental health status, interventions which were to be implemented to assist Individual #4 to manage his mental health symptoms, how his medications were being monitored for desired effect and adverse consequences, etc. When asked about the assessment, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated since Individual #4 had not displayed any maladaptive behaviors while at the facility that there was nothing to assess. The Clinical Director, who was also present during the interview, stated Individual #4 was new to the facility and they were not sure how the new environment would impact him so they were establishing baseline information. The QIDP stated they were monitoring Individual #4 mental health using the same signs and symptoms that had been used at his previous residential habilitation placement. The QIDP stated monitoring had begun in March 2015, but the data sheet could not be found. However, Individual #4's QIDP data summaries documented he had engaged in depressive symptoms at the following rates: - April 2015: 41 - May 2015: 30 - June 2015: 46 Additionally, June data documented Individual #4 had engaged in suicidal ideation and had eloped from the facility. However, updates to Individual #4's behavior assessment were not evident until 7/28/15.	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 97 When asked about Individual #4's Behavior Assessment, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed the Behavior Assessment was not updated until 7/28/15. a. Individual #4's Functional Behavioral Assessment, dated 7/28/15, and revised 12/9/15 and 2/16/16, stated he moved to the facility on 2/25/15 due to physical health issues and documented he had refused to eat, drink and get out of bed. The assessment stated he "has a history of isolating, self-induced vomiting to avoid doing tasks and over and under eating..." The assessment stated in July 2015 he began showing signs of severe depression, made a suicide threat, eloped, and his sleep patter changed. The assessment stated "many medication changes have been done to the current date." The assessment also stated in October of 2015 "due to 2 reported incidents of sexual misconduct towards his suitemate" he was placed on "line of sight supervision." The assessment stated he remained on line of sight "due to his and other's safety." i. The facility's records included an investigation related to Individual #4's suicide threat on 6/3/15. The investigation included a hand-written note by the QIDP, dated 6/4/15, which stated "Due to history of trying to run away through his bedroom window, Graveyards please sit in his room by the window..." The facility's records also included an incident report, dated 6/7/15, which documented Individual #4 had eloped from the facility at 8:00 p.m. The investigation summary stated Individual #4 had taken his medications and went to his	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 98 room at approximately 7:45 p.m. When staff went to check on him, he was not found. He was located at approximately 9:00 p.m. at a local gas station. An investigation summary into the incident, dated 6/8/15, completed by the Clinical Director stated "I talked to [Individual #4] when he arrived back at the home. [Individual #4] stated that he was feeling bad and that the [sic] wanted to go to [name of town] to see his parents gravesite [sic]..." Further, his 6/9/15 Medication Management Progress Note documented Individual #4 "reports he is 'not good.' He states 'I'm mad at life.' He doesn't like his living situation. He eloped last Sunday with the plan to go to [town that his parents' grave sites were at]. He attempted to leave again last night..." When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had attempted to elope from the facility since his admission to the facility. The QIDP stated he had taken the screen to his bedroom window off. The Clinical Director, who was also present during the interview stated, Individual #4 would attempt to elope because he wanted to go see his parents, who were deceased and their grave sites were in another town. Further, an ABC log, dated 1/11/16 at 7:00 a.m., documented he was refusing all tasks and stated he did not care about going to another town and seeing his parents and a "Staff Statement" sheet dated 10/16/15 stated "Please watch for [Individual #4's] window when it is open. I noticed today that the screen was push [sic] out and	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 99 broken. He was laying on bed stairing [sic] at open window. I took screen [sic] off front of house & placed in [Individual #4's] window." However, the information was not present in Individual #4's Functional Behavioral Assessment and no additional information was garnered or assessed (e.g. review of previous information related to how talking about his parents was indicative of his mental health status, a review of data to determine how many times Individual #4 had attempted to elope and if the incidents were all predicated by him talking about his parents, a review of data to assess how frequently Individual #4 had been talking about his parents, how staff were to respond if Individual #4 talked about his parents, the efficacy of past interventions, etc.) and no information was present regarding Individual #4's attempts to elope, as indicated in his 6/9/15 Medication Management Progress Note. The facility failed to ensure Individual #4's Functional Behavioral Assessment included comprehensive information regarding his elopements and attempts to elope. ii. The assessment did not include additional information regarding sexual misconduct or the impacts that line of sight supervision had on Individual #4. Individual #4's records included an ABC log, dated 10/22/15 at 12:30 p.m., which stated Individual #1 had reported an incident to the staff. Individual #1 reported he was in his bathroom putting on deodorant and Individual #4 was laying on his bed. The door to the bathroom was open and Individual #4 pulled down his pants and	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 100 showed Individual #1 his "private area." The log documented Individual #1 "then came out and told me [staff] of the incident." Another ABC log, dated 10/23/15 at 12:00 p.m., stated Individual #1 reported to staff that he was in the bathroom and Individual #4 had exposed himself to Individual #1 "a second time after the first incident." A third ABC log, dated 10/23/15 at 1:30 p.m., documented Individual #1 went to use the restroom and the door was "wide open so staff did not realize another client [Individual #1] was using that restroom until [Individual #1] came out. [Individual #1] hadn't done up his pants yet. Staff pulled [Individual #1] to the side to ask if he felt like [Individual #4] was trying to expose his privates to him. [Individual #1] stated no he did not feel that way. Staff informed [Individual #1] if he ever felt that way to immediately [sic] notify staff on shift." A corresponding investigation report, dated 10/27/15, stated "It is concluded that when the individual was in the bathroom his housemate did expose himself from his bedroom." However, no information related to how this was concluded was present in the investigation. There was no documentation related to 10/23/15 report and there was no information that Individual #4 or other Individuals (beyond Individual #1) had been asked about Individual #4's behavior. Additionally, Individual #4's Social Service evaluation, dated 3/24/15 and revised on "1/28/15 [sic]," documented he "has attended SANE classes in his past due to sexually inappropriate behavior when he lived with his parents and	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 101 allegations of inappropriate behavior when he lived at the State School and Hospital." However, no additional information (e.g. was inappropriate conduct directed toward females, males, or both, what the outcome of the SANE classes was, etc.) was present in the evaluation. A "Line of Sight Guidelines" information sheet, dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. A thorough investigation into the incidents and a comprehensive assessment of his past and current sexual behavior was not included in Individual #4's Functional Behavioral Assessment, and information related to how the line of sight supervision was impacting his behaviors was not found. However, Individual #4's PCLP included an "Addendum," dated 2/4/16, which stated he was to see a neurologist "to rule out early onset dementia and/or Parkinson's disease" and would be "scheduled for a sexual assessment as soon as all medical issues are ruled out." When asked during an interview on 3/7/16 from	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 102 2:05 - 4:35 p.m., about ruling out medical issues prior to conducting a sexual assessment, the Clinical Director stated that was a judgement error. The facility failed to ensure Individual #4's sexual behaviors were comprehensively assessed prior to implementing restrictive interventions. b. The definitions section of the assessment stated Individual #4 exhibited depressive type symptoms by "irritable mood, diminished interest in activities, increase or decrease in appetite, changes in sleep pattern, fatigue or loss of energy, laying on bed isolating at odd times and/or suicidal ideation." No further information regarding what observable, measurable behaviors constituted the depressive symptoms was present in the assessment. i. The assessment stated his "diminished interest in activities causes him to be fatigued most of his day." No further information was present regarding the "diminished interest in activities," such as how many refusals were required to be considered symptomatic of his depression, if refusals to participate in known non-preferred activities were included in the definition, etc. Further, the assessment did not include information related to how Individual #4's "fatigue or loss of energy" was to be evaluated to determine normal amounts of fatigue (e.g. after increased amounts of physical exertion, when he was not feeling well, after a night in which he did not sleep well, etc.). ii. The assessment stated when Individual #4 was "...asked to participate in an activity, such as taking a shower, going to work, going to a	W 214		

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W 214	Continued From page 103 community activity, making a meal, etc. [Individual #4] will state that he doesn't feel like it, will say 'no!' and/or gets agitated if asked to [sic] frequently." The assessment did not include additional information related to what observable behaviors constituted "agitated." The assessment also stated "[Individual #4] will become irritated and if asked to [sic] frequently, he has physically assaulted staff which is uncharacteristic of his typical behavior." The assessment did not include additional information related to what observable behaviors constituted "irritated" prior to Individual #4 becoming physically assaultive. No information was present regarding how Individual #4 was assaultive (e.g. hitting, kicking, biting, throwing objects, etc.). Individual #4's pre-admission information, dated 2/5/15, stated he disliked "being over cued" and "people getting into his business." Additionally, his 3/24/15 PCLP stated Individual #4 did not like over-cuing, he "gets angry" when he is told what to do and he did not like people helping him when they "tell him what to do." Individual #4's ABC logs documented multiple incidents of aggression and other potential precursory statements in response to staff prompting. Examples included, but were not limited to the following: - 8/9/15 at 8:55 a.m.: Individual #4 was being prompted to take a shower. Staff documented on the third cue he "clenched his fists and brought them to his chest and said, 'oh brother, NO!' in a loud voice." - 9/1/15 at 7:56 a.m.: Staff documented Individual	W 214		

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W 214	Continued From page 104 #4 stated "Oh brother" three times, "Oh geez" and "You're a meanie" in response to prompting, then got up and "started to come after" the staff. - 9/21/15 9:45 p.m.: Staff documented Individual #4 stated "Oh brother" prior to throwing his clothes. - 9/21/15 at 7:10 p.m.: Charged at staff with his fists clenched. Further a Medication Management Progress Note, dated 9/24/15, stated "Staff report that pt. needs repeated prompting to shower. Pt. reports it irritates him to be prompted and would like to do it on his own..." - 10/2/15 from 4:00 - 4:15 p.m.: Staff documented Individual #4 was being prompted to participate and talked to about his deal with the QIDP to get out of the house once per day. Individual #4 stated "Alright, GOSH," then "got up with his fists clenched and advanced towards" staff. - 10/6/15 at 8:00 p.m.: Individual #4 was being prompted while brushing his teeth. He stated "Jesus Christ" three times. - 10/19/15 at 8:15 a.m.: Individual #4 was being prompted during his shower to wash his hair with soap and to get more soap for his "pits." Staff documented he said "Jesus Christ and fisted up and punched me in stomache [sic]." - 11/28/15 from 7:00 a.m. - 3:00 p.m.: Staff documented all cues "resulting in aggression, closed fists, body posture of coming at you." - 12/7/15 at 1:30 p.m.: Staff documented he was	W 214		

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	13G037		03/08/2016

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W 214	Continued From page 105 asked which fingernail clippers he would like to use. Individual #4 closed his fist and yelled. Staff documented Individual #4 "got all puffed up and was shaking" and staff was "in fear" of Individual #4 "attacking." - 12/15/15 at 4:10 p.m.: Staff documented Individual #4 was prompted to take his medications and he began breathing heavy and clenching his fists. - 12/21/15 at 12:00 p.m.: Staff documented Individual #4 wanted to air dry his hands after washing them and staff prompted him to use a paper towel to dry them. "He said NO! and clenched his fists and [his] face got puffed up." Staff documented Individual #4 said no 2 more times, then staff "backed up" and asked him again to get a paper towel. - 12/24/15 at 7:30 a.m.: Staff were prompting Individual #4 to get out of bed. Individual #4 said "no." Staff asked him why and Individual #4 "sat up made a fist pulled his arm back and said you better watch out buddy or I will put you in the hospital." - 1/4/16 at 9:00 a.m.: Staff was prompting Individual #4 to go to the pharmacy to obtain lancets. Staff documented Individual #4 "replied no several times," then became "agitated," was shaking and had a "puffed up face." - 1/18/16 at 1:15 p.m.: Staff documented Individual #4 became "agitated at staff cues to complete responsibilities & a shower. He kept saying 'No' or 'I don't know' after a couple more prompts [Individual #4] became really angry & got up, yelled 'no, no, no' and attacked [staff's name].	W 214		

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W 214	Continued From page 106 He backed her into the kitchen punching her 7x. He then stopped & went back & sat on the couch." The staff documented "The police were called (non-emergency) & are coming to speak with [Individual #4]." Additionally, his psychiatric Medication Management Progress Note, dated 10/27/15, stated he "has been more agitated and depressed...'charging at staff, with raised fists'...has not wanted to do anything...not showered for four days prior to today...has not been eating breakfast for the past week...isolating in his room...not going to work...punched two different staff after they asked him to use shampoo when he showered...has not been physically aggressive since staff made a behavior plan last week that included calling police if he is assaultive...replied 'I don't know' to most questions...not interested in anything..." The medication changes section stated Latuda 60 mg "every evening with meals." However, Individual #4's Functional Behavioral Assessment did not include any assessment information related to his aggression and it did not include information related to the behavior plan of calling the police. Further, the "Recommended refusal guidelines" section of his Functional Behavioral Assessment stated when Individual #4 does not engage in a task "prompt him again in 15 minutes by following the prompt hierarchy, up to light physical..." The assessment did not include information regarding how the 15 minute timeframe was established or how it was determined prompting every 15 minutes was not too frequent.	W 214		

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W 214	Continued From page 107 Additionally, the 15 minute recommendations were not consistent with Individual #4's Visual Calendar plan (which was identified as his replacement behavior programming on his Functional Behavioral Assessment) or his ADL programs. Individual #4's 8/1/15 Visual Calendar plan stated staff were to follow the prompt hierarchy up to a light physical prompt to assist Individual #4 to schedule the tasks he needed to do during the morning and evening shifts. The plan stated staff were to "allow at least 10 seconds between prompts." As stated Individual #4 was given an initial prompt, then 4 additional prompts within less than 1 minute. The plan also stated if Individual #4 refused all prompting, staff were to "re-cue in 5 minutes by following the prompt hierarchy." The plan was not consistent with the Functional Behavioral Assessment's 15 minute recommendation. Further, Individual #4's ADL programs were reviewed. Individual #4's ADL programs stated staff were to follow the prompt hierarchy in order to assist him to complete the tasks identified in the objectives. However, the programs were not consistent in providing direction to staff regarding how long to wait between prompts when following the prompt hierarchy. Examples included, but were not limited to, the following: - Individual #4's hygiene program, revised 9/10/15, stated staff were to wait at least 5 seconds between prompts. - Individual #4's hand washing program, revised	W 214		

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W 214	Continued From page 108 6/2/15, stated staff were to wait at least 15 seconds between prompts. - Individual #4's showering program, revised 6/2/15, did not specify the amount of time to wait between prompts. Additionally, the status section of Individual #4's vocational program for following 2 step directions, revised 10/2/15, stated "[Individual #4] can follow directions with verbal, gestural and physical prompts. [Individual #4] will comply with a request in 30 seconds..." Further, Individual #4's pre-admission records also included a Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, which stated "Depending on [Individual #4's] mental health status, he can complete his ADL's independently. When his mental health is unstable, he will isolate and not want to do anything. This is one of the main reasons he is coming back to Cougar Creek." However, Individual #4's Functional Behavioral Assessment did not include information related to adjusting prompt frequency based on his mental health status. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed prompting time frames had not been assessed. iii. The assessment stated Individual #4 "lays on the couch in the living room for long periods of time and does not interact with anyone." The assessment did not include information related to when it was reasonable and appropriate for Individual #4 to be on the couch or how long	W 214		

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W 214	Continued From page 109 Individual #4 was to remain on the couch (15 minutes, 2 hours, etc.) prior to it being considered symptomatic of his depression. Further, the definitions section of the plan stated "laying on bed isolating at odd times." No additional information was present regarding what "odd times" were and no information was included regarding when it was reasonable and appropriate for Individual #4 to be in his bedroom in private (e.g. separating himself from housemates who were being loud or creating an otherwise chaotic environment, etc.). iv. The assessment did not include any further information related to what constituted a change in Individual #4's sleep pattern. No information was present regarding what his normal sleep pattern was, when it was reasonable and appropriate to nap during the day (e.g. if he was not feeling well, if he did not sleep well the night before, etc.), how much sleep he required, etc. Additionally, Individual #4's Medication Management Progress Note, dated 6/9/15, documented Ativan (an anxiolytic drug) 1 mg each evening was being prescribed for sleep. His medication reduction plan, dated 7/8/15, stated it would be considered for discontinuation once Individual #4 was sleeping an average of 8 hours per night, but did not document for how long (e.g. a week, a month, etc.). Further, his 9/24/15 Medication Management Progress Notes documented the Ativan would be tapered and discontinued. When asked, during an interview on 3/4/16 from 2:00 p.m. - 4:35 p.m., if Individual #4's sleep had been assessed to determine what was adequate	W 214		

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W 214	Continued From page 110 but not excessive or too little, the QIDP stated it had not been assessed. v. The assessment did not include any further information related to increases or decreases in appetite (e.g. information related to what constituted a decrease such as not eating one meal, only eating half of a meal, refusing liquids once when offered, etc. and what an increase was, eating double portions, eating multiple snacks throughout the day, continuous eating, etc.). Further, no information related to his self-induced vomiting was present beyond the statement that Individual #4 had a history of self-induced vomiting to avoid doing tasks and that he would "try to self-induce vomiting so he can say he's sick." However, Individual #4's ABC Logs documented he had continued to attempt to self-induce vomiting. Examples included, but were not limited to, incidents documented on ABC logs dated 6/20/15, 7/8/15, 7/22/15, 10/3/15, 10/11/15 and 10/16/15. When asked, during an interview on 3/4/16 from 2:00 p.m. - 4:35 p.m., if Individual #4's self-induced vomiting had been assessed, the QIDP stated it had not been. vi. The assessment stated "Suicide ideation has been discontinued as a formal objective as [Individual #4] has went 7 consecutive months without a threat." No additional information, such as how many times Individual #4 had threatened suicide prior to his admission, what threats he had made, if he had ever acted on his threats, what was his method of choice (e.g. stabbing himself, threatening to hang himself, etc.) were	W 214		

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W 214	Continued From page 111 included in the assessment. Further, a QIDP note documented the QIDP and Individual #4's guardian had a meeting on 2/4/15 from 11:00 a.m. to 12:00 p.m., prior to Individual #4's admission to the facility on 2/25/15. The note documented he was refusing to eat and drink regularly, which had resulted in hospitalization. Individual #4's record included a corresponding report from the hospital, dated 7/30/14, which stated he had experienced lithium toxicity which was "likely caused by renal failure." When asked about Individual #4's admission, during an interview on 3/4/16 from 2:00 - 4:30 p.m., the QIDP stated Individual #4's mental health was unstable and the guardian was worried he might die if he stayed in his current placement. He had not been eating or drinking. When asked if Individual #4's failure to eat and drink was symptomatic of his depression or if he was actively suicidal, the QIDP stated she did not know. However, no information was present in the assessment which addressed the potential relationship between Individual #4's increases and decreases in appetite and his suicidal ideology. Additionally, the facility's records include an investigation related to the suicide threat Individual #4 made on 6/8/15. However, the incident was not adequately assessed and incorporated into Individual #4's Functional Behavioral Assessment. Examples included, but were not limited to, the following: - The investigation included the QIDP's 6/3/15	W 214		

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W 214	Continued From page 112 written statement on an ABC sheet. The ABC sheet documented Individual #4 stated he did not want to live at the facility anymore and that Individual #4 stated "he hates living here, hates all of the staff and clients." No information related to the pre-cursory statements was included in Individual #4's Functional Behavioral Assessment. - The QIDP's 6/3/15 written statement documented Individual #4 "...said he doesn't have any friends." - The QIDP's 6/3/15 written statement documented Individual #4 stated he wanted to die and he wanted to get a knife and stab himself. - Staff also documented on 6/3/15 that Individual #4 "was also quieter than normal and seemed less interested in what was going on around him." Another staff documented "he has been acting weird in the last two weeks...more tierd [sic] or afraid to speak and I don't know whats [sic] triggering this." No additional information was reviewed or garnered from staff related to the behaviors Individual #4 had displayed in order to assess and identify antecedent or triggering events. Further, a Medication Management Progress Note, dated 9/24/15, stated Individual #4's guardian reported Individual #4 "has not been talking spontaneously, typically says very little unless he asks him a question." However, no information was included in Individual #4's Functional Behavioral Assessment regarding being "quieter" as identified by the staff on 6/3/15 or a a lack of talking spontaneously as	W 214		

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W 214	Continued From page 113 identified by his guardian on 9/24/15. - Typed information from the QIDP, dated 6/3/15, stated Individual #4 was to be on suicide watch and remain under line of sight supervision at all times. The note stated due to Individual #4 wanting to use a knife, he was to be restricted from the kitchen and all knives were to be removed from the house and placed in the garage. - The QIDP note also stated Individual #4's guardian had been contacted. The guardian reported Individual #4 would try to drink excessively to make himself throw up. Drinking was to be restricted to 2-3 small cups at a time with a 30 minute wait until he could have more to drink. - The note stated interactions were to be limited and in the past Individual #4 had tried to talk about his parents, who were deceased, worrying about them. The note instructed staff to acknowledge Individual #4 with "I understand" and then stop interacting with him. - The note also stated the guardian reported Individual #4 "has not acted upon any of his threats but this does not mean that he might not. If [Individual #4] attempts to hurt himself, block and redirect him. [Individual #4] does respond in the past and has stopped. The biggest concern for [guardian's name] is that he will drink excessively to make himself throw up and not eat. If this happens, do not react, have [Individual #4] clean up his mess. If he does not want to eat, it is OK [sic] at this time and I will continue to monitor this."	W 214		

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W 214	Continued From page 114 No additional information was garnered, reviewed and assessed (e.g. pre-admission information related to past major depressive episodes, Individual #4's previous binging and purging and assessment of the efficacy of intervention strategies implemented prior to his admission, prior statements regarding his parents, the frequency of suicidal threats which had been made prior to his admission, additional information regarding the types of treats made, the frequency of episodes in which Individual #4 had attempted to hurt himself requiring staff intervention, etc.). - A suicide risk assessment was conducted on 6/5/15 at 3:45 p.m. The assessment documented Individual #4 had "not slept for the last 3 days. He continues to be very fidgety and told me he is not tired. He also stated that he 'doesn't feel right inside.' " Further, staff notes, dated 6/5/15, documented Individual #4 seemed confused when deciding what to wear and changed his mind several times. Staff also documented his energy was extremely low and when doing familiar tasks he required direction in tasks such as dressing, showering, and picking out his clothes. Another staff documented on, 6/5/15, that Individual #4 wanted to keep sleeping and went back to bed after taking his medications and eating breakfast. The note documented his hands and legs were fidgety and he was checking around the room to see if people were still watching. Staff documented they prompted him to watch a movie and sit outside. Other documented interventions included opening a window and "Turned Happy light on."	W 214		

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W 214	Continued From page 115 No additional information was garnered from staff, reviewed and assessed (e.g. if other episodes of being "fidgety" had been previously observed, if this a new manifestation caused by sleep deprivation, if fidgeting decreased subsequent to the medication increase, what impacts line of sight supervision was having on his depressive symptoms, was his low energy and confusion related to his depressive symptoms, sleep deprivation or both, was staff prompting negatively impacting his symptoms, as his PCLP had previously identified staff prompting resulted in Individual #4 becoming "angry," how long did staff allow Individual #4 to sleep during the day and did it result in a decrease in symptoms or impact his ability to sleep at night, were the interventions staff documented, such as the full spectrum light, appropriate, was the light left on for an appropriate amount of time and was the intervention attempted by other staff, what was the results of the interventions, did staff implement other interventions which were not documented and what was Individual #4's response, etc.) Further, Individual #4's ABC logs documented other instance of "fidgeting." Examples included, but were not limited to, the following: - 6/20/15 from 8:00 a.m. - 3:00 p.m.: staff documented Individual #4 was "fidgeting with beard and nose." - 7/8/15 at 3:15 p.m.: Staff documented he was "Constantly fidgeting with his face." Individual #4's ABC logs also documented other instance of "happy light" use. For example, staff documented in the antecedent section of the log	W 214		

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W 214	Continued From page 116 on 4/9/15 at 9:00 - 9:30 a.m.: "Morning Routine/Meds" and documented he was not upset and was prompted once. The behavior section of the log stated after eating breakfast and taking his medications, Individual #4 had returned to his room and layed in his bed. Staff prompted him to "...hang with rest of roommates while waiting for [roommate's initials and name] to get out of shower." The staff documented Individual #4 refused and 5 minutes later staff prompted him to brush his teeth, which he did. The consequences section of the log documented "offered happy light...offered open blinds...offered tooth brushing." No information related to a "happy light" was present on Individual #4's data sheets or his Functional Behavior Assessment (e.g. related to how or when it was to be used or if its use had been an effective intervention for Individual #4, etc.) When asked about the assessment, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had a full spectrum light and confirmed its use had not been assessed or addressed. c. Individual #4's Functional Behavioral Assessment stated he had started counseling on 6/15/15 and stopped on 7/8/15 due to "[Individual #4] not being able to discuss his issues." However, Individual #4's pre-admission information included a 2/11/13 Comprehensive Diagnostic Assessment from a mental health provider. The report documented Individual #4 was to be seen for counseling to address symptoms of depression, guilt, and bipolar mood	W 214		

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W 214	Continued From page 117 swings to develop coping strategies, process emotions and feelings and increase his self-esteem. Further, Individual #4's 2/5/15 pre-admission Preliminary Evaluation Form/Tentative Treatment Plan stated "New staff are hard for [Individual #4] to learn to build rapport with them." No additional information related to his past counseling was present in the Functional Behavioral Assessment and the assessment did not include an analysis related to why the 6/15/15 counseling attempt was unsuccessful (e.g. Individual #4 did not like the counselor, Individual #4 was experiencing severe depressive symptoms which interfered with his ability to express himself, not enough time was provided for Individual #4 to build rapport with the counselor, etc.). d. The Functional Behavioral Assessment stated the presumed function of the behavior was to "avoid participating in his active treatment" and included a replacement behavior objective for Individual #4 to "schedule his task for the shift using his visual calendar." No information related to Individual #4's ability to identify and manage the symptoms of his Bipolar Disorder was included in the assessment. However, Individual #4's pre-admission information included a 2/11/13 Comprehensive Diagnostic Assessment from a mental health provider. The report documented Individual #4 had limited insight and that his "ability to recognize and report symptoms is fair, but he does require some coaching to articulate symptoms and the impact they have on his stability and functioning. [Individual #4] states	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 214	Continued From page 118 that when he feels depressed he gets sad, lonely, and worries a lot. He has trouble recognizing triggers for his symptoms. Stressful situations can lead to him getting more depressed. He states he has some mood swings. [Individual #4] required some assistance in recognizing symptoms of low motivation, isolation and anger." Further, Individual #4's ABC logs documented multiple interventions which had been attempted but were not defined, consistently applied or evaluated for efficacy. Examples included, but were not limited to, the following: - 6/16/15: Individual #4 was "overeating" and staff asked him to use "coping skills." On 9/21/15 at 7:10 p.m., Individual #4 "charged" at staff. Staff documented "Tried getting him to use coping skills." No additional information related to what Individual #4's coping skills were was present on the ABC log or in his Functional Behavioral Assessment. - 9/1/15 at 7:56 p.m.: Staff documented the used "first this, then this" interventions and giving choices. - 10/2/15 from 4:00 - 4:15 p.m.: Staff documented Individual #4 was being prompted to participate and talked to about his deal with the QIDP to get out of the house once per day. No information was present regarding what the "deal" was or how long it was in effect. - 10/26/15 at 3:00 p.m.: Cued to participate every 15 - 30 minutes. - 1/18/16 at 1:15 p.m.: Staff documented Individual #4 became "agitated at staff cues to	W 214		

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W 214	Continued From page 119 complete responsibilities & a shower. He kept saying 'No' or 'I don't know' after a couple more prompts [Individual #4] became really angry & got up, yelled 'no, no, no' and attacked [staff's name]. He backed her into the kitchen punching her 7x. He then stopped & went back & sat on the couch." The staff documented "The police were called (non-emergency) & are coming to speak with [Individual #4]." No additional information was present on the ABC log which indicated if or when the police spoke to Individual #4 and what the outcome was. e. Individual #4's records documented other factors impacting his mental health, which were not addressed in his Functional Behavioral Assessment. Examples included, but were not limited to, the following: i. Individual #4's pre-admission information stated Individual #4 had a job but was fired due to poor attendance and "He currently does not want to work but this could be due to his unstable mental health." The preliminary information further stated "It is hoped that he will have interest when he moves back to Cougar Creek." Additionally, Individual #4's 2/26/15 OT Report, completed after he was admitted to the facility, stated in the past Individual #4 had worked at a gas station and "states he would like to work there again. This was a big motivator for [Individual #4] to get out of bed compared to prior vocational training activities." The assessment also stated Individual #4 would "like to maximize outings including: eating out, movies, park, fishing, basketball at the YMCA, swimming and baseball." The assessment included a recommendation to "Inquire with potential	W 214		

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W 214	Continued From page 120 employers to obtain work if appropriate." However, Individual #4's Functional Behavioral Assessment did not include information related to how not having a job and not participating in community activities either impacted or were symptomatic of his mental health status. ii. Individual #4's 2/5/15 pre-admission Preliminary Evaluation Form/Tentative Treatment Plan stated "New staff are hard for [Individual #4] to learn to build rapport with them." Further, Individual #4's Medication Management Progress Note, dated 7/30/15, stated the QIDP "reports that there has been many staff changes over the past month an that is most likely why pt. has exhibited an increase in symptoms." However, Individual #4's Functional Behavioral Assessment did not include information related to how staff changes impacted his behavior. iii. Individual #4's records included a "Comprehensive Diagnostic Assessment", dated 2/4/16, from his mental health medication management agency. The assessment stated in the 2016 update section that "[Individual #4] had minimal to report and allowed others to contribute for him. His team reports he experienced a major depressive episode in July and is still getting back to baseline; though he has shown a few 'manic behaviors' in the past few days." No information related to what baseline was or what "manic behaviors" Individual #4 had demonstrated was present in the assessment. The assessment stated "The team reports 'A	W 214		

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W 214	Continued From page 121 tough year with positive moments' and multiple 'not so good days' in which the client does not leave his room or couch, attend to personal hygiene, does not eat, and refuses to get his blood sugar levels checked. Client has had a few instances of getting physically aggressive with staff when he is angry. The team also reports some concerns about Parkinson's or dementia as some of his skills have been diminishing and he has severe hand tremors; an appointment has been scheduled with his medical doctor. Client was in a positive mood and reported liking where he currently resides." Additionally, Individual #4's PCLP included an "Addendum", dated 2/4/16 and signed by the QIDP, which stated the following: "Despite multiple positive reinforcements/interventions, [Individual #4] still continues to refuse to participate in his active treatment program. He continues to struggle with depressive type symptoms and is seen regularly by his med manager." "It is the team's consensus that [Individual #4] has lost many skills that he used to have in his ADL's and ability to think. [Individual #4] exhibits many signs of dementia/Parkinson's disease. [Individual #4] has been referred to his primary physician for a referral for a brain scan and possible referral to a neurologist to rule out early onset dementia and/or Parkinson's disease. Therefore, until it is confirmed or denied, no changes will be made in [Individual#4's] programming. Staff will continue to document every 1/2 hour the activities/tasks that are offered to [Individual #4] and his response. 1 hour documentation will be done on the graveyards..."	W 214		

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W 214	Continued From page 122 When asked, during an interview on 3/7/16 from 2:05 - 4:35 p.m. about the signs of dementia Individual #4 was displaying, the QIDP and the Administrator stated he would become confused, such as not being able to remember how to put on his shirt. However, Individual #4's 9/1/15 behavior plans included "Decreased ability to think" as a depressive symptom, until the plan was revised on 2/16/16. The 9/1/15 plan included the following: - Symptom: "Decreased ability to think." Behavior: "Being confused as to what to wear, what the next step of a task is that [Individual #4] knows, standing in front of an item i.e. dresser and doesn't know what he needs." QIDP summaries documented he had demonstrated a "decreased ability to think" at the following rates: April 2015: 1 May 2015: 0 June 2015: 4 July 2015: 3 August 2015: 1 September 2015: 0 October 2015: 0 November 2015: 0 December 2015: 0 January 2016: 0 When asked, during an interview on 3/7/16 2:05 - 4:35 p.m., the QIDP and the Administrator could not differentiate confusion when Individual #4 was depressed or how it was determined confusion	W 214		

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W 214	Continued From page 123 was not an adverse side effect of his psychotropic medications. When asked what other symptoms Individual #4 demonstrated, the QIDP stated the nurse would need to be asked. When asked what symptoms of Parkinson's Individual #4 was demonstrating, the QIDP stated he had hand tremors. However, Individual #4's Social Evaluation, revised 1/28/15 [sic], stated Individual #4 had been on Propranolol, but the medication was discontinued in 2007 or 2008 to "monitor for reduced hand tremor" and his 3/20/15 Annual Nursing Assessment documented "his physician had recommended discontinuation of Depakote due to persistent hand tremors some time between 2007 and 2008. No information was present to differentiate when hand tremors were a known, normal occurrence or when they were an adverse side effect of his psychotropic medications. When asked what other symptoms of Parkinson's Individual #4 was demonstrating, the QIDP stated the nurse would need to be asked. The facility failed to ensure Individual #4's Functional Behavioral Assessment contained comprehensive information on which to base intervention decisions. 2. Individual #1's IPP, dated 2/23/16, stated he was a 29 year old male with diagnoses including bipolar disorder, OCD, and autism. a. His Functional Behavior Assessment, dated 2/23/16, stated his verbal aggression occurred when Individual #1 was bored, when he wanted to engage in a power struggle, when teasing was going on in the house, when he was seeking	W 214		

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W 214	Continued From page 124 attention, or when he was overwhelmed by his environment and needing to let out frustration. However, the presumed function of the behavior section stated only "to get attention." The assessment did not include additional information regarding the other causes of his verbal aggression (when he was bored,when he wanted to engage in a power struggle, when teasing was going on in the house, or when he was overwhelmed by his environment and needing to let out frustration). b. His Functional Behavior Assessment stated his physical aggression occurred when the environment was noisy/unorganized, when he was seeking attention, when programs were changed, when a peer was having difficulty, or when he was asked to wait for an activity. However, the presumed function of the behavior section stated only "to get attention." The assessment did not include additional information regarding the other causes of his physical aggression (when the environment was noisy/unorganized, when programs were changed, when a peer was having difficulty, or when he was asked to wait for an activity). c. His Functional Behavior Assessment stated his maladaptive behavior of elopement occurred when he wanted attention, had a change in routine, or when he was asked to wait to do an activity. However, the presumed function of the behavior section stated only "to get attention."	W 214		

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W 214	Continued From page 125 The assessment did not include additional information regarding the other causes of his elopement (when he had a change in routine, or when he was asked to wait to do an activity). In an interview on 3/7/16 from 2:05 - 4:35 p.m., the QIDP confirmed Individual #1's Functional Behavioral Assessment information. The facility failed to ensure Individual #1's Functional Behavioral Assessment included consistent, comprehensive information regarding the function of his maladaptive behaviors.	W 214		
W 216	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's CFA included comprehensive health information for 1 of 4 individuals (Individual #4) whose CFAs were reviewed. This resulted in a lack of information being available on which to base program intervention and health decisions. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. His record did not include accurate, consistent information related to his health, as follows: Individual #4's pre-admission information included a hospital report, dated 7/30/14, which	W 216		

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	13G037		03/08/2016

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W 216	Continued From page 126 stated he had experienced lithium toxicity which was "likely caused by renal failure." However, the "Relevant History" section of his initial History and Physical form, signed by a Nurse Practitioner on 3/19/15 did not include the hospitalization and illness. Further, the medications section was not consistent with the medications listed in the dictation notes attached to the History and Physical form. Additionally, Individual #4's 3/20/15 Nursing Summary did not include information related to his 7/28/14 hospitalization. The Nursing Summary also stated he was seen for an examination of his vision on 4/29/08 and it was noted at the time of the appointment that Individual #4 had lost his glasses from a previous prescription. The note stated Individual #4 was given a modified prescription for protective lenses but he usually refused to wear glasses. T he note stated staff continued to encourage Individual #4 to wear his glasses on a daily basis. No current information related to the status of Individual #4's vision or whether he required glasses was included in the Nursing Summary. Further, the Nursing Assessment stated Individual #4 continued to work part time at a convenience store. However, another section of the report documented he was volunteering in the Meals on Wheels program. The information was not consistent with Individual #4's 2/26/15 OT Report which stated in the past Individual #4 had worked at a gas station and "states he would like to work there again. This was a big motivator for [Individual #4] to get out of bed compared to prior vocational training activities." When asked about the assessments during an	W 216		

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W 216	Continued From page 127 interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had quit his job prior to being admitted. The Administrator, who was also present during the interview, stated Individual #4 had previously been a resident of the company. She stated staff may have pulled up his previous records and updated them, but had not changed the language to ensure the information was clear as to what was historic and what was new. When asked, the QIDP stated it was her responsibility to ensure discrepancies between assessments were resolved. When asked about Individual #4's vision, the QIDP stated she had not been told he needed glasses. She stated she had recently read the information related to his glasses, but had not been told about the need previously. The LPN, who was also present during the interview, stated Individual #4 had an updated eye exam on 3/25/15. She stated the recommendations were not clear in specifying whether or not Individual #4 required glasses and the QIDP stated the issue needed to be clarified. The facility failed to ensure Individual #4's physical assessments included comprehensive, accurate information.	W 216		
W 217	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a dietary assessment contained comprehensive information for 1 of 4 individuals (Individual #4) whose dietary assessments were reviewed. This	W 217		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 217	Continued From page 128 resulted in a lack of comprehensive information being available necessary to ensure Individual #4's dietary needs were being addressed. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male. His diagnoses included mild intellectual disability, Bi-polar I Disorder, hand tremors, hyperlipidemia, and diabetes mellitus type II. A QIDP note documented the QIDP and Individual #4's legal guardian had a meeting on 2/4/15 from 11:00 a.m. to 12:00 p.m., prior to Individual #4's admission to the facility on 2/25/15. The note documented Individual #4 had been receiving services in a residential habilitation program and had lost "a lot of skills." The note documented he was refusing to shower, isolating in his room, did not want to change his clothes, was very unmotivated, did not want to leave his apartment, and could not remember things. The note also documented he was refusing to eat and drink regularly, which had resulted in hospitalization. Individual #4's record included a corresponding hospital report, dated 7/30/14, which stated he had experienced lithium toxicity which was "likely caused by renal failure." The hospital report also documented Individual #4 had diagnoses which included diabetes mellitus and "h/o bipolar." Individual #4's record also included a 2/5/15 Preliminary Evaluation Form/Tentative Treatment Plan that documented Individual #4 "may binge and purge." However, Individual #4's 2/27/15 Nutritional	W 217		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 217	Continued From page 129 Assessment did not include the diagnoses of diabetes mellitus or information related to his depression, including his previous refusals to eat and drink which required hospitalization, and that he may binge and purge. Further, the assessment documented Individual #4 was admitted to the facility on 5/2/03. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated it was her responsibility to ensure discrepancies between assessments were resolved. The facility failed to ensure Individual #4's Nutritional Assessment contained comprehensive, accurate information.	W 217		
W 219	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include affective development. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure affective development was comprehensively assessed for 1 of 4 individuals (Individual #4) whose CFAs were reviewed. This failure significantly impeded staff's ability to consistently identify changes in an individual's mood. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability, Bi-polar I Disorder, hand tremors. He was admitted to the facility on 2/25/15.	W 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 219	Continued From page 130 Individual #4's record documented the following regarding his affect: - Individual #4's 5/8/15 psychiatric progress note stated "staff and guardian report that pt. seems 'flat,' does not respond excitedly about things as he used to." - Staff documented on 6/3/15, that Individual #4 "was also quieter than normal and seemed less interested in what was going on around him." Another staff documented on 6/3/15, "he has been acting weird in the last two weeks...more tierd [sic] or afraid to speak and I don't know whats [sic] triggering this." - His 7/8/15 psychiatric progress note stated "...has no interest in things...not himself, he has no personality..." - His 7/30/15 psychiatric progress note stated he "actually had an increase in depressive systems...his affect has been brighter..." - His 9/24/15 psychiatric progress note stated "[guardian] reports pt. has not been talking spontaneously, typically says very little unless he asks him a question." However, Individual #4's 3/16/15 CFA did not include information related to his usual affect. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated all updates would be documented in Individual #4's CFA. Without comprehensive information related to Individual #4's usual mood, staff's ability to	W 219		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 219	Continued From page 131 identify changes would be significantly impeded. The facility failed to ensure Individual #4's CFA included comprehensive information regarding his affect.	W 219		
W 222	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include cognitive development. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure cognitive development was adequately assessed for 1 of 4 individuals (Individual #4) whose assessments were reviewed. This resulted in the potential for an individual to not receive necessary programming and interventions to meet his needs. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. He was admitted to the facility on 2/25/15. Individual #4's pre-admission records included a Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, which stated "Depending on [Individual #4's] mental health status, he can complete his ADL's independently. When his mental health is unstable, he will isolate and not want to do anything. This is one of the main reasons he was coming back to Cougar Creek." The evaluation also stated Individual #4 learned faster when he was shown what to do and disliked "being over cued" and "people getting into his business."	W 222		

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W 222	Continued From page 132 Further, Individual #4's PCLP stated Individual #4 did not like over-cuing, he "gets angry" when he is told what to do and he did not like people helping him when they "tell him what to do." His 2/16/16 Functional Behavioral Assessment stated when Individual #4 was "...asked to participate in an activity, such as taking a shower, going to work, going to a community activity, making a meal, etc. [Individual #4] will state that he doesn't feel like it, will say 'no!' and/or gets agitated if asked to [sic] frequently." The assessment also stated "[Individual #4] will become irritated and if asked to [sic] frequently, he has physically assaulted staff which is uncharacteristic of his typical behavior." Further a Medication Management Progress Note, dated 9/24/15 stated "Staff report that pt. needs repeated prompting to shower. Pt. reports it irritates him to be prompted and would like to do it on his own..." However, Individual #4's 3/16/15 CFA included a prompt hierarchy to document his level of independence on all ADL tasks. The facility's prompt hierarchy was set as follows: SI - Self initiate G - Gesture NV - Non-Specific Verbal SV - Specific Verbal LP - Light Physical FP - Full Physical R - Resident refuses The CFA did not include modeling or showing Individual #4 how to do things, rather than providing progressively intrusive prompts.	W 222		

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W 222	Continued From page 133 When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated all updates would be documented in Individual #4's CFA. The facility failed to ensure Individual #4's CFA reflected his preferred learning style.	W 222		
W 223	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include social development. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's CFA include consistent comprehensive social information for 1 of 4 individuals (Individual #4) whose CFAs were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. However, his Social Service evaluation, dated 3/24/15 and revised on "1/28/15 [sic]," documented he was admitted to the facility on 2/18/15. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m. about the discrepancies, the Clinical Director, who was also the facility's Social Worker, stated Individual #4's admission date had been moved several times and he was admitted on 2/25/15. He stated he would correct the evaluation.	W 223		

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W 223	Continued From page 134 Individual #4's Social Evaluation did not include comprehensive information, as follows: a. Individual #4's pre-admission information included a Comprehensive Diagnostic Assessment from a mental health provider, dated 12/11/13, which documented Individual #4 did not make friends easily, and stated "he gets nervous around people." However, Individual #4's 3/24/15 Social Evaluation did not include information related to Individual #4's friends, and only identified his guardian and his guardian's wife as non-staff and non-family members who were important in his life. Individual #4's Social Evaluation also stated he continued to work at a part time job, he had attended SANE classes in the past due to sexually inappropriate behavior, he had a brother who lived out of state who occasionally visited, and 3 sisters that Individual #4 visited when he could. However, Individual #4's CFA, completed by the QIDP, stated he was not working, did not include information related to his sexual misconduct, and stated he could not have unsupervised visits with his siblings. However, Individual #4's pre-admission information included a Comprehensive Diagnostic Assessment from a mental health provider, dated 12/11/13, which documented abuse among the siblings, but no information was present regarding visit restrictions. Further, the report stated he visited his sisters on holidays and birthdays and had a lot of nieces and nephews. The report stated he saw his extended family as often as possible and staff reported that Individual #4's	W 223		

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W 223	Continued From page 135 family "has a good time when they are together and look forward to seeing each other. He states he receives as much support as possible from his family." When asked about the discrepancies during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had quit his job prior to being admitted. The Clinical Director, who was also the facility's Social Worker stated the Social Evaluation captured historical information related to Individual #4's SANE classes and sexual misconduct and the CFA was more current as they were not aware of Individual #4 engaging in sexual misconduct currently or in the recent past. When asked about the supervised visits with his siblings, the QIDP stated they had always been restricted and the information came from Individual #4's guardian. When asked about documentation to support the restriction necessary to ensure Individual #4's right to the opportunity to communicate, associate and meet privately with individuals of his choice was not violated, the Clinical Director stated he did not think the restriction was for a specific reason, but a matter of staff needing to take Individual #4 to visit his family. When asked, the QIDP stated it was her responsibility to ensure discrepancies between assessments were resolved. b. Individual #4's pre-admission records included a Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, which stated he would need assistance to increase his leisure activities. Individual #4's CFA home leisure section stated he was independent when selecting something to do at home for fun when given a choice, plays	W 223		

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	13G037		03/08/2016

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W 223	Continued From page 136 with a pet without hurting it or getting hurt, and puts similar objects together in a collection as a hobby. The comments section stated due to his unstable mental health, he had lost interest in leisure activities. However, a comprehensive list of what leisure activities had been tried and found to be of current interest to Individual #4 was not present on his CFA. Additionally, the recreational, leisure, and retirement section of his CFA stated Individual #4 said he would like to learn how to read. However, no objectives or programming related to teaching Individual #4 was present on his PCLP, and his CFA did not include additional information, such as Individual #4 being developmentally incapable of learning to read. Further, Individual #4's Behavioral Assessment, dated 3/23/15, stated he exhibited depressive type symptoms which included "diminished interest in activities." The assessment also stated his "diminished interest in activities causes him to be fatigued most of his day." When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated all updates would be documented in Individual #4's CFA. Without comprehensive information related to Individual #4's interest in activities, staff's ability to identify diminished interest would be significantly impeded. The facility failed to ensure Individual #4's CFA included comprehensive information regarding his interests.	W 223		

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W 227	Continued From page 137	W 227		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's PCLPs included objectives to meet the needs of 1 of 4 individuals (Individual #4) whose PCLPs were reviewed. This resulted in a lack of program plans designed to promote an individual's independence and maximize his developmental potential. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated the IDT would spend the first 30 days "assessing the strengths and needs of the individuals." The policy stated "The strengths and needs of the individual are then reviewed and prioritized into goals and objectives by the interdisciplinary team, the individual being served, and/or the legal guardian." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's PCLP did not include specific objectives designed to meet his individualized needs.	W 227		

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W 227	Continued From page 138 Examples included, but were not limited to, the following: a. Individual #4's records documented he had eloped and attempted to elope from the facility on 6/7/15 and 6/8/15. Further, the facility's records included an investigation related to a suicide threat Individual #4 had made on 6/3/15. The investigation included a hand-written note by the QIDP, dated 6/4/15, which stated "Due to history of trying to run away through his bedroom window, Graveyards please sit in his room by the window..." When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual had attempted to elope from the facility since his admission to the facility. The QIDP stated he had taken the screen to his bedroom window off. The Clinical Director, who was also present during the interview, stated Individual #4 would attempt to elope because he wanted to go see his parents, who were deceased and their grave sites were in another town. Further, an ABC log dated 1/11/16 at 7:00 a.m., documented he was refusing all tasks and stated he did not care about going to another town and seeing his parents, and a "Staff Statement" sheet, dated 10/16/15, stated "Please watch for [Individual #4's] window when it is open. I noticed today that the screen was push [sic] out and broken. He was laying on bed stairing [sic] at open window. I took screen [sic] off front of house & placed in [Individual #4's] window." However, no objective or program plans addressing the behavior had been developed.	W 227		

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W 227	Continued From page 139 b. Individual #4's ABC Logs documented he had attempted to self- induce vomiting. Examples included, but were not limited to, ABC logs completed on 6/20/15, 7/8/15, 7/22/15, 10/11/15, 10/3/15 and 10/16/15. However, no objective or program plans addressing the behavior had been developed. c. A 10/27/15 investigation report documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet dated, 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. However, no objective or program plans addressing the behavior had been developed. d. Individual #4's ABC logs documented multiple incidents of aggression and other potential precursory statements in response to staff prompting. Examples included, but were not limited to, ABC logs completed on 8/9/15, 9/1/15,	W 227		

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W 227	Continued From page 140 10/2/15, 10/19/15, 11/28/15, and 12/24/15. Further, staff documented, on 1/18/16 at 1:15 p.m., Individual #4 became "agitated at staff cues to complete responsibilities & a shower. He kept saying 'No' or 'I don't know' after a couple more prompts [Individual #4] became really angry & got up, yelled 'no, no, no' and attacked [staff's name]. He backed her into the kitchen punching her 7x. He then stopped & went back & sat on the couch." The staff documented "The police were called (non-emergency) & are coming to speak with [Individual #4]." Additionally, his psychiatric Medication Management Progress Note, dated 10/27/15, stated he "was more agitated and depressed...'charging at staff, with raised fists'...has not wanted to do anything...not showered for four days prior to today...has not been eating breakfast for the past week...isolating in his room...not going to work...punched two different staff after they asked him to use shampoo when he showered...has not been physically aggressive since staff made a behavior plan last week that included calling police if he is assaultive...replied 'I don't know' to most questions...not interested in anything..." The medication changes section stated Latuda (an antipsychotic drug) 60 mg "every evening with meals." However, no objective or program plans addressing the behavior (including the intervention of calling the police) had been developed. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed the behaviors had not been assessed and objectives	W 227		

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W 227	Continued From page 141 had not been developed. The facility failed to ensure objectives were developed to meet Individual #4's needs.	W 227		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clear, consistent direction to staff was provided in each written training program for 1 of 4 individuals (Individual #4) whose training plans were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program strategies. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "training programs must first be designed to utilize the least restrictive method as is possible and specify...The methods to be used." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. a. The "Recommended refusal guidelines" section of Individual #4's Functional Behavioral Assessment stated when Individual #4 does not engage in a task "prompt him again in 15 minutes by following the prompt hierarchy, up to light physical..."	W 234		

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W 234	Continued From page 142 Individual #4's 8/1/15 Visual Calendar plan stated staff were to follow the prompt hierarchy (self-initiation, gesture, non-specific, specific verbal, and light physical prompt) up to a light physical prompt to assist Individual #4 to schedule the tasks he needed to do during the morning and evening shifts. The plan stated staff were to "allow at least 10 seconds between prompts." As stated, Individual #4 was given an initial prompt, then 4 additional prompts within 40 seconds. The plan also stated if Individual #4 refused all prompting, staff were to "re-cue in 5 minutes by following the prompt hierarchy." The plan was not consistent with the Functional Behavioral Assessment's 15 minute recommendation. Further, Individual #4's ADL programs were reviewed. Individual #4's ADL programs stated staff were to follow the prompt hierarchy in order to assist him to complete the tasks identified in the objectives. However, the programs were not consistent in providing direction to staff regarding how long to wait between prompts when following the prompt hierarchy. Examples included, but were not limited to, the following: - Individual #4's hygiene program, revised 9/10/15, and tooth brushing program, revised 3/24/15, stated staff were to wait at least 5 seconds between prompts. - Individual #4's hand washing program, revised 6/2/15, stated staff were to wait at least 15 seconds between prompts. - Individual #4's showering program, revised	W 234		

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W 234	Continued From page 143 6/2/15, did not specify the amount of time to wait between prompts. Additionally, the status section of Individual #4's vocational program for following 2 step directions, revised 10/2/15, stated "[Individual #4] can follow directions with verbal, gestural and physical prompts. [Individual #4] will comply with a request in 30 seconds..." When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed prompting time frames had not been assessed. The facility failed to ensure Individual #4's training programs contained consistent information based on his assessed strengths and needs. b. A "Line of Sight Guidelines" information sheet dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was to be cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. Additionally, Individual #4's formal showering program stated he would wash his hair while showering with a non-specific verbal prompt. His individual support plan, dated 6/2/15, stated staff were to provide as much privacy as possible but	W 234		

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W 234	Continued From page 144 remain in the area to ensure he washed all his body parts and hair. The plan did not include information related to how staff were to implement Individual #4's showering program and provide line of sight supervision. Further, interviews were conducted with 4 facility staff on 3/1/16 from 11:05 - 11:15 a.m. regarding Individual #4's Line of Sight Guidelines. - One staff stated Individual #4 was to be in line of sight at all times and staff were to be able to see him from head to toe at all times. When he was in the shower or the bathroom, the door to the bathroom was to be open to make sure he did not leave the bathroom through the other bathroom door. - Another staff stated when Individual #4 was in the shower or bathroom, the bathroom door was to be open to make sure he was in the bathroom. When he was in the shower, the shower curtain would be opened in the shape of a window to ensure he was in the shower. - Another staff stated when Individual #4 was in the bathroom, the door would be open so that Individual #4 could be visualized in the mirror. When he was in the shower, staff were to keep the bathroom door partially open. - Another staff stated when Individual #4 was in the bathroom, the door was to be open. When he was in the shower, the shower curtain would be opened in the shape of a window to ensure he was in the shower. The facility failed to ensure Individual #4's program instructions were consistent and	W 234		

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	13G037		03/08/2016

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W 234	Continued From page 145 included sufficient information on how to implement his training programs.	W 234		
W 238	483.440(c)(5)(v) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the inappropriate client behavior(s), if applicable. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure training programs specified behaviors which interfered with functional abilities for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in programming which was insufficient to meet an individual's active treatment needs. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's pre-admission records included a Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, which stated "Depending on [Individual #4's] mental health status, he can complete his ADL's independently. When his mental health is unstable, he will isolate and not want to do anything. This is one of the main reasons he is coming back to Cougar Creek." Individual #4's ADL programs (including showering, laundry, tooth brushing, etc.) were reviewed. The programs stated staff were to follow the prompt hierarchy in order to assist him	W 238		

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	13G037		03/08/2016

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W 238	Continued From page 146 to complete the tasks identified in the objectives. However, the programs did not include information related to how Individual #4's mental status impacted his ability and willingness to complete the programs or if staff were to adjust programming (e.g. number of prompts given, time frames between prompts given, etc.) based on Individual #4's mental status. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed prompting time frames had not been assessed. The facility failed to ensure individual training programs specified behaviors which interfered with Individual #4's functional abilities.	W 238		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure replacement behavior training was appropriate to address individuals maladaptive behaviors for 2 of 4 individuals (Individuals #1 and #4) whose behavior plans were reviewed. This resulted in individuals not receiving functional training related to maladaptive behaviors. The findings include: The facility's Active Treatment/Growth and	W 239		

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W 239	Continued From page 147 Development policy, revised 9/23/15, stated "training programs must first be designed to utilize the least restrictive method as is possible and specify...Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar 1 Disorder. Individual #4's Functional Behavioral Assessment, revised 12/9/15 and 2/16/16, stated he moved to the facility on 2/25/15 due to physical health issues and documented he had refused to eat, drink and get out of bed. The assessment stated he "has a history of isolating, self-induced vomiting to avoid doing tasks and over and under eating..." The assessment stated in July 2015 he began showing signs of severe depression, made a suicide threat, eloped, and his sleep pattern changed. The assessment stated "many medication changes have been done to the current date." The assessment also stated in October of 2015 "due to 2 reported incidents of sexual misconduct towards his suitemate" he was placed on line of sight supervision. The assessment stated he remained on line of sight "due to his and other's safety." The assessment stated the "presumed function" of his depressive symptoms was to "avoid task requests" and included replacement behavior training of following a "visual calendar."	W 239		

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W 239	Continued From page 148 a. Individual #4's pre-admission information included a 2/11/13 Comprehensive Diagnostic Assessment from a mental health provider. The report documented Individual #4 had limited insight and that his "ability to recognize and report symptoms is fair, but he does require some coaching to articulate symptoms and the impact they have on his stability and functioning. [Individual #4] states that when he feels depressed he gets sad, lonely, and worries a lot. He has trouble recognizing triggers for his symptoms. Stressful situations can lead to him getting more depressed. He states he has some mood swings. [Individual #4] required some assistance in recognizing symptoms of low motivation, isolation and anger." The Assessment stated Individual #4 was to be seen for counseling to address symptoms of depression, guilt, and bipolar mood swings to develop coping strategies, process emotions and feelings and increase his self-esteem. However, Individual #4's Functional Behavioral Assessment did not include any information related to teaching Individual #4 to recognize and manage his mental health symptoms by developing appropriate coping skills to replace his maladaptive behaviors. b. Individual #4's record included a Behavior Intervention Plan, revised on 2/16/16, which stated his replacement behavior was using his visual calendar to schedule his tasks for the shift. As soon as he displayed any of the identified depressive type symptoms, staff were to have him look at his visual calendar to see if there are any tasks/activities that he had not completed for the shift.	W 239		

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W 239	Continued From page 149 His record also included an 8/1/15 Individual Support Plan which documented he had a Visual Calendar plan that stated "[Individual #4] is very dependent on staff to tell him what activity/tasks need to be completed and when to do them. To assist [Individual #4] to be less cue dependent, this program is being implemented to give him control over his day and to get him to participate in his active treatment throughout the day." His Visual Calendar plan stated the program was to be run at the beginning of the day shift and the beginning of the swing shift. Individual #4's record did not include information as to how the visual calendar was a replacement behavior as the visual calendar was used on a daily basis to assist Individual #4 to give him control over his day and to get him to participate in his active treatment throughout the day. Further, Individual #4's Functional Behavior Assessment stated "[Individual #4] will become irritated and if asked to [sic] frequently, he has physically assaulted staff which is uncharacteristic of his typical behavior." However, his behavior plan included prompting him to the visual calendar and the visual calendar stated staff were to assist him to participate in the visual calendar plan by following the prompt hierarchy. Individual #4's record did not include documentation of how the replacement behavior was to be effective if it angered Individual #4 to be prompted.	W 239		

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	13G037		03/08/2016

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W 239	Continued From page 150 Further, Individual #4 raw data documented he refused to participate in his Visual Calendar program every time it was offered, which was, 21 times in November 2015 and 24 times in December 2015. Further, his January 2016 data documented he refused to participate 24 times out of 27 times it was offered. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated the visual calendar was used as his replacement behavior. The facility failed to ensure an appropriate replacement behavior was developed to address Individual #4's inappropriate behaviors. 2. Individual #1 was a 29 year old male with diagnoses including mild intellectual disability, Bipolar I Disorder and Autism. a. His Functional Behavior Assessment, dated 2/23/16, stated verbal aggression occurred when Individual #1 was bored, when he wanted to engage in a power struggle, when teasing was going on in the house, when he was seeking attention, or when he was overwhelmed by his environment and needing to let out frustration. However, the presumed function of the behavior section stated only "to get attention." The assessment did not include additional information regarding the other causes of his verbal aggression (when he was bored,when he wanted to engage in a power struggle, when teasing was going on in the house, or when he was overwhelmed by his environment and needing to let out frustration).	W 239		

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W 239	Continued From page 151 Further, his BIP for the maladaptive behavior of verbal aggression, dated 2/23/16, included replacement behaviors as running formal programs for "ask for positive attention" and "ask to wait." A replacement behavior with a functional relationship to Individual #1's engaging in verbal aggression when he was bored, when he wanted to engage in a power struggle, when teasing was going on in the house, or when he was overwhelmed by his environment and needing to let out frustration, was not included in his behavior assessment or his BIP. b. His Functional Behavior Assessment stated his physical aggression occurred when the environment was noisy/unorganized, when he was seeking attention, when programs were changed, when a peer was having difficulty, or when he was asked to wait for an activity. However, the presumed function of the behavior section stated only "to get attention." The assessment did not included additional information regarding the other causes of his physical aggression (when the environment was noisy/unorganized, when programs were changed, when a peer was having difficulty, or when he was asked to wait for an activity). Further, his BIP for the maladaptive behavior of physical aggression, dated 2/23/16, included replacement behaviors as running formal programs for "ask for positive attention" and "ask to wait." A replacement behavior with a functional	W 239		

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W 239	Continued From page 152 relationship to Individual #1's engaging in physical aggression when the environment was noisy/unorganized, when programs were changed, when a peer was having difficulty, or when he was asked to wait for an activity was not included in his behavior assessment or his BIP. c. His Functional Behavior Assessment stated his maladaptive behavior of elopement occurred when he wanted attention, had a change in routine, or when he was asked to wait to do an activity. However, the presumed function of the behavior section stated only "to get attention." The assessment did not include additional information regarding the other causes of his elopement (when he had a change in routine, or when he was asked to wait to do an activity). Further, his BIP for the maladaptive behavior of elopement, dated 2/23/16, included replacement behaviors as running formal programs for "ask for positive attention" and "ask to wait." A replacement behavior with a functional relationship to Individual #1's eloping when he had a change in routine, or when he was asked to wait to do an activity was not included in his behavior assessment or his BIP. In an interview on 3/7/16 from 2:00 - 4:35 p.m., the QIDP confirmed Individual #1's Functional Behavioral Assessment information. The facility failed to ensure Individual #1's Functional Behavioral Assessment included consistent, comprehensive information regarding	W 239		

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W 239	Continued From page 153 the function of his maladaptive behaviors.	W 239		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals received training and services consistent with identified needs and program plans for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in a lack of programs being implemented to meet an individual's identified needs. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. a. A QIDP note documented the QIDP and Individual #4's guardian had a meeting on 2/4/15 from 11:00 a.m. to 12:00 p.m., prior to Individual #4's admission to the facility on 2/25/15. The note documented Individual #4 had been receiving services in a residential habilitation program and had lost "a lot of skills." The note documented he was refusing to shower, isolating in his room, did not want to change his clothes,	W 249		

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W 249	Continued From page 154 was very unmotivated, did not want to leave his apartment, and could not remember things. The note also documented he was refusing to eat and drink regularly, which had resulted in hospitalization. The note stated he began receiving Risperdal (an antipsychotic drug) while in the hospital. Individual #4's record included a corresponding hospital report, dated 7/30/14, which documented Individual #4 was admitted to the hospital on 7/28/14 with lithium toxicity and acute renal failure. The QIDP note stated the guardian would like to see Individual #4 re-learn skills he had forgotten and listed bathing, clean clothes, laundry, cooking, eating regularly, and going into the community. The note stated "would like him to move as soon as possible for health reasons and more training." When asked about Individual #4's admission, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4's mental health was unstable and the guardian was worried he might die if he stayed in his current placement. He had not been eating or drinking. When asked if Individual #4's failure to eat and drink was symptomatic of his depression or if he was actively suicidal, the QIDP stated she did not know. Individual #4's record included pre-admission information garnered from staff at his residential habilitation placement on 2/5/15. However, Individual #4's record did not include documentation that an IDT meeting had been held in order to evaluate the preliminary information and determine if Individual #4's needs could be met by the facility and what services and activities were essential to Individual #4's daily	W 249		

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	13G037		03/08/2016

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W 249	Continued From page 155 functioning upon admission. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated she had scheduled a meeting prior to Individual #4's admission, however others failed to attend. Individual #4's record documented he was admitted on 2/25/15. His record included 2/2015 data sheets for ADLs including laundry, tooth brushing, showering, etc. However, data collection methods and interventions related to his mental health issues could not be found. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., why services and supports related to Individual #4's mental health had not been implemented, the QIDP stated the guardian wanted the facility to concentrate on ADLs and not his mental health issues. The facility's "Active Treatment/Growth and Development" policy, revised 9/23/15, stated in the assessment section that "When a new individual moves into one of the group homes, a team of professionals (Physician, Social Worker, QIDP, Dietician, Guardian, etc.) spends the first 30 days assessing the strengths and needs of the individual. This team is called the interdisciplinary team." The policy stated "The strengths and needs of the individual are then reviewed and prioritized into goals and objectives by the interdisciplinary team, the individual being served, and/or the legal guardian...." Further, the facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 9/23/15,	W 249		

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W 249	Continued From page 156 documented on admission, the facility would make a determination of whether a safety plan needed to be implemented while further assessments were being completed. The factors to be considered included but were not limited to: - "Historical maladaptive behavior - the risk of harm to self and/or others past behaviors will be the indicator that the need of a safety plan must be in place prior to admission. The safety plan will be in effect for a minimum of the first 30 days after admission, while further assessments are being completed." - "Potential environmental and medical factors that may contribute to the maladaptive behavior." The facility failed to ensure essential services, as determined by the IDT, were implemented upon Individual #4's admission to the facility. b. Individual #4's 7/31/15, 9/1/15 and 2/16/16 depressive symptom plans stated as soon as staff noticed Individual #4 displaying depressive type symptoms, they were to ask him to participate in an activity or task. How many times Individual #4 was to be prompted or the frequency of prompts was not included in the plan. Staff were to also let Individual #4 know they were there to talk with him if he would "like to talk about how he is feeling." Individual #4's ABC logs documented multiple interventions which had been attempted which were not consistent with Individual #4's plan. Examples included, but were not limited to, the following: - 9/1/15 at 7:56 p.m.: Staff documented the used	W 249		

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W 249	Continued From page 157 "first this, then this" interventions and giving choices. - 9/21/15 at 7:10 p.m.: Individual #4 "charged" at staff. Staff documented "Tried getting him to use coping skills." - 10/2/15 from 4:00 - 4:15 p.m.: Staff documented Individual #4 was being prompted to participate and talked to about his deal with the QIDP to get out of the house once per day. - 1/18/16 at 1:15 p.m.: Staff documented Individual #4 became "agitated at staff cues to complete responsibilities & a shower. He kept saying 'No' or 'I don't know' after a couple more prompts [Individual #4] became really angry & go [sic] up, yelled 'no, no, no' and attacked [staff's name]. He backed her into the kitchen punching her 7x. He then stopped & went back & sat on the couch." The staff documented "The police were called (non-emergency) & are coming to speak with [Individual #4]." No additional information was present on the ABC log which indicated if or when the police spoke to Individual #4 and what the outcome was. The facility failed to ensure Individual #4's Depressive Symptoms plan was consistently implemented. c. The facility's records included a 10/27/15 investigation report which documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet, dated 10/23/15, stated "As of today, [Individual	W 249		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
W 249	Continued From page 158 #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. However, Individual #4's formal showering program stated he would wash his hair while showering with a non-specific verbal prompt. His individual support plan, dated 6/2/15, stated staff were to provide as much privacy as possible but remain in the area to ensure he washed all his body parts and hair. The plan did not include information related to how staff were to implement Individual #4's showering program and provide line of sight supervision. Further, Interviews were conducted with 4 facility staff, on 3/1/16 from 11:05 to 11:15 a.m., regarding Individual #4's Line of Sight Guidelines. - One staff stated Individual #4 was to be in line of sight at all times and staff were to be able to see him from head to toe at all times. When he was in the shower or the bathroom, the door to the bathroom was to be open to make sure he did not leave the bathroom through the other bathroom door. - Another staff stated when Individual #4 was in the shower or bathroom, the bathroom door was	W 249		

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	13G037		03/08/2016

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W 249	Continued From page 159 to be open to make sure he was in the bathroom. When he was in the shower, the shower curtain would be opened in the shape of a window to ensure he was in the shower. - Another staff stated when Individual #4 was in the bathroom, the door would be open so that Individual #4 could be visualized in the mirror. When he was in the shower, staff were to keep the bathroom door partially open. - Another staff stated when Individual #4 was in the bathroom, the door was to be open. When he was in the shower, the shower curtain would be opened in the shape of a window to ensure he was in the shower. The facility failed to ensure Individual #4's program plans were consistently implemented.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 1 of 4 individuals (Individual #4) whose behavioral data was reviewed. That failure had the potential to impede the ability of the treatment team in evaluating the effectiveness of programmatic techniques. The findings include:	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 252	Continued From page 160 The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "training programs must first be designed to utilize the least restrictive method as is possible and specify...The type of data and frequency of collection necessary to be able to assess progress toward desired objectives." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's 7/31/15, 9/1/15 and 2/16/16 depressive symptom plans stated staff were to complete an ABC log for all depressive symptoms Individual #4 displayed. Individual #4's ABC logs from 10/2015 - 1/2016 were reviewed. The ABC logs did not include comprehensive information. Examples included, but were not limited to, the following: - An ABC log, dated 10/29/15, documented Individual #4 had become agitated after being teased by another individual. The intervention was documented as letting Individual #4 know it was ok and she was there to help. It further documented she had assisted him to calm down. No other information related to how he was assisted to calm down was documented. - An ABC log, dated 11/16/15, documented Individual #4 got out of bed and went to the bathroom and urinated on the floor. No other information related to what the DCS or individual had done after the incident was documented.	W 252		

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W 252	Continued From page 161 - An ABC log, dated 12/7/15, documented Individual #4 was being assisted by a DCS to have his fingernails trimmed and became agitated. The DCS called for another DCS for assistance. No other information was documented. - An ABC log, dated 12/24/15, documented Individual #4 threatened to put a staff "...in the hospital." The intervention or response to the behavior section documented the DCS told Individual #4 "...that would not be a good choice" and that he would try back in 10 minutes. No other information related to Individual #4's response was documented. - An ABC log, dated 1/18/16, documented Individual #4 became agitated after two DCS were cueing him to get up. He then became agitated and assaulted one of the DCS and then sat back down. The consequence was documented as staff blocked punches and called the police. No other information was documented after the assaults occurred. During an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed not all ABC data was adequate. The facility failed to ensure sufficient ABC Log data related to interventions was documented for Individual #4's depressive symptoms.	W 252		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified intellectual disability	W 255		

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W 255	Continued From page 162 professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure PCLPs were revised as appropriate for 1 of 4 individuals (Individual #4) whose PCLPs and program summaries were reviewed. This resulted in an individual continuing to receive formal training on objectives he had successfully completed. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "The Individual Program Plan must be reviewed at least by the QIDP and revised as Necessary [sic] (by the 10th of each month), including, but not limited to situations in which the individual: ...Has successfully completed an objective or objectives identified in the Individual Program Plan." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's ADL programs stated staff were to follow the prompt hierarchy in order to assist him to complete the tasks identified in the objectives. The prompt hierarchy specified in Individual #4's programs included the following: SI - Self initiate G - Gesture NV - Non-Specific Verbal	W 255		

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W 255	Continued From page 163 SV - Specific Verbal LP - Light Physical R - Refuse Individual #4's QIDP summaries, dated 3/2015 - 1/2016, were reviewed. The summaries documented Individual #4 met criteria on established objectives without program revisions being made that were reflective of his demonstrated ability. Examples included, but were not limited to, the following: a. Individual #4's PCLP included an objective for Self-Feeding, which stated he would use a napkin during a meal with a specific verbal prompt in 10 of 12 trials per month for 3 consecutive months. A hand-written revision to a non-specific verbal prompt was made 10/2/15. His QIDP summaries documented the following: - 3/2015: The QIDP summary stated he was successful 7 of 7 trials and this was the first month criteria was met, but it was not a full month of data. The data sheet documented 5 of the trials were completed with a NV prompt or better. - 4/2015: The QIDP summary stated he was successful 11 of 11 trials. The data sheet documented 9 of the trials were completed with a NV prompt or better. - 5/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the second month. The data sheet documented all trials were completed with a NV prompt or better. - 6/2015: The QIDP summary stated he was successful 12 of 12 trials. The summary stated it was the "3rd consecutive month" Individual #4	W 255		

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W 255	Continued From page 164 met criteria and that the program was being revised to a NV prompt. The data sheet documented 10 of the trials were completed with a NV prompt or better. It was not clear why Individual #4's Self-Feeding objective was revised to a NV prompt when he was consistently meeting the objective at a NV prompt or higher. - 7/2015: The QIDP summary stated he was successful 12 of 12 trials, and was the first month Individual #4 "was able to meet criteria with the revised prompt level." However, the objective on the data sheet had not been revised and stated "specific verbal prompt in 10 of 12 trials per month..." The data sheet documented Individual #4 required 1 SV prompt, but competed 11 trials with a G prompt or better. - 8/2015: The QIDP summary stated he was successful 12 of 12 trials. The data sheet had not been revised and documented Individual #4 required 2 SV prompts, but completed 10 trials with a G prompt or better. - 9/2015: The QIDP summary stated he was successful 12 of 12 trials. The summary stated it was the "3rd consecutive month" Individual #4 met criteria and that the program was being revised to a"non-specific verbal" prompt. The data sheet documented 2 trials were completed with a G prompt level and 10 trials were completed with an SI prompt level. It was not clear why the prompt level was being revised to a NV prompt. Individual #4 met criteria in June 2015 at which point the criteria was revised to a NV prompt. Additionally, Individual	W 255		

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W 255	Continued From page 165 #4's data sheets consistently documented the ability to complete the task with a G prompt or better during the majority of trials. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m. the QIDP stated she revised programs following the prompt hierarchy. b. Individual #4's PCLP included an objective for SAM, which stated he would clean a finger with an alcohol wipe for blood testing with a specific verbal prompt in 10 of 12 trials per month for 3 consecutive months. A hand written revision to a non-specific verbal prompt was made 10/2/15. His QIDP summaries documented the following: - 3/2015: The QIDP summary stated he was successful 2 of 2 trials and was the first month criteria was met, but it was not a full month of data. The data sheet documented 2 trials were completed with a SV prompt or better. - 4/2015: The QIDP summary stated he was successful 12 of 12 trials and was the second month criteria was met. The data sheet documented 8 of the trials were completed with a G prompt or better. - 5/2015: The QIDP summary stated he was successful 12 of 12 trials and was "the 2nd consecutive month" Individual #4 met criteria. The data sheet documented 10 of the trials were completed with a G prompt or better. It was not clear why the 5/15 summary stated it was the second consecutive month of met criteria when this had already been stated in the 4/15 summary.	W 255		

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W 255	Continued From page 166 - 6/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the third consecutive month criteria was met. The summary stated the prompt would be revised to a "non-specific verbal" prompt. The data sheet documented 9 of the trials were completed at a G prompt and 3 at a NV prompt. It was not clear why Individual #4's SAM objective was revised to a NV prompt when he was consistently meeting the objective at a NV prompt or higher. - 7/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the first month. However, the objective on the data sheet had not been revised and stated "specific verbal prompt in 10 of 12 trials per month..." The data sheet documented Individual #4 required 2 SV prompts, but completed 10 trials with a G prompt or better. - 8/2015: The QIDP summary stated he was successful 10 of 10 trials and met criteria for the second consecutive month. The data sheet had not been revised and documented Individual #4 required 1 SV prompt, but completed 9 trials with a NV prompt. - 9/2015: The QIDP summary stated he was successful 12 of 12 trials. The summary stated it was the "3rd consecutive month" Individual #4 met criteria and that the program was being revised to a NV prompt. The data sheet had not been revised and documented Individual #4 required 1 SV prompt, but completed 10 trials with a G prompt or better. It was not clear why the prompt level was being	W 255		

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W 255	Continued From page 167 revised to a NV prompt. Individual #4 met criteria in June 2014 at which point the criteria was revised to a NV prompt. Additionally, Individual #4's data sheets consistently documented the ability to complete the task with a G prompt or better during the majority of trials. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m. the QIDP stated she revised programs following the prompt hierarchy. c. Individual #4's PCLP included an objective for Hygiene, which stated he would apply deodorant after getting dressed with a specific verbal prompt in 10 of 12 trials for 3 consecutive months. A hand-written revision changed the prompt to a non-specific verbal prompt on 6/2/15, and to a gesture prompt on 9/10/15. His QIDP summaries documented the following: - 3/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the first month. The data sheet documented 10 of the trials were completed with a NV prompt or better. - 4/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the second month. The data sheet documented 8 of the trails were completed with a NV prompt or better. - 5/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the third month. The summary stated the program would be revised to a NV prompt. The data sheet documented 10 trials were completed with a G prompt or better.	W 255		

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W 255	Continued From page 168 It was not clear why Individual #4's Hygiene objective was revised to a NV prompt when he was consistently meeting the objective at G prompt or better. - 6/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the first month. - 7/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the second month. The data sheet documented 11 of the trails were completed with a G prompt or better. - 8/2015: The QIDP summary stated he was successful 10 of 12 trials and met criteria for the third month. The summary stated the objective would be revised to a G prompt. The data sheet documented 8 of the trials were completed with a G prompt or better. It was not clear why Individual #4's Hygiene objective was revised to a G prompt when he was consistently meeting the objective at a G prompt or higher for the majority of trials. When asked, during an interview on 3/4/16 from 2:00 - 4:30 p.m. the QIDP stated she revised programs following the prompt hierarchy. d. Individual #4's PCLP included an objective for Dressing which stated he would put on clean clothes before leaving with a specific verbal prompt in 10 of 12 trials per month for 3 consecutive months. His QIDP summaries documented the following: - 3/2015: The QIDP summary stated he was	W 255		

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	13G037		03/08/2016

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W 255	Continued From page 169 successful 12 of 12 trials and met criteria for the first month. The data sheet documented 9 of the trials were completed with a NV prompt or better. - 4/2015: The QIDP summary stated he was successful 12 of 12 trials and met criteria for the second month. The data sheet documented 7 trials were completed with a SI prompt. - 5/2015: The QIDP summary stated he was successful for 12 of 12 trials and met criteria for the third month. The summary stated the objective would be revised to a "non-specific verbal" prompt. The data sheet documented Individual #4 required 2 NV prompts, but completed 10 trials with a G prompt or better. It was not clear why Individual #4's Dressing program was revised to a NV prompt when he was consistently meeting the objective at a NV prompt or higher. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m. the QIDP stated she revised programs following the prompt hierarchy. The facility failed to ensure objectives were revised based on Individual #4's actual performance.	W 255		
W 256	483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.	W 256		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 256	Continued From page 170 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure IPPs were revised as appropriate for 1 of 4 individuals (Individual #1) whose IPP and program summaries were reviewed. This resulted in a consistent regression of an individual's skills without appropriate programmatic revisions being made. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "The Individual Program Plan must be reviewed at least by the QIDP and revised as Necessary [sic]..." The policy was not implemented, as follows: 1. Individual #1 was a 29 year old male with diagnoses including bipolar disorder, OCD, and autism. On a 3/10/15 QIDP summary, Individual #1 was shown to have had episodes of physical aggression 25 times, an average of 2.5 times a month, from 4/2014 - 2/2015. The objective for physical aggression was set at 0 episodes of aggression per month for 6 consecutive months. Positive interventions and replacement behaviors remained as originally stated when the plan was initiated on 8/10/13. His QIDP summary, dated 8/5/15, showed Individual #1's episodes of physical aggression had increased to 31 times, an average of 4.4 times a month, from 1/2015 - 7/2015. The objective for physical aggression remained at 0 episodes per month for 6 consecutive months	W 256		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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W 256	Continued From page 171 with no changes to positive interventions or replacement behaviors. This lack of intervention continued until 11/19/15, a period of 8 months, with episodes of physical aggression increasing to an average of 5 times per month. In an interview on 3/7/16 from 3:00 - 3:45 p.m., the QIDP confirmed the lack of changes to positive intervention and replacement behaviors and the increased number of physical aggression episodes. The facility failed to identify and address Individual #1's regression.	W 256		
W 258	483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 1 of 4 individuals (Individual #4), whose records were reviewed, was being considered for new objectives. This failure resulted in plans which did not meet an individual's needs. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "The	W 258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
W 258	Continued From page 172 Individual Program Plan must be reviewed at least by the QIDP and revised as Necessary [sic] (by the 10th of each month), including, but not limited to situations in which the individual: ...Is being considered for training towards new objectives." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability, Bi-polar I Disorder and hand tremors. He was admitted to the facility on 2/25/15. Individual #4's raw program data, dated 10/2015 - 1/2016, was reviewed. The summaries documented Individual #4 continued to refuse to participate in specific programming as follows: a. Individual #4's raw program data documented he refused to participate in his Money management program when offered, 10 times in December 2015 and 8 times in January 2016. b. Individual #4's raw program data documented he refused to participate in his hygiene program when offered, 11 times in October 2015, 18 times in November 2015, 19 times in December 2015, and 22 times in January 2016. c. Individual #4 raw data documented he refused to participate in his Visual Calendar program every time it was offered, which was, 21 times in November 2015 and 24 times in December 2015. Further, his January 2016 data documented he refused to participate 24 times out of 27 times it was offered.	W 258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 258	Continued From page 173 When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated she reviewed all program data. However, Individual #4's records did not include documentation that he was being considered for new and/or revised objectives, given his refusals. The facility failed to ensure new objectives were considered for Individual #4.	W 258		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure assessments were updated annually or as needed for 1 of 4 individuals (Individual #4) whose assessments were reviewed. This resulted in a lack of assessment information on which to base program decisions. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "After the initial assessment, each individual's progress is assessed and monitored by the QIDP and other professionals on a regular basis regarding their progress or regression..." The policy stated "...the comprehensive assessment of each individual must be reviewed by the interdisciplinary team for relevancy and updated as needed."	W 259		

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	13G037		03/08/2016

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W 259	Continued From page 174 The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. The facility's prompt hierarchy was set as follows: SI - Self initiate G - Gesture NV - Non-Specific Verbal SV - Specific Verbal LP - Light Physical FP - Full Physical R - Resident refuses Individual #4's CFA, revised 10/8/15, was reviewed and had not been revised to reflect his current status. Examples included, but were not limited to, the following: - Individual #4's Showering objective stated he would wash his hair while showering. The objective was revised from a specific verbal cue to a non-specific verbal cue on 6/2/15. However, the CFA stated he required a specific verbal cue to shampoo his hair. - Individual #4's Hygiene objective stated he would apply deodorant after getting dressed. The objective was revised from a specific verbal cue to a non-specific verbal cue on 6/2/15, and to a gesture cue on 9/10/15. However, the CFA stated he required a specific verbal cue to apply deodorant, and was revised to a non-specific verbal cue on 1/2/16. - Individual #4's Dressing objective stated he	W 259		

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W 259	Continued From page 175 would put on clean clothes before leaving. The objective was revised from a specific verbal cue to a non-specific verbal cue on 6/2/15. However, the CFA stated he was independent in selecting clean clothes, and was revised to a specific verbal cue on 1/6/16. - Individual #4's Hand Washing objective stated he would wash his hands at the appropriate times. The objective was revised from a specific verbal cue to a non-specific verbal cue on 6/2/15. However, the CFA stated he may need reminders to wash his hands at the appropriate times with a specific verbal cue. - Individual #4's Self-Feeding objective stated he would use a napkin during meal time with a specific verbal prompt. The objective was revised from a specific verbal cue to a non-specific verbal cue on 10/2/15. However, the CFA stated he required a specific verbal cue to wipe his hands and face with a napkin. Further, the 6/2015 QIDP summary stated he met criteria for the 3rd consecutive month and the prompt level would be revised to a non-specific verbal cue. - His Money Management objective stated when presented with a coin, Individual #4 would use other coins to equal the value of that coin. The objective was revised from a light physical cue to a specific verbal cue on 10/2/15. However, his CFA documented he could independently identify all coins, and independently knew the value of all coins with the exception of a half dollar. The CFA stated he required a full physical cue to count change. - Individual #4's CFA documented he had a full	W 259		

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W 259	Continued From page 176 beard and staff would provide full assistance to ensure it was adequately trimmed. However, during an observation on 2/29/16 from 12:45 - 1:15 p.m., Individual #4 was observed to be clean shaven. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director stated the CFA should have been updated as changes occurred. The facility failed to ensure Individual #4's CFA was updated as his status and needs changed.	W 259		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure PCLPs were revised to accurately reflect and respond to an individual's current needs and functional changes for 1 of 4 individuals (Individual #4) whose records and PCLPs were reviewed. That failure resulted in an individual's PCLP not reflecting his current status/needs. The findings include: The facility's Active Treatment/Growth and Development policy, revised 9/23/15, stated "The Interdisciplinary Team then prepares a written plan prioritizing the goals and objectives and determining when they will be accomplished." The policy stated "The plan must address how	W 260		

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	13G037		03/08/2016

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W 260	Continued From page 177 the services provided will assist each individual to achieve a higher level of independence." 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male admitted to the facility on 2/25/15. His diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's PCLP was reviewed and did not reflect current status/needs, and thereby did not assist Individual #4 to achieve a higher level of independence. Examples included, but were not limited to, the following: a. Individual #4's CFA stated he was independent in all aspects of tooth brushing with the exception of brushing at regular times, using dental floss and using mouthwash, for which he required a specific verbal cue. The CFA stated he required supervision to ensure he brushed all his teeth and did a thorough job. Individual #4's 6/2015 QIDP summary stated he had met criteria for his tooth brushing objective to brush for 3 minutes and the objective was being revised to a "self-initiate" prompt level. However, his PCLP included an objective for Tooth Brushing which stated he would brush his teeth for 3 minutes using a timer with a specific verbal cue. The objective was revised to a gesture cue on 2/1/16. The PCLP was not consistent with Individual #4's CFA and QIDP summary notes. b. Individual #4's 6/2015 QIDP summary stated he met criteria for 3 consecutive months on his SAM objective, and the objective would be	W 260		

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W 260	Continued From page 178 revised to a non-specific verbal cue. However, his PCLP included a SAM objective which stated he would clean the finger he was going to use for a blood test with an alcohol wipe with a specific verbal cue. The objective was not revised to a non-specific verbal cue until 10/2/15. c. Individual #4's 6/2015 QIDP summary stated he met criteria for 3 consecutive months on his Self-Feeding objective, and the objective would be revised to a non-specific verbal cue. However, his PCLP included a Self-Feeding objective which stated he would use his napkin during meal time with a specific verbal cue. The objective was not revised to a non-specific verbal cue until 10/2/15. d. Individual #4's 6/2015 QIDP summary stated he met criteria for 3 consecutive months on his Laundry objective, and the objective would be revised to a non-specific verbal cue. However, his PCLP included a Laundry objective which stated he would complete the laundry sequence with a specific verbal cue. The objective was not revised to a non-specific verbal cue until 10/2/15. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the Clinical Director stated the PCLP was to be updated as changes occurred. The facility failed to ensure Individual #4's PCLP was updated as his status and needs changed.	W 260		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES	W 266		

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W 266	Continued From page 179 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W278 as it relates to the facility's failure to ensure an individual's record included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior. 2. Refer to W285 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the health and human rights. 3. Refer to W288 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were not used as a substitute for an active treatment program. 4. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans.	W 266		

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	13G037		03/08/2016

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W 266	Continued From page 180 5. Refer to W311 as it relates to the facility's failure to ensure the IDT approved drugs used for the control of inappropriate behavior. 6. Refer to W312 as it relates to the facility's failure to ensure a behavior modifying drug was used only as a comprehensive part of an individual's PCLP that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drug was employed. 7. Refer to W315 as it relates to the facility's failure to ensure drugs used for control of inappropriate behavior were monitored closely for adverse side effects. 8. Refer to W317 as it relates to the facility's failure to ensure drugs used to control behavioral symptoms were gradually withdrawn in a carefully monitored program. The cumulative effect of these deficient practices significantly impeded the facility's ability to develop, consistently implement and closely monitor individuals' behavioral needs.	W 266		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by:	W 278		

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	13G037		03/08/2016

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W 278	Continued From page 181 Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 3 individuals (Individual #4) whose behavior management plans were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. The facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 9/23/15, stated "Behavior Support Programs are implemented at the recommendation of the Interdisciplinary Team, after review of baseline data and analysis of potential causes." The policy also stated "Behavior Support Programs are to utilize the least restrictive techniques needed, as exhibited through failure of positive interaction/less restrictive techniques." The policy was not implemented, as follows: Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. The facility's records included a 10/27/15 investigation report which documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet, dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the	W 278		

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	13G037		03/08/2016

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W 278	Continued From page 182 bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. However, Individual #4's Functional Behavioral Assessment did not include additional information regarding sexual misconduct. Further, Individual #4's Preliminary Evaluation Form/Tentative Treatment Plan, dated 2/5/15, stated he could provide for his own privacy, but did not do so when he was in his own room, he required supervision to not invade the privacy of others and he required supervision to shut the bathroom door. However, no updated information or programming was in place to teach Individual #4 to maintain his own privacy or respect the privacy of others. Without comprehensive assessment information it would not be possible for the IDT, the guardian, and the HRC to comprehensively evaluate the need for the restrictive intervention or ensure less restrictive alternates (e.g. implementing training programs to teach Individual #4 to respect the privacy of others or programs to teach Individual #1 and others to protect their privacy by shutting the bathroom door) would not be effective. When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the Clinical Director stated an assessment of Individual #4's alleged sexual	W 278		

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	13G037		03/08/2016

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W 278	Continued From page 183 misconduct had not been completed. The facility failed to ensure the use of less restrictive interventions was systematically tried and found to be ineffective prior to implementing restrictions to Individual #4's privacy.	W 278		
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the health and human rights for 1 of 3 individuals (Individual #4) whose restrictive interventions were reviewed. This resulted in a lack of adequate protections being provided to an individual. The findings include: 1. Refer to W128 as it relates to the facility's failure to ensure qn individual was not subjected to drug use without appropriate justification. 2. Refer to W129 as it relates to the facility's failure to ensure restrictive interventions did not infringe on an individual's right to personal privacy. 3. Refer to W130 as it relates to the facility's failure to ensure restrictive interventions did not	W 285		

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W 285	Continued From page 184 infringe on an individual's right to privacy during care of personal needs.	W 285		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques to manage inappropriate behavior were not used as a substitute for an active treatment program for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in behavioral interventions being utilized due to a lack of appropriate training programs. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. The facility's records included a 10/27/15 investigation report documented Individual #4 had exposed his genitals to Individual #1. The investigation report stated "The QIDP has created new guidelines for [Individual #4]." A "Line of Sight Guidelines" information sheet dated 10/23/15, stated "As of today, [Individual #4] will be line of sight at all times. This will include when he is in the shower and/or using the bathroom." The guidelines stated 24 hours a day, 7 days a week, staff were to ensure they could always see Individual #4. The guidelines stated the bathroom door was cracked enough to see	W 288		

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	13G037		03/08/2016

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W 288	Continued From page 185 Individual #4 when showering or using the bathroom to ensure he did not have the opportunity to sexually offend any of his roommates. The guidelines also stated Individual #4's bedroom door was to be cracked enough for staff to see Individual #4 on his bed, but to not watch him when he was masturbating. Individual #4's Functional Behavioral Assessment did not include additional information regarding sexual misconduct or the impacts that line of sight supervision had on Individual #4. Further, the line of sight guidelines were not incorporated into any of Individual #4's program plans. However, Individual #4's PCLP included an "Addendum," dated 2/4/16, which stated he was to see a neurologist "to rule out early onset dementia and/or Parkinson's disease" and would be "scheduled for a sexual assessment as soon as all medical issues are ruled out." When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., about ruling out medical issues prior to conducting a sexual assessment, the Clinical Director stated that was a judgement error. The facility failed to ensure the use of line of sight supervision was not used as a substitute for an active treatment program.	W 288		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of	W 289		

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	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
W 289	Continued From page 186 this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 2 of 3 individuals (Individuals #1 and #4) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include: The facility's "Behavioral Support Method Hierarchy & Definitions" policy, revised 9/23/15, stated "Behavior Support Programs are implemented at the recommendation of the Interdisciplinary Team, after review of baseline data and analysis of potential causes." The policy stated plans were to include "Positive Instruction/Proactive Prevention - specific staff instructions on teaching and reinforcing the individual for appropriate replacement behavior..." and "Intervention Techniques/Situational management - specific staff instructions on applicable intervention techniques if the individual being served begins to exhibit behaviors which place that individual or others at risk." The policy was not sufficiently implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability and Bi-polar I Disorder. Individual #4's 2/16/16 depressive symptom plan was not sufficiently designed and implemented	W 289		

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	13G037		03/08/2016

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W 289	Continued From page 187 necessary to ensure his individualized mental health needs were met. Examples included, but were not limited to, the following: Individual #4's depressive symptoms plan listed depressive type symptoms and associated behaviors. However, the program definitions were not sufficiently developed to include observable behavior or to allow Individual #4 to express normal, appropriate emotions. Examples included, but were not limited to, the following: - Symptom: "Irritable mood." Behavior: "Being agitated, angry." No additional information related to observable behavior was included and no information related to Individual #4 becoming irritated and angry as a normal, human emotion (e.g. due to staff over-cueing, etc.) was present. - Symptom: "Diminished interest in activities." Behavior: "Refusing to leave the house to participate in a community activity." The plan did not include information such as how many refusals were required to be considered symptomatic of his depression, if refusals to participate in known non-preferred activities were included in the definition, etc. - Symptom: "Increase in appetite." Behavior: "Stealing others food, eating food out of the pantry or refrigerator that is not part of the meal." Information related to drinking excessive amounts of fluids and self-induced vomiting was not included. - Symptom: "Decrease in appetite." Behavior: "Refusing to eat or drink." Information related to what constituted a refusal (e.g. not eating one meal, only eating half of a meal, refusing liquids	W 289		

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W 289	Continued From page 188 once when offered, etc.) was not included. - Symptom: "Change in sleep pattern." Behavior: "Not sleeping through the night or sleeping during the day time (waking hours 7:30 AM - 8:30 PM)." The time frame given was equal to 11 hours of sleep. However, the status section of the plan gave his historical sleep average as 10 hours a night. The Depressive Symptoms plan did not include symptom criteria which was based on Individual #4's sleeping pattern history, or allow for any variation (e.g. sleeping 8 - 11 hours a night) depending on other factors such as the events of his day, prior night's ability to sleep, etc. - Symptom: "Fatigue or loss of energy." Behavior: "Having no energy to do an activity/task, being tired." The plan did not include information related to how Individual #4 was to be evaluated to determine normal amounts of fatigue (e.g. after increased amounts of physical exertion, when his was not feeling well, an a night in which he did not sleep well, etc.). - Symptom: "Laying on bed-isolating at odd times." Behavior: "During waking hours 7:30 AM - 8:30 PM." The plan did not include information related to when it was reasonable and appropriate for Individual #4 to be in his bedroom in private (e.g. separating himself from housemates who were being loud or creating an otherwise chaotic environment, separating himself to his bedroom when he was angry rather than assaulting others, etc.). - Symptom: "Suicidal Ideation." Behavior: "Making statements such as 'I want to die', 'I should get a knife and stab myself'." The plan did	W 289		

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W 289	Continued From page 189 not include other precursory statements (e.g. "hating things," etc.) that Individual #4 had expressed prior to making a suicide threat on 6/3/15. The depressive symptoms plan stated as soon as staff noticed Individual #4 displaying depressive type symptoms, they were to ask him to participate in an activity or task. How many times Individual #4 was to be prompted or the frequency of prompts was not included in the plan. Staff were to also let Individual #4 know they were there to talk with him if he would "like to talk about how he is feeling." However, Individual #4's records included typed information from the QIDP, dated 6/3/15, which were completed in response to a suicide threat made by Individual #4. The note stated interactions were to be limited and in the past Individual #4 had tried to talk about his parents, who were deceased, worrying about them. The note instructed staff to acknowledge Individual #4 with "I understand" and then stop interacting with him. The depressive symptoms plan did not include information related to whether staff were to engage in conversations with Individual #4 regarding his parents. The plan did not include additional information to staff regarding how to intervene when Individual #4 was displaying depressive symptoms (e.g. if staff were to try to remove food that Individual #4 took from someone else, if staff were to allow Individual #4 to sleep during the day, or if they were to wake him, how often staff were to offer Individual #4 fluids if he was refusing to drink,	W 289		

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W 289	Continued From page 190 how staff were to intervene if he began drinking excessive fluids, etc). Further, Individual #4's ABC logs documented "happy light" use on 4/9/15 at 9:00 - 9:30 a.m. However, no additional information related to the light was present on the ABC log, Individual #4's Functional Behavioral Assessment, or his Depressive Symptoms Plan. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated Individual #4 had a full spectrum light and confirmed its use had not been assessed or incorporated into a plan but it probably should have been. The facility failed to ensure all interventions were incorporated into Individual #4's Depressive Symptoms Plan and that interventions were sufficiently designed to meet his mental health needs. b. His psychiatric Medication Management Progress Note, dated 2/10/16, stated Latuda (an antipsychotic drug) 60 mg tablet every "evening with meals." The note stated Individual #4 "reports his mood has been 'good,' but staff report he has been acting depressed. Staff reports he refuses to shower, his appetite is poor, he doesn't want to participate in activities...Guardians report he has been meeting some goals the past few weeks. They give him a checklist of daily goals and if he completes them, he gets to pick an activity such as bowling or playing pool. He has met his goals the past two weeks." However, the checklist and "getting to pick an activity" was not included in Individual #4's	W 289		

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W 289	Continued From page 191 program plans. c. Individual #4's psychiatric Medication Management Progress Note, dated 10/27/15, stated he "has been more agitated and depressed...'charging at staff, with raised fists'...has not wanted to do anything...not showered for four days prior to today...has not been eating breakfast for the past week...isolating in his room...not going to work...punched two different staff after they asked him to use shampoo when he showered...has not been physically aggressive since staff made a behavior plan last week that included calling police if he is assaultive...replied 'I don't know' to most questions...not interested in anything..." The medication changes section stated Latuda 60 mg "every evening with meals." However, Individual #4's record did not include documentation that the intervention had been assessed or incorporated into his program plans. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP confirmed the behaviors had not been assessed and objectives and plans had not been developed. The facility failed to ensure all interventions were incorporated into Individual #4's program plans. 2. Individual #1 was a 29 year old male with diagnoses including mild intellectual disability, Autism, and Bipolar I Disorder. A BIP, dated 2/23/16, identified Elopement as a maladaptive behavior for Individual #1, caused by his Bipolar I Disorder, and defined as "leaving the house/area without permission." It was a recent	W 289		

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W 289	Continued From page 192 escalating behavior having occurred 9 times in the past 5 months. Methods to be used by staff for dealing with Individual #1's elopement were included in his BIP as follows: "Most of the time, [Individual #1] will tell staff he is going to elope or leave the house. If he tries to leave the house without permission, staff will block and redirect [Individual #1] from leaving the house. HE CANNOT leave the house...Staff need to ensure [Individual #1's] safety... Once [Individual #1] is calm staff will use his incidental social stories along with his problem solving service to solve appropriate ways to react to social situations." No further instructions were given related to what staff should do if blocking and redirecting was not effective, or how staff was to ensure Individual #1's safety such as walking with him, following him in a vehicle, contacting law enforcement, etc. In an interview on 3/7/16 from 2:00 - 4:35 p.m., the QIDP confirmed the lack of direction for staff in the plan. The facility failed to provide staff with appropriate methods for responding to Individual #1's elopement and keeping him safe.	W 289		
W 311	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team. This STANDARD is not met as evidenced by:	W 311		

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W 311	Continued From page 193 Based on record review and staff interview, it was determined the facility failed to ensure sufficient information regarding drug use was shared and discuss by the IDT for 1 of 3 individuals (Individual #4) reviewed. This resulted in the IDT's inability to make informed recommendation regarding the use of an individual's psychotropic medications. The findings include: The facility's "Behavior Support Method Hierarchy & Definitions" policy, revised 9/23/15, stated "Use of psychotropic medications for the purposes of decreasing inappropriate behaviors or treating negative symptoms of psychiatric disorders must be approved by the entire Interdisciplinary Team, including the individual's psychiatrist." The policy stated "All psychotropic medications first require...HRC consent prior to implementation." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included Mild Intellectual Disability and Bi-polar I Disorder. Individual #4's record documented multiple medication changes. When asked about the medication changes, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated she attend the meetings with the psychiatric practitioner and the guardian. She stated the psychiatric practitioner and the guardian made medication changes that the other members of the IDT did not always agree with. She stated at each meeting she presented data, but did not feel like it was taken into consideration. She further stated that some IDT	W 311		

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W 311	Continued From page 194 members also attend a "pre-psych" meeting and discussed drug use. However, Individual #4's record did not include consistent documentation of the IDT's discussion, as follows: - His Medication Reduction Plan and psychiatric Medication Management Progress Note, both dated 5/8/15, stated Risperdal (an antipsychotic drug) was decreased from 1.0 mg two times a day to 1.5 mg per day, and then to .5 mg two times a day. The plan was to "decrease Risperdal." The note stated "Staff and guardian report that pt seems 'flat' does not respond excitedly about things as he used to." However, there were no IDT meeting notes prior to the 5/8/15 psychiatric Medication Management Progress Note. The IDT meeting notes, dated 5/12/15, stated Risperdal was decreased to .5 mg two times a day and the next meeting was scheduled for 6/9/15. - His psychiatric Medication Management Progress Note, dated 6/9/15, stated "Pt. reports he is 'not good.' He states 'I'm mad at life.' He doesn't like his living situation. He eloped last Sunday with the plan to go to [name of town where his parents' grave site was]. He attempted to leave again last night. He is now on LOS [Line of Sight]. Staff report that he had been doing well, but last Wednesday his mood changed abruptly. He has not been interested in doing anything, does not want to come out of his room to eat, has seemed more anxious and restless, and his sleep has been erratice [sic]. He has not slept in the past two nights, but had slept well the two nights prior to that. He has not been working	W 311		

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W 311	Continued From page 195 at his lawn mowing job or going for walk with staff..." The current medications section stated he received Risperdal 1 mg tablet two times a day. The medication changes section stated "add Ativan (an anxiolytic drug) 1 mg qhs [every night at bedtime]." - His Medication Reduction Program, dated 6/9/15, stated he received .5 mg of Risperdal in the morning, 1 mg every night before bed, and on 6/5/15 the Risperdal was "changed back to 1.0 mg BID [two times a day]." Ativan 1 mg qhs was hand-written under current medications. However, there were no IDT meeting notes prior to the 6/9/15 Medication Management Progress Note. - His psychiatric Medication Management Progress Note, dated 7/8/15, stated "start Latuda (an antipsychotic drug) 40 mg 1/2 qd [every day] x 1 week then 1/2-1 qd. Decrease Risperdal 1 mg qhs x 1 week then d/c [discontinue]." - His Medication Reduction Program, dated 7/8/15, stated Risperdal was to be decreased to 1 mg every night before bed for one week then discontinue. Latuda was added "up to 40 mg q am [every morning]." However, there were no IDT meeting notes prior to the 7/8/15 Medication Management Progress Note. - His psychiatric Medication Management Progress Note, dated 7/30/15, stated "Latuda 40 mg...1 tablet by mouth once a day with meals..." The note also stated [Individual #4] reported his	W 311		

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	13G037		03/08/2016

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W 311	Continued From page 196 mood had been "good." Staff reported that though he "has actually had an increase in depressive symptoms, he seemed to overall be doing better." The Program Manager reported that there "has been many staff changes over the past month" and that was most likely why he "has exhibited an increase in symptoms." - His Medication Reduction Plan, dated 7/30/15, stated he received Latuda 40 mg every morning. However, there were no IDT meeting notes prior to the 7/30/15 Medication Management Progress Note. - His psychiatric Medication Management Progress Note, dated 9/24/15, stated Latuda 40 mg once a day with meals and Ativan was to be tapered and then discontinued. - His Medication Reduction Plan, dated 9/28/15, stated he received Latuda 40 mg every morning and was to taper off Ativan. - The IDT meeting notes, dated 9/16/15, stated his legal guardian "is probably going to stop the Ativan. Team thoughts? Team is fine with discontinuing Ativan." - His psychiatric Medication Management Progress Note, dated 10/13/15, stated he received Latuda 40 mg tablet by mouth once a day with meals. He "has been 'charging at staff,' refusing to shower, isolating in his room...has been purging, 'four times in the past two weeks'...more irritable 'clenching his fists' when he does not want to do what staff tell him to do...has not been wanting to do anything...c/o [complained of] not liking where he is	W 311		

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W 311	Continued From page 197 living...Increase Latuda to 60 mg qd. In two weeks, if mood not improved, increase to 80 mg qd." - His Medication Reduction Plan, dated 10/13/15, stated Latuda was increased to 60 mg "QAM [every morning]." However, there were no IDT meeting notes prior to the 10/13/15 Medication Management Progress Note. - His psychiatric Medication Management Progress Note, dated 10/27/15, stated he "has been more agitated and depressed...'charging at staff, with raised fists'...has not wanted to do anything...not showered for four days prior to today...has not been eating breakfast for the past week...isolating in his room...not going to work...punched two different staff after they asked him to use shampoo when he showered...has not been physically aggressive since staff made a behavior plan last week that included calling police if he is assaultive...replied 'I don't know' to most questions...not interested in anything..." The medication changes section stated Latuda 60 mg "every evening with meals." - His Medication Reduction Plan, dated 10/27/15, stated Latuda 60 mg QAM. - The IDT meeting notes, dated 10/20/15, stated on 10/13/15 he was "seen by [practitioner] for psych appointment d/t [due to] an increase in irritability and aggression." Ativan was discontinued. "Latuda increased to 60 mg qd, will reassess in 2 weeks, if no behaviors not improved [sic] will increase Latuda to 80 mg."	W 311		

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W 311	Continued From page 198 - His psychiatric Medication Management Progress Note, dated 11/19/15, stated Latuda 60 mg "every evening with meals." The note stated Individual #4 "reports his mood is 'better'...could not tell me how it was better...less agitated, but [QIDP] and his guardians believe it's because everyone is careful not to confront him...continues to avoid showering for days at a time...have been times he refused to eat and drink." - The IDT meeting notes, dated 11/17/15, stated "continues to refuse his programs, bathing, and leaving the house...continues to refuse all activities other than meds and meals..." - His Medication Reduction Plan, dated 12/17/15, stated he received Latuda 60 mg QHS. - His psychiatric Medication Management Progress Note, dated 2/10/16, stated Latuda 60 mg tablet every "evening with meals." The note stated Individual #4 "reports his mood has been 'good,' but staff report he has been acting depressed. Staff reports he refuses to shower, his appetite is poor, he doesn't want to participate in activities...Guardians report he has been meeting some goals the past few weeks. They give him a checklist of daily goals and if he completes them, he gets to pick an activity such as bowling or playing pool. He has met his goals the past two weeks." - His psychiatric Medication Management Progress Note, dated 2/10/16, stated Latuda 60 mg "every evening with meals." However, there were no IDT meeting notes prior to the 2/10/16 psychiatric Medication Management Progress Note.	W 311		

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W 311	Continued From page 199 The facility failed to ensure IDT discussions related to Individual #4's medication use were consistently documented. Additionally, Individual #4's Depressive Symptoms plan, initiated on 6/8/15 and subsequently revised on 7/31/15, 9/1/15 and 2/16/16, was reviewed. The plan included depressive type symptoms and associated behaviors. However, the plan's definitions were not sufficiently defined to include observable behavior or to allow Individual #4 to express normal, appropriate human emotions. Examples included, but were not limited to, the following: - Symptom: "Irritable mood." Behavior: "Being agitated, angry." No additional information related to observable behavior was included and no information related to Individual #4 becoming irritated and angry as a normal, appropriate human emotion was present. - Symptom: "Diminished interest in activities." Behavior: "Refusing to leave the house to participate in a community activity." The plan did not include information such as how many refusals were required to be considered symptomatic of his depression, if refusals to participate in known non-preferred activities were included in the definition, etc. - Symptom: "Change in sleep pattern." Behavior: "Not sleeping through the night or sleeping during the day time (waking hours 7:30 AM - 8:30 PM)." The time frame given was equal to 11 hours of sleep. However, the status section of the plan gave his historical sleep average as 10 hours a night. The Depressive Symptoms plan did not	W 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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W 311	Continued From page 200 include symptom criteria which was based on Individual #4's sleeping pattern history, or allow for any variation (e.g. sleeping 8 - 11 hours a night) depending on other factors such as the events of his day, prior night's ability to sleep, etc. - Symptom: "Fatigue or loss of energy." Behavior: "Having no energy to do an activity/task, being tired." The plan did not included information related to how Individual #4 was to be evaluated to determine normal amounts of fatigue (e.g. after increased amounts of physical exertion, when his was not feeling well, after a night in which he did not sleep well, etc.). - Symptom: "Laying on bed-isolating at odd times." Behavior: "During waking hours 7:30 AM - 8:30 PM." The plan did not include information related to when it was reasonable and appropriate for Individual #4 to be in his bedroom in private (e.g. separating himself from housemates who were being loud or creating an otherwise chaotic environment, separating himself to his bedroom when he was angry rather than assaulting others, etc.). Without appropriate data collection, it would not be possible for the IDT, including the prescribing practitioner and Individual #4's guardian, to make fully informed decisions regarding Individual #4's medication use.	W 311		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual	W 312		

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	13G037		03/08/2016

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W 312	Continued From page 201 elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's PCLP that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drug was employed for 1 of 3 individuals (Individual #4) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified how the drug may change in relation to progress or regression. The findings include: The facility's "Behavior Support method Hierarchy & Definitions" policy, revised 9/23/15, stated "The Interdisciplinary Team will ensure that a decrease in psychotropic medication is attempted at least annually or sooner if warranted by progress to the criteria for reduction as established in the individual program plan, by the particular drug which is being used or the specific condition for which the drug is being prescribed. This involves careful monitoring of the progress or regression of the individual involved in the drug reduction by the Interdisciplinary team." The policy was not implemented, as follows: 1. Individual #4's PCLP, dated 3/24/15, documented a 45 year old male whose diagnoses included mild intellectual disability and bipolar I disorder.	W 312		

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	13G037		03/08/2016

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W 312	Continued From page 202 His record contained a medication reduction plan, dated 2/10/16, which documented he was receiving Latuda (an antipsychotic drug) 60 mg in the evening and Brintellix (an antidepressant drug) 10 mg at noon. His medication reduction plan documented both drugs were given for depressive symptoms related to his diagnosis of Bipolar I Disorder. The criteria for a reduction stated his IDT would consider a reduction of Latuda if his depressive symptoms were 35 or less per month for six consecutive months. The criteria for a reduction of Brintellix was also set for 35 or less depressive symptoms per month for six consecutive months after he was no longer taking the Latuda. His medication reduction plan, dated 3/1/16, documented he was still receiving the same drugs at the same dosages. However, the criteria for a medication reduction had been increased to 60 or less depressive symptoms per month for six consecutive months for a reduction of Latuda. The criteria for a reduction of Brintellix had also been increased to 60 or less depressive symptoms per month for six consecutive months after he was no longer taking the Latuda. However, no documentation related to the reason the criteria was changed could be found. When asked on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated the guardian attended the medication management appointments and controlled what medications Individual #4 was administered. The facility failed to ensure behavior modifying drugs were appropriately incorporated into an	W 312		

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	13G037		03/08/2016

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W 312	Continued From page 203 individualized plan for Individual #4.	W 312		
W 315	483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used for control of inappropriate behavior were monitored closely for adverse side effects for 1 of 4 individuals (Individual #4) whose medical records were reviewed. This resulted in an individual receiving a behavior modifying drug without appropriate monitoring to determine if adverse effects were noted. The findings include: The facility's "Behavior Support method Hierarchy & Definitions" policy, revised 9/23/15, stated "The facility will ensure that precautions are followed prior to and during the use of psychotropic medications. This could include lab values & monitoring side effects." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included Mild Intellectual Disability, Bi-polar I Disorder, hand tremors, diabetes mellitus type II, and hyperlipidemia. Individual #4's psychiatric medication management progress note, dated 2/10/16, documented Individual #4 received Latuda (an	W 315		

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	13G037		03/08/2016

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W 315	Continued From page 204 anti-psychotic drug) and Brintellix (an anti-depressant drug). Individual #4's medication reduction plan, dated 3/1/16, documented he received Latuda and Brintellix for depressive type symptoms related to Bi-polar I Disorder. Individual #4's PCLP included an "Addendum," dated 2/4/16 and signed by the QIDP, which stated the following: "Despite multiple positive reinforcements/interventions, [Individual #4] still continues to refuse to participate in his active treatment program. He continues to struggle with depressive type symptoms and is seen regularly by his med manager." "It is the team's consensus that [Individual #4] has lost many skills that he used to have in his ADL's and ability to think. [Individual #4] exhibits many signs of dementia/Parkinson's disease. [Individual #4] has been referred to his primary physician for a referral for a brain scan and possible referral to a neurologist to rule out early onset dementia and/or Parkinson's disease. Therefore, until it is confirmed or denied, no changes will be made in [Individual #4's] programming. Staff will continue to document every 1/2 hour the activities/tasks that are offered to [Individual #4] and his response. 1 hour documentation will be done on the graveyards..." When asked, during an interview on 3/7/16 from 2:05 - 4:35 p.m., about the signs of dementia Individual #4 was displaying, the QIDP and the Administrator stated he would become confused, such as not being able to remember how to put on his shirt.	W 315		

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	13G037		03/08/2016

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W 315	Continued From page 205 However, Individual #4's 9/1/15 behavior plans included "Decreased ability to think" as a depressive symptom, until the plan was revised on 2/16/16. The 9/1/15 plan included the following: - Symptom: "Decreased ability to think." Behavior: "Being confused as to what to wear, what the next step of a task is that [Individual #4] knows, standing in front of an item i.e. dresser and doesn't know what he needs." QIDP summaries documented he had demonstrated a "decreased ability to think" at the following rates: April 2015: 1 May 2015: 0 June 2015: 4 July 2015: 3 August 2015: 1 September 2015: 0 October 2015: 0 November 2015: 0 December 2015: 0 January 2016: 0 Additionally, according www.drugs.com (http://www.drugs.com/sfx/brintellix-side-effects.html) the side effects for Brintellix included, but were not limited to agitation, confusion, trembling or shaking, twitching, and unusual tiredness or weakness. When asked, during an interview on 3/7/16 from 2:05 to 4:35 p.m., the QIDP and the Administrator could not differentiate confusion when Individual #4 was depressed or how it was determined confusion was not an adverse side effect of his	W 315		

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W 315	Continued From page 206 psychotropic medications. When asked what other symptoms Individual #4 demonstrated, the QIDP stated the nurse would need to be asked. Further, the 2016 Nursing Drug Handbook, adverse reactions for Latuda included parkinsonism. When asked what symptoms of Parkinson's Individual #4 was demonstrating, the QIDP stated he had hand tremors. However, Individual #4's Social Evaluation, revised 1/28/15, stated Individual #4 had been on Propranolol (an antianginal drug), but the medication was discontinued in 2007 or 2008 to "monitor for reduced hand tremor." Individual #4's 3/20/15 Annual Nursing Assessment documented "his physician had recommended discontinuation of Depakote (an anticonvulsant drug) due to persistent hand tremors some time between 2007 and 2008." No information was present to differentiate when hand tremors were a known, normal occurrence or when they were an adverse side effect of his psychotropic medications. When asked what other symptoms of Parkinson's Individual #4 was demonstrating, the QIDP stated the nurse would need to be asked. When asked about how staff monitored side effects, the Clinical Director stated the Nursing Drug Handbook was available for staff as a reference. The facility failed to ensure Individual #4's anti-psychotic and anti-depressant medications were monitored for adverse side effects or contra-indications based on his previously identified, individualized needs.	W 315		

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	13G037		03/08/2016

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W 317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure drugs used to control behavioral symptoms were gradually withdrawn in a carefully monitored program for 1 of 3 individuals (Individual #4) who received behavior modifying drugs. This resulted in an individual receiving no supportive interventions during a drug reduction. The findings include: The facility's "Behavior Support method Hierarchy & Definitions" policy, revised 9/23/15, stated "The Interdisciplinary Team will ensure that a decrease in psychotropic medication is attempted at least annually or sooner if warranted by progress to the criteria for reduction as established in the individual program plan, by the particular drug which is being used or the specific condition for which the drug is being prescribed. This involves careful monitoring of the progress or regression of the individual involved in the drug reduction by the Interdisciplinary team." The policy was not implemented, as follows: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability, Bi-polar I Disorder, hand tremors, diabetes mellitus type II, and	W 317		

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	13G037		03/08/2016

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W 317	Continued From page 208 hyperlipidemia. Individual #4's 5/8/15 medication reduction plan documented his "team will consider a reduction in his Risperdal (an antipsychotic drug) when he has 0 episodes of isolation for 6 consecutive months." The plan did not include information related to how the IDT had established the criteria for reduction while they were still gathering baseline data for Individual #4's depressive symptoms. The medication reduction plan also included a hand-written note which documented a plan to reduce Individual #4's Risperdal. Corresponding psychiatric Medication Management Progress Notes, dated 5/8/15, documented Individual #4's mood had been good, he was getting along with the other residents at his home, was working 16 hours a week doing lawn care, and was sleeping 11 hours per night. The note stated "Staff and guardian report that pt seems 'flat' does not respond excitedly about things as he used to." The psychiatric notes did not include information related to the 41 depressive type signs that Individual #4 had displayed, per his April 2015 QIDP data summaries, or information related to how the facility had been monitoring his medications for desired effect and adverse consequences. Further, no assessment information, data or other documentation related to Individual #4's "flat" affect, could not be found in Individual #4's record. When asked about the medication reduction, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the QIDP stated the guardian wanted the medication to be reduced, but other members of the IDT did not always agree with the reduction.	W 317		

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	13G037		03/08/2016

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W 317	Continued From page 209 However, Individual #4's record did not include documentation of assessment or analysis of his symptoms or other information related to an assessment of the medications use (e.g. documentation of desired effect and adverse consequences) in an effort to determine whether a Risperdal reduction was warranted or contra-indicated. Further, documentation that the IDT had discussed concerns related to the Risperdal reduction prior to the 5/8/15 meeting with the psychiatric practitioner were not found and post-psych clinic meeting minutes dated 5/12/15, stated "Psych Clinic on 5/8/15 [Individual #4's Risperdal was decreased to .5 BID [two times a day]. He will be seen in July and possibly discontinue it then." No information related to how the facility was going to support Individual #4 through the reduction (e.g. increasing the frequency of his reinforcement, increasing reinforcing activities and outings, decreasing demands, etc.) was present in the notes of Individual #4's record. Individual #4's record also documented additional drug reductions/changes, as follows: - His psychiatric Medication Management Progress Note, dated 7/8/15, stated "start Latuda (an anti-psychotic drug) 40 mg 1/2 qd [every day] x 1 week then 1/2-1 qd. Decrease Risperdal 1 mg qhs x 1 week then d/c [discontinue]." - His psychiatric Medication Management Progress Note, dated 9/24/15, stated Latuda 40 mg once a day with meals and Ativan (anxiolytic	W 317		

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	13G037		03/08/2016

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W 317	Continued From page 210 drug) was to be tapered and then discontinued. However, no information related to how the facility was going to support Individual #4 through the medication reductions/changes was present in the notes of Individual #4's record. When asked during an interview on 3/4/16 from 2:00 - 4:35 p.m., what adjustments had been made based on the medication changes, the QIDP stated none were made. The facility failed to ensure Individual #4 was carefully monitored and provided with supportive interventions during his medications changes/reductions.	W 317		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to obtain special studies as recommended for 1 of 4 individuals (Individual #2) whose records were reviewed. This resulted in an individual not receiving a bone density screening to meet his needs. The findings include: 1. The National Center for Biotechnology Information (www.ncbi.nlm.nih.gov) published an article by the American Epilepsy Society in 2009 summarizing bone density studies on individuals receiving long term antiepileptic drug therapy. The article stated "Antiepileptic drug (AED)	W 326		

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	13G037		03/08/2016

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W 326	Continued From page 211 therapy for epilepsy is associated with metabolic bone disease and high risk for fractures. Reduced bone mineral density (BMD) has been reported in 20 to 75 percent of patients taking AEDs in cross-sectional studies." The article stated 3 to 5 years of AED therapy was a reasonable interval before assessing BMD. Individual #2's 5/26/15 IPP stated he was a 24 year old male whose diagnoses included moderate mental retardation and seizure disorder. His 10/5/15 Physician's Order stated he received oxcarbazepine (an anticonvulsant drug) 600 mg twice a day for seizures. His 5/20/15 H&P report stated a DEXA (bone density) scan was completed on 8/4/11 and was to be repeated in 3-4 years. However, Individual #2's record did not include information related to a bone density screening being completed as recommended. During an interview on 3/7/16 from 2:05 - 4:35 p.m., the LPN reviewed Individual #2's medical record and said the record did not include a bone density screening being completed as recommended. The facility failed to ensure Individual #2 received special studies for bone density screening in accordance with his needs.	W 326		
W 329	483.460(b)(1) PHYSICIAN PARTICIPATION IN THE IPP A physician must participate in the establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs.	W 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 329	Continued From page 212	W 329		
	This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medical status was assessed by a physician and incorporated into the PCLP for 1 of 1 individual (Individual #4) who was admitted to the facility within the last year. This resulted in the potential for the individual to not receive all necessary services. The findings include: 1. Individual #4's 3/24/15 PCLP stated he was a 45 year old male whose diagnoses included mild intellectual disability, Bi-polar I Disorder, hand tremors, Diabetes Mellitus type II, and hyperlipidemia. Individual #4's medical record contained an initial H&P, dated and signed by a Nurse Practitioner on 3/19/15. His initial PCLP, dated 3/24/15, listed contributors to the PCLP, which did not include a physician. Next to the "Physician:" listed on the PCLP was the name of the Nurse Practitioner. When asked, during an interview on 3/4/16 from 2:00 - 4:35 p.m., the LPN confirmed the name on the PCLP was that of the Nurse Practitioner, who had completed Individual #4's PCLP. The facility failed to ensure a physician participated in the establishment of Individual #4's initial PCLP.			
W 361	483.460(i) PHARMACY SERVICES	W 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

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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
W 361	Continued From page 213 The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the provision of routine drugs and biologicals was maintained for 2 of 4 individuals (Individuals #2 and #3) whose medical records were reviewed. This resulted in individuals not consistently receiving scheduled drugs and biologicals due to unavailability. The findings include: 1. Individual #3's IPP, dated 7/7/15, documented a 20 year old male whose diagnoses included mild intellectual disability and fetal alcohol syndrome. His record contained a Physician's Order, signed by the physician on 7/18/13, which documented Individual #3 had received Benzoyl Peroxide 5% (an antiacne drug) and Tretinoin cream 0.5% (an antiacne drug) since that time. His record also contained MARs for 12/2015 and 1/2016 which documented the Benzoyl Peroxide and Tretinoin cream had not been administered due to lack of availability as follows: December 2015: - 12/14/15 - 12/18/15 - 12/19/15 - 12/20/15	W 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 361	Continued From page 214 - 12/22/15 - 12/23/15 - 12/27/15 - 12/29/15 - 12/30/15 January 2016: - 1/15/16 - 1/16/16 - 1/17/16 - 1/21/16 - 1/22/16 - 1/23/16 - 1/24/16 - 1/25/16 - 1/26/16 When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the LPN stated Individual #3's medications were not available due to issues with his insurance. The facility failed to ensure Individual #3's acne drugs were provided as prescribed. 2. Individual #2's 5/26/15 IPP stated he was a 24 year old male whose diagnoses included moderate mental retardation and seizure disorder. Individual #2 was seen by a Podiatrist on 2/1/16 for a detached left great toenail. At that time, the Podiatrist ordered the left foot to be soaked in 2 tablespoons of Epsom Salts diluted in one gallon of warm water for 10-20 minutes, two times a day. Individual #2's MARs for 2/1/16 - 3/7/16 were reviewed and documented he did not receive the Epsom Salts soak in warm water on 2/29/16 due	W 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 361	Continued From page 215 to "none to give." When asked during an interview on 3/7/16 from 2:05 - 4:35 p.m., the LPN said Individual #2 did not receive the foot soaks on 2/29/16 as ordered due to the facility running out of Epsom Salts. The facility failed to ensure Epsom Salts were provided for Individual #2.	W 361		
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 pharmacist conducted routine comprehensive drug regimen reviews for 4 of 5 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. When asked during an interview on 3/7/16 from 2:05 - 4:35 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	W 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COUGAR CREEK	1230 EAST COUGAR CREEK MERIDIAN, ID 83642

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W 362	Continued From page 216 completed for Individuals #1 - #4.	W 362		

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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - COUGAR

STREET ADDRESS, CITY, STATE, ZIP CODE: 1230 EAST COUGAR CREEK, 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
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		
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, W104 and W111.	MM080		
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 W122, W123, W125, W128, W129, W130, W144, W149, W153, W154, W155 and W157.	MM134		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Moss
TITLE: Clinical Director
(X6) DATE: 4/4/16

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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER
PREFERRED COMMUNITY HOMES - COUGAR

STREET ADDRESS, CITY, STATE, ZIP CODE
1230 EAST COUGAR CREEK
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
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 W159.	MM155		5/13/16
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 W195, W196, W199, W206, W210, W212, W214, W216, W217, W219, W222, W223, W227, W234, W238, W239, W249, W252, W255, W258, W259, and W260.	MM159		5/13/16
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.	MM162		5/13/16

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
	13G037		03/08/2016

NAME OF PROVIDER OR SUPPLIER
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MM162	Continued From page 2 This Rule is not met as evidenced by: Refer to W266, W278, W285, W288, W289, W311, W312, W315 and W317.	MM162		
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 W326 and W362.	MM166		5/13/16

ASPIRE
HUMAN SERVICES, LLC

5/3/16

RECEIVED
MAY 03 2016
FACILITY STANDARDS

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

RE: Cougar Creek, Provider #13G037

Dear Karen Marshall:

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

W102

Please see the responses given under W104 and W111 as it relates to systematic changes ensuring oversight is provided to the facilities.

W104

1. Individual #4 is no longer residing in the facility. In addition, a root cause analysis has been completed with recommendations to prevent future reoccurrences of deficient practices.
2. Aspire Human Services has revised the Suicide Policy. The revised policy will include guidance for how the ITD assesses individuals with a history of suicide ideation. Specifically, the policy clarifies all historical information related to suicide ideation. The policy outlines when an individual's objective for suicide ideation can be removed from the Individual Program Plan. Aspire Human Services will also review all individuals with suicide guidelines to ensure the suicide policy is being followed and implemented. Training on the Suicide Policy will occur at each facility. The ITD will revise the Pre-Psych checklist to include reviewing suicide guidelines at their pre-psych meeting and at the monthly team meeting ensuring plans follow the Suicide Policy.
   Aspire Human Services will be completing an Internal Review for all individuals residing at Cougar Creek. The purpose of the review will be to ensure individual's records are complete with accurate information, individual needs are met and rights are being upheld, identifying active treatment needs are comprehensively addressed and therefore are receiving comprehensive active treatment services based on their assessed needs, and techniques being used to manage inappropriate behavior are sufficiently developed. Ongoing Internal Reviews will continue as scheduled.

3. Aspire Human Service's Boise is eliminating the Clinical Director's position and replacing the position with a Program Manager. Aspire Human Service's Boise will be making the systemic change of having 2 Program Managers. Each Program Manager will oversee 4 facilities; including the facilities QIDP, Program Supervisor, Nurse, Lead Worker(s), and Direct Support Professionals. This provides more time for the Program Manager to be involved with the day to day operations, oversight and monitoring (including active treatment services), training, and to be involved in Individual Program Plans. This systemic change will provide Aspire Human Services Governing Body the ability to ensure individual's records are complete with accurate information, individual needs are not being neglected, and individual rights are being upheld.
   Current Direct Support Professional receive annual and ongoing training from the Program Supervisor, QIDP, facility Nurse, Program Manager, or designee. The training includes but is not limited to: IPP implementation and revisions, Active Treatment, Therapeutic Options, monthly staff meetings, in-services, and observations. There will be a minimum training of one staff meeting a month, two SAM observations, two floor observations, and in-services as needed.
   Training for new Direct Support Professionals is being revised. A meeting will be set up with new Direct Support Professionals at the end of their New Hire Orientation training meeting with a Post Training Designee to complete a Post Training Assessment. Direct Support Professionals will have the opportunity to ask for additional training if they feel necessary. A meeting with the Program Supervisor will be scheduled to address concerns and provide any additional training needed. In addition, a Post Training Feedback survey will be completed on the training experience. The purpose of the Post Training Feedback survey is to identify areas of success and needed improvements in our training program for Direct Support Professionals.
   New Program Supervisors will be not be taking calls for the first 6 weeks while they are in training. This will provide new Program Supervisors the time to learn their job. Also, this will ensure all concerns or allegations are appropriately handled while the Program Supervisor is learning their job. Program Supervisors will be taken off of the master schedules as floor staff, opening up time for quality training and/or observations with Direct Support Professionals.
   A manual has been created for the QIDP position that provides guidance and expectations for the integration, coordination, implementation, and monitoring of each individual's active treatment program. In addition, it provides guidance on coordination between all providers in order to ensure that discrepancies between any aspects of the individual's programming (vocational, medical, dietary, etc.) are resolved. Further guidance and expectation is provided to ensure that the individual maintains access to all assistive devices or environmental supports in order to promote the highest level of independence.
4. QIDP case files will now be stored in the Program Managers office. At any given moment all case files (nursing, Q book, and INA's) can be pulled together for verification or review for any individual living at Aspire Human Services. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The current Internal Review schedule includes a file review with a minimum of 4 individuals every month. The Internal Review form is being revised to include a review of current INA's. This will provide a review of the whole picture for all individuals

served. The Program Manager will receive the completed Internal Review form. The Program Manager will have a meeting monthly with their facilities QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented.

QIDP's will be assigned to spend a portion of their time in the Boise office. This will provide time for uninterrupted Q work and collaboration between QIDP's. Another benefit of having the QIDP's in the office is when working on individual plans, Q's will be able to pull all case file information from INA's and nursing immediately. With these systemic changes, Aspire Human Services can provide sufficient monitoring and oversight to ensure deficient practices do not reoccur.

5. Person Responsible: Program Manager, QIDP & Program Supervisor
6. Completion Date: 5/13/2016

Please see the responses given under W111, W122, W149, W154, W159, W195, W206, W210, W214, W227, W234, W239, W249, W252, W255, W258, W259, W260, W266, W278, W289, W311, W312, W315, and W317.

W111

1. Individual #4 is no longer residing in the facility.
2. Individual #2's record is in the process of being revised to include accurate information. Individual #1's record is in the process of being revised to include accurate information. Refer to 104.
3. QIDP case files will now be stored in the Program Managers office. At any given moment all case files (nursing, Q book, and INA's) can be pulled together for verification or review for any individual living at Aspire Human Services. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. This tool is being revised to include review of current INA's. This will provide a review of the whole picture for all individuals served. The Program Manager will receive the completed Internal Review. The Program Manager will have a meeting monthly with their facilities QIDP, Program Supervisor, and facility Nurse. During these monthly meetings, documented follow up on the Internal Review will occur. The Program Manager will be looking at individual case files holistically for verification of discrepancies being corrected or addressed with timelines in a plan in action to complete before the next monthly meeting.

   The Program Manager will review all Preliminary Program Plans and Individual Program Plans prior to implementation.
4. All INA's are audited weekly ICF Program Supervisor Meeting to ensure the INA's have been processed within 5 days along with proper notification, documentation, and is complete. All INA's will be reported Monday – Friday 8am-5pm to the Program Manager. Additionally, a second review will be conducted during the monthly meeting.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor
6. Completion Date: 5/13/2016

W122

Please see the responses given under W123, W125, W128, W129, W130, W144, W149, W154, W155 and W157.

W123

1. Individual #4 is no longer residing in the facility.
2. Each individual currently residing in the facility has a consent in their file giving approval for the use of the video cameras.
3. The Program Manager will review all pre-admissions and Preliminary Program Plans prior to admissions. A pre-admission checklist is being created. One part of the review will be verifying consents are received prior to admission.
4. The Program Manger will document their review of the Preliminary Program Plan, including consents. All identified corrections will be made prior to admission.
5. Person Responsible: Program Manager & QIDP.
6. Completion Date: 5/13/2016

W125

1. Individual #4 is no longer residing in the facility.
2. Each individual currently residing in the facility has a consent in their file giving approval for the use of the video cameras. If a guardian does not give consent to a restrictive procedure an IDT (including individual and guardian) meeting will be scheduled to discuss further the risks and benefits and explore alternative options to ensure the safety of the individual and the guardians concerns are addressed.
3. Each individual's financial plan will be revised to include information about their will. Aspire Human Services is revising their Rights policy to ensure due processes occurs.
4. Aspire Human Services has revised the admission checklist to include information about the status of their living will. The Financial Specialist and Program Manager will meet quarterly to review financial plans.
5. Person Responsible: Program Manager, QIDP, & Financial Specialist
6. Completion Date: 5/13/2016

W128

1. Individual #4 is no longer residing in the facility.
2. A team meeting has been scheduled to discuss each individual residing at the facility that utilizes behavior modifying medications. The focus of the meeting will be to discuss if medication management decisions are being based on data collected at the facility.
3. Aspire Human Services is implementing a QIDP Manual. This will provide guidance to QIDP's to review data and lesser restrictive interventions during pre-psych meetings. Pre-psych meeting notes will be stored in the case file for each individual. The Program Manager will verify pre-psych notes are in the case file prior to their psych appointment to ensure the data supports the recommendations and lesser restrictive intervention have occurred.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review tool is being revised to include a review to verify that medication management decisions are based on data collected from observed behavior. Any discrepancies will be addressed immediately.

Refer to 104.

5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W129

1. Individual #4 is no longer residing in the facility.
2. All files are being reviewed to verify that appropriate assessments have been obtained, guidelines have been generated and staff in the facility are implementing guidelines as they are written.
3. Aspire Human Services is implementing a QIDP Manual. The QIDP Manual will provide guidance on how to proceed when implementing a restrictive intervention ensuring all rights to privacy are not being violated.
4. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the Boise office. All restrictive interventions will be reviewed to ensure policies are implemented as written. If discrepancies are identified a meeting with the Program Supervisor, QIDP, facility Nurse, guardian/advocate, and individual immediately to address the violation of their rights. The team will discuss rights, safety concerns, and review current Individual Program Plan. Revisions to the plan ensuring rights are not violated will occur immediately. Two documented observations will be completed monthly to ensure all supervision guidelines are being implemented as written in the Individual Program Plan and individual's rights are not being violated. Training will occur immediately if supervisions guidelines are not followed.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W130

1. Individual #4 is no longer residing in the facility.
2. All individual files are being reviewed to verify that appropriate assessments have been obtained, guidelines have been generated and staff in the facility are implementing guidelines as they are written.
3. Aspire Human Services is implementing a QIDP Manual. The QIDP Manual will provide guidance on how to proceed when implementing a restrictive intervention ensuring all rights during personal care tasks are not being violated.
4. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the Boise office. All restrictive interventions will be reviewed to ensure policies are implemented as written. If discrepancies are identified a meeting with the Program Supervisor, QIDP, facility Nurse, guardian/advocate, and individual immediately to address the violation of their rights. The team will discuss rights, safety concerns, and review current Individual Program Plan. Revisions to the plan ensuring rights are not violated will occur immediately. Two documented observations will be completed monthly to ensure all supervision guidelines are being implemented as written in the

Individual Program Plan and individual's rights are not being violated. Training will occur immediately if supervisions guidelines are not followed.

5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W144

1. Individual #4 is no longer residing in the facility.
2. All files are being reviewed to verify communications from legal guardians are promptly responded to.
3. The current Guardianship/Advocacy Policy states: All communications from individual's families and friends (including Advocates, Guardians & Conservators) will be responded to as soon as possible but no later than 72 hours. The Program Manager will train the ICF team on the expectation of 72 hours per the current policy.
4. Aspire Human Services is making systematic changes to assist in providing oversight to the QIDP's. The QIDP's will store their case files in the Program Manager office. They will be assigned to spend a portion of their time in the office. Refer to 104. Aspire Human Services will follow up with the concerns as soon as possible but no later than 72 hours
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W149

1. Individual #4 is no longer residing in the facility.
2. All individual files are being reviewed to verify that all mental health needs are being addressed and comprehensive interventions are implemented to avoid unnecessary restrictive interventions. Behavior logs will be review to ensure all elopements are on an INA. If a discrepancy is identified and INA will be filled out immediately. In addition, a root cause analysis has been completed with recommendations to prevent future reoccurrences of deficient practices.
3. Aspire Human Services is revising the policy to include the definition for mistreatment or other types of exploitation: physical, sexual, or criminal. Aspire Human Services will then train all facilities on the revised policy definitions.
4. The revised tool for tracking and trending will provide Aspire Human Services with the means to identify trends (client to clients and elopements) within the facility. The Program Manager and Program Supervisor will meet monthly to ensure all INA's are entered accurately and trends are being addressed.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

Please refer to the responses given under W154, W155 and W157.

W154

1. A training has been scheduled for the Program Supervisors at Aspire Human Services. The training will focus on the completion of a thorough investigation. Specifically, interviewing the individuals involved in all investigations and a thorough record review including incidents prior to admission to the facility if applicable.

2. After the training has occurred, the Program Manager and Program Supervisors will review all investigations in our current INA books to ensure all allegations have been thoroughly investigated.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
4. All investigations will be audited weekly by the Program Supervisors to ensure they are thorough and all concerns have been addressed. Any identified concerns will be addressed by the Program Manager immediately. Additionally a second review will be conducted during monthly IDT team meeting.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W155

1. A training has been scheduled for the Program Supervisors at Aspire Human Services. The training will focus on the implementation of the facility Abuse, Neglect and Mistreatment policy. Specifically, protecting individuals during investigations.
2. All Direct Support Professionals, QIDP's, Program Supervisors, and LPN's will be retrained on the policy definitions of Abuse, Neglect or Mistreatment to ensure all incidents are investigated thoroughly.
3. Program Supervisors currently meet at least weekly to audit previous weeks INA and verify that a thorough investigation has occurred including the protection of individuals during all allegations of Abuse, Neglect or Mistreatment. Currently all Program Supervisors report to the Program Manager immediately all concerns of Abuse, Neglect, or Mistreatment. The Program Manager will provide instruction on protecting the individual(s) and provide guidance on company policy. In addition, the second Program Manager will review the investigation once completed to ensure all allegations are thoroughly investigated.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review tool is being revised to include a review of all current INA's to verify company policy has been implemented as written. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W157

1. Individual #4 is no longer residing in the facility. Individual #1's CFA will be reviewed to verify all of his needs are being met.
2. A training has been scheduled for the Program Supervisors. The training will focus on the completion of thorough investigations and considering revisions to an individual's active treatment programming as one part of a plan of correction.
3. After the training has occurred for the Program Supervisors all individuals with be affected as each incident will be thoroughly investigated and appropriate corrective action will be considered. All other concerns identified will be investigated immediately.

4. Program Supervisors currently meet at least weekly audit each incident report and verify that a thorough investigation has occurred including appropriate corrective actions taken. Deficiencies will be corrected during the meeting along with any training as needed. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review tool is being revised to include a review of all incident & accident reports.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W159

Please refer to the responses given under W122, W195 and W266.

W195

Please refer to the response given under W196.

W196

Please refer to the responses given under W199, W206, W210, W212, W214, W216, W217, W219, W222, W223, W227, W234, W238, W239, W249, W252, W255, W256, W258, W259 and W260.

W199

1. Individual #4 is no longer residing in the facility.
2. Aspire Human Services has revised the admission and pre-admission policy to include a checklist. The checklist will have the Program Supervisor, QIDP, facility Nurse, and Program Manager reviewing current evaluations prior admission indicating the facility can meet their needs.
3. The Program Manager will review all pre-admissions and Preliminary Program Plans prior to admissions. One part of the review will be verifying consents are received prior to admission. If a consent is missing the Program Manager will inform the QIDP and guardian/advocate to ensure it is completed and consent is given or denied prior to admission. If denied a meeting with the guardian/advocate will occur prior to admissions.
4. The Program Manager will document their review of the Preliminary Program Plan, including consents. At the new admits Individual Program Plan the Program Manager will review the current consents for accuracy of needs and plan since moving in.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W206

1. Individual #4 is no longer residing in the facility.
2. There currently are no new admits at Cougar Creek.
3. The IDT will review the Preliminary Program Plan prior to admission ensuring safety plans are in place, if needed, and all needs will be met until the Individual Program Plan is implemented. Part of the Preliminary Program Plan will include the new admissions current medication list with side effects. The Program Manager and QIDP will verify all assessments are received prior to IPP. A revision to the admission policy will be that all

contracted professionals attend the initial IPP for all new admits. Contracted Professionals will be trained on Aspire Human's Services revised admissions policy.

4. The Program Manager will review all pre-admissions and Preliminary Program Plans prior to admissions ensuring all needs are being met and the individual is safe. If concerns are identified a meeting will be scheduled prior to admission.
5. Person Responsible: Program Manager, QIDP, LPN, Program Supervisor, and Professionals
6. Completion Date: 5/13/2016

W210

1. Individual #4 is no longer residing in the facility.
2. There currently are no new admits at Cougar Creek.
3. The Program Manager and QIDP will verify all comprehensive assessments are conducted within the first 30 days. Training with contracted Professionals completing their comprehensive assessments within the firsts 30 days in the facility will occur.
4. The Program Manager and QIDP will verify all comprehensive assessments are conducted within the first 30 days. The Program Manager will meet with Program Supervisor, QIDP, and facility Nurse after admission to ensure the individual's needs are still being met, all safety concerns are addressed, and comprehensive assessments are being completed or scheduled within the first 30 days.
5. Person Responsible: Program Manager, QIDP, LPN, Program Supervisor, and Professionals
6. Completion Date: 5/13/2016

W212

1. Individual #4 is no longer residing in the facility. Individual #1's assessment will be revised to include his current diagnosis.
2. A team meeting has been scheduled to discuss each individual residing at the facility to verify that there is consistent diagnostic information in each file. The focus of the meeting will be to discuss each individuals mental health needs as they relate to diagnostic information.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will store their case files in the Program Manager's office and will be assigned to spend a portion of their time in the Boise office. This will provide time for uninterrupted Q work and collaboration between QIDP's. Another benefit of having the QIDP's in the office when working on individual plans is, Q's will be able to pull case files from INA's and nursing immediately to maintain consistent diagnostic information in individual's records.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review verifies that each individuals file contains consistent diagnostic information. Discrepancies will be corrected immediately.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W214

1. The Program Supervisor, QIDP, and facility Nurse is currently in the process of revising Individual #1's assessments to include comprehensive information. Individual #4 is no longer residing in the facility. Refer to 104.
2. All individual's charts are currently being reviewed to assure that assessments contain comprehensive information regarding the function of maladaptive behavior and INA's match ABC logs.
3. Aspire Human Service's Boise is eliminating the Clinical Director's position and replacing the position with a Program Manager. Aspire Human Service's Boise will be making the systemic change of having 2 Program Managers. Each Program Manager will oversee 4 facilities; including the facilities QIDP, Program Supervisor, Nurse, Lead Worker(s), and Direct Support Professionals. This provides more time for the Program Manager to be involved with the day to day operations, oversight and monitoring (Functional Behavior Assessment), training, new admissions, and to be involved in Individual Program Plans. A manual has been created for the QIDP position that provides guidance on including comprehensive information regarding the function of individual's maladaptive behaviors. The Program Supervisor, Program Manager, QIDP, and facility Nurse meet monthly to review all individuals in the facility.
   During the monthly meeting, the Program Supervisor, Program Manager, QIDP, and facility Nurse will discuss/review observations, review of data sheets, ABC logs, assessments, INA's, staff meetings, nursing files and all other necessary documentation needed to provide comprehensive information to ensure all intervention techniques relate to each maladaptive behavior.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The current Internal Review schedule includes a file review with a minimum of 4 individuals every month. The Program Manager will receive the completed Internal Review form. The Program Manager will have a meeting monthly with their facilities QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings a plan in action will be created with completions dates before next meeting. QIDP's will be assigned to spend a portion of their time in the Boise office. This will provide time for uninterrupted Q work and collaboration between QIDP's. Another benefit of having the QIDP's in the office is when working on individual plans, Q's will be able to pull all case file information from INA's and nursing immediately.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor
6. Completion Date: 5/13/2016

W216

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are being reviewed to assure that physical assessments include compressive accurate information.
3. The Program Manager will review all pre-admissions and Preliminary Program Plans prior to admissions. One part of the review will be verifying relevant history is included in the Preliminary Program Plan.

4. Aspire Human Services is making systematic changes to assist in providing oversight to the QIDP's. The QIDP's will store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor
6. Completion Date: 5/13/2016

W217

1. Individual #4 is no longer residing in the facility.
2. All individual's assessments are being reviewed for compressive accurate information.
3. The Program Manager will review all pre-admissions and Preliminary Program Plans prior to admission. One part of the review will be verifying relevant history is included in the Preliminary Program Plan. The Preliminary Program Plan is provided to all IDT members. This will assist in assessments having comprehensive, accurate information. The Program Manager and QIDP will verify all comprehensive assessments are conducted.
4. The Program Manager will meet with the Program Supervisor, QIDP, and facility Nurse after admission to ensure the individual's assessments are comprehensive and accurate. If discrepancies are identified they will be added to the IDT's agenda for the Individual Program Plan meeting. In addition, the Program Manager and QIDP will review assessments for Individual Program Plans prior to the meeting for comprehensive, accurate information or as needed throughout the year.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W219

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are being reviewed to assure their physical affect have been assessed.
3. Aspire Human Services is currently in the process of revising the CFA to include a section to assess each individual's affect. Refer to 104.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. One part of the review verifies that each individual's affect is assessed. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/16

W222

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are being reviewed to assure that specific learning styles have been assessed and are being utilized. Future discrepancies identified for preferred learning styles will be corrected before the next month's data is implemented.
3. Aspire Human Services is currently in the process of revising the CFA to include a section to assess the specific learning style of each individual being served. The Program Manager will be involved with the day to day operations, oversight and monitoring (comprehensive information regarding affect by preferred learning styles), and Individual Program Plans. The Program Supervisor, Program Manager, QIDP, and facility Nurse

meet monthly to review all individuals in the facility. During the monthly meeting, the Program Supervisor, Program Manager, QIDP, and facility Nurse will discuss/review observations, review of data sheets, ABC logs, assessments, INA's, staff meetings, nursing files and all other necessary documentation needed to provide comprehensive information to ensure all preferred learning styles are incorporated in the Individual Program Plan. Corrections will be completed before the next meeting.

4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. One part of the review verifies that each individual's specific learning style is assessed. Refer to 214 and 216.
5. Person Responsible: Program Manager, QIDP, LPN & QIDP.
6. Completion Date: 5/13/16

W223

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to assure that each individual is assessed in regards to their interest in activities. Discrepancies are being corrected immediately.
3. A training has been scheduled with the QIDP's with Aspire Human Services. The training will focus on the expectation that each individual is assessed in regards to their interest in activities.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. One part of the review verifies that each individual is assessed on their interest in activities. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W227

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to ensure that objectives are being developed to meet the needs and are not lacking program plan designs promoting individual's independence and maximizing their potential of each individual served. Deficiencies will be corrected immediately.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104 and 214.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. One part of the review verifies objectives are developed to meet the needs of each individual. Refer 104 and 214.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/16

W234

1. Individual #4 is no longer residing in the facility.

2. All individual's charts are currently being reviewed to assure that each IPP includes sufficient information on how to implement the training programs. Currently weekly staff meetings are occurring to train Direct Support Professionals on individual's plans.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. In addition, the QIDP Manual is being revised to provide instructions on a staff meeting after every Individual Program Plan. Training for new Direct Support Professionals is being revised. A meeting will be set up with new Direct Support Professionals at the end of their New Hire Orientation training meeting with a Post Training Designee to complete a Post Training Assessment. Direct Support Professionals will have the opportunity to ask for additional training if they feel necessary. A meeting with the Program Supervisor will be scheduled to address concerns and provide any additional training needed. Current Direct Support Professional receive annual and ongoing training from the Program Supervisor, QIDP, facility Nurse, Program Manager, or designee. The training includes but is not limited to: IPP implementation and revisions, Active Treatment, monthly staff meetings, in-services, and observations ensuring staff have a clear understanding of the instructions provided to Direct Support Professionals o how to implement program strategies. There will be a minimum training of one staff meeting a month, two SAM observations, two floor observations, and in-services as needed. Refer to 104.
4. One part of the review verifies program plans contain sufficient information on how to implement training programs that are provided to Direct Support Professionals. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W238

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to assure that training programs specify behaviors which interfere with functioning abilities per their active treatment schedule. Areas identified will be corrected immediately.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans ensuring specific behaviors are addressed in relation to their active treatment needs. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. The Program Manager reviews all Individual Program Plans prior to implementation. When being reviewed if areas of specified behaviors are not identified corrections will be made prior to implementation. Refer to 104.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review form is being revised to include a review of current INA's. This will provide a review of the whole picture for all individuals served. The Program Manager will receive the completed Internal Review form. The Program Manager will have a meeting monthly with their facilities QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program

Manager will verify that corrections have been made for current Internal Reviews. Refer to 104.

5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor. .
6. Completion Date: 5/13/2016

W239

1. Individual #4 is no longer residing in the facility. Individual #1's Functional Behavior Assessment will be reviewed to ensure consistent, comprehensive information regarding the function of his behaviors relating to replacement behaviors.
2. All individual's charts are currently being reviewed to ensure Functional Behavioral Assessment included consistent, comprehensive information regarding the function of maladaptive behaviors in relations to replacement behaviors. Areas identified will be corrected immediately.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans including replacement behaviors in relation to the function on individuals behavioral assessments. At the Individual's Program Plan meeting discussion on replacement behaviors meet the function of individual's maladaptive behavior. The QIDP's will store their case files in the Program Manager office. They will be assigned to spend a portion of their time in the office. Refer to 104.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review form is being revised to include a review of current INA's. This will provide a review of the whole picture for all individuals served for the function of replacement behaviors. The Program Manager will receive the completed Internal Review form. The Program Manager will have a meeting monthly with their facilities QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. QIDP's will be assigned to spend a portion of their time in the Boise office. This will provide time for uninterrupted Q work and collaboration between QIDP's with replacement behaviors. Another benefit of having the QIDP's in the office is when working on individual plans, Q's will be able to pull all case file information from INA's and nursing immediately.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor. .
6. Completion Date: 5/13/2016

W249

1. Individual #4 is no longer residing in the facility.
2. Weekly staff meetings are occurring to train the Direct Support Professionals on all individual's plans.
3. Aspire Human Service's Boise is eliminating the Clinical Director's position and replacing the position with a Program Manager. Aspire Human Service's Boise will be making the systemic change of having 2 Program Managers. This provides more time for the Program Manager to be involved in training and Individual Program Plans. Current Direct Support Professional receive annual and ongoing training from the Program Supervisor, QIDP, facility Nurse, Program Manager, or designee. The training includes but is not limited to: IPP implementation and revisions, Active Treatment, monthly staff meetings, in-services, and observations. A manual has been created for the

QIDP position that provides guidance on the implementation of Individual Program Plans. All new or annual Individual Program Plans will have a staff meeting to train Direct Support Professionals ensuring consistent implementation.

4. There will be a minimum training of one staff meeting a month, two SAM observations, two floor observations, and in-services as needed to assist in program plans being consistently implemented. The QIDP, Program Supervisor, facility Nurse, Program Manager, or designee will train in the moment when witnessing a program being ran inconsistently or will schedule a meeting within the week if recognizing inconsistencies off of data review. Refer to 104.
5. Person Responsible: Program Manager, QIDP and Program Supervisor.
6. Completion Date: 5/13/2016

W252

1. Individual #4 is no longer residing in the facility.
2. Direct support professionals will be provided training related to sufficient data collection for all individuals residing in the facility.
3. QIDP case files will now be stored in the Program Managers office. At any given moment all case files (nursing, Q book, and INA's) can be pulled together for verification or review for any individual living at Aspire Human Services. QIDP's will be assigned to spend a portion of their time in the Boise office. By having the QIDP's in the office is when working on individual plans, Q's will be able to pull all case file information from INA's and nursing immediately for review. With these systemic changes, Aspire Human Services can provide sufficient monitoring and oversight to ensure deficient practices do not reoccur.
4. One time per week the Program Supervisor, QIDP, and facility Nurse complete a review of the ABC data sheets from the prior week. Areas identified in the data affecting intervention strategies that could potentially impede the ability in evaluating the effectiveness of the programmatic techniques will be addressed immediately with the employee.
5. Person Responsible: Program Manager, QIDP and Program Supervisor
6. Completion Date: 5/13/2016

W255

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to ensure objectives are based on the performance of each individual. Areas identified will be corrected immediately.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the implementation of program plans. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served. One part of the review verifies that objectives are based on individual's actual performance. Areas identified will be corrected immediately. Refer to 104.
5. Person Responsible: Program Manager and QIDP
6. Completion Date: 5/13/2016

W256

1. Individual #1's plan was revised on 11/19/15 to assist him to decrease his regression.
2. All individual's charts are currently being reviewed to ensure interventions have occurred when appropriate to address documented needs. Areas identified will be corrected immediately.
3. Aspire Human Services is making systematic changes to assist in providing oversight program monitoring and change. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served. One part of the review verifies program monitoring and change is occurring. Areas identified will be corrected immediately. Refer to 104.
5. Person Responsible: Program Manager, QIDP, & Program Supervisor
6. Completion Date: 5/13/2016

W258

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to ensure current objectives meet individuals training needs. Training for QIDP's will cover situation's being considered for training towards new objectives ensuring new training objectives are being considered. Areas identified will be corrected immediately.
3. Aspire Human Services is making systematic changes to assist in providing oversight on program monitoring and change. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served. Part of the Internal Review tool will provide oversight on program monitoring and change. Areas identified will be corrected immediately. Refer to 104.
5. Person Responsible: Program Manager, QIDP, & Program Supervisor
6. Completion Date: 5/13/2016

W259

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to ensure objectives are based on the performance of each individual. A training has been scheduled with the QIDP's with Aspire Human Services. The training will focus on ensuring objectives are revised based on actual performance of each individual and the expectation that the CFA is revised as individuals status changes.
3. Aspire Human Services is making systematic changes to assist in providing oversight on ensuring annual or as needed assessments are completed providing comprehensive information on which to base program decisions on. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.

4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served; including review of individuals CFA's. Areas identified will be corrected immediately. Refer to 104.
5. Person Responsible: Program Manager and QIDP.
6. Completion Date: 5/13/2016

W260

1. Individual #4 is no longer residing in the facility.
2. All individual's charts are currently being reviewed to ensure objectives are based on the performance of each individual current status and need. A training has been scheduled with the QIDP's with Aspire Human Services. The training will focus on ensuring objectives are revised based on actual performance of each individual and the expectation that the Individual Program Plan is revised as individuals status or need changes.
3. The QIDP Manual is being revised to provide instruction on how to complete monthly program summaries. Instructions on revising the Individual Program Plan as the status and needs changing will be included in the manual. Refer to 104.
4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served. One part of the review verifies that objectives are based on individual's actual performance of their current status or needs are reflected in the Individual Program Plan. Areas identified will be corrected immediately. Refer to 104.
5. Person Responsible: Program Manager and QIDP
6. Completion Date: 5/13/2016

W266

Please refer to the responses given under W278, W285, W288, W289, W311, W312, W315 and W317.

W278

1. Individual #4 is no longer residing in the facility.
2. All files are being reviewed to verify that appropriate assessments have been obtained, guidelines are being generated and staff in the facility are implementing guidelines as they are written.
3. The QIDP Manual is being revised to provide guidance on restrictive interventions. It will include a checklist verifying appropriate steps for restrictive interventions. Guidance will include when implementing a restrictive intervention the individual program plan and active treatment schedule must be revised to reflect changes. Additionally, the use of lesser restrictive interventions tried and found to be ineffective will be documented in the plan. Refer to 104.
4. Aspire Human Services is making systematic changes to assist in providing oversight on the management of inappropriate client behavior. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W285

Please refer to the responses given under W128, W129 and W130.

W288

1. Individual #4 is no longer residing in the facility.
2. All files are being reviewed to verify that less restrictive interventions were implemented before restrictive programming has been put in place along with training programs. Areas identified will have a meeting scheduled with the Program Supervisor, QDIP, facility Nurse, and guardian/advocate to discuss the restrictive interventions ensuring all lesser restrictive interventions have been tried.
3. A training is scheduled for the QIDP's at Aspire Human Services. One part of the training will focus on ensuring that before restrictive interventions are implemented that appropriate assessments are completed, training programs have been implemented and tried, guidelines are created from the assessments based on team input and staff training has occurred. Documentation will be included in the Individuals Program Plan on lesser restrictive interventions that were unsuccessful. The QIDP Manual is being revised to provide guidance on interventions; including a checklist for restrictive interventions. Guidance will include when implementing a restrictive intervention the individual program plan and active treatment schedule will be revised to reflect current status or need.
4. Currently Aspire Human Services has scheduled at a minimum of Internal Reviews annually for each individual served. The Internal Review verifies that each individual has the appropriate assessments in the record and lesser restrictive interventions have been tried (training programs) before restrictive interventions occur and is not a substitute to for active treatment. Errors will be corrected immediately. Aspire Human Services is making systematic changes to assist in providing oversight on the monitoring and implementation of program plans. The QIDP's will have store their case files in the Program Manager's office. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W289

1. Individual #4 is no longer residing in the facility. Individual #1's program has been revised to include appropriate methods for staff.
2. All individual's charts are currently being reviewed to assure that each Individual Program Plans includes sufficient information on how to implement the training programs. Weekly staff meetings are occurring to train the Direct Support Professionals on individual's plans.
3. Aspire Human Services is making systematic changes to assist in providing oversight on the management of inappropriate client behavior ensuring staff have appropriate methods in place to respond. The QIDP's will have store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. One part of the review will verify staff have the

appropriate methods to respond to individuals served behaviors. Areas identified will be corrected immediately. Refer to 104.

5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W311

1. Individual #4 is no longer residing in the facility.
2. A team meeting has been scheduled to discuss each individual residing at the facility that utilizes behavior modifying medications. The focus of the meeting will be to discuss medication management decisions being based on data collected in relationship to programing for the medication.
3. Aspire Human Services is implementing a QIDP Manual. This will provide guidance to QIDP's to review data during pre-psych meetings. Pre-psych meeting notes will be stored in the case file for each individual. The Program Manager will verify pre-psych notes are in the case file prior to their psych appointment and is being based on data collected in relationship to programing for the medication.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review tool is being revised to include a review to verify that medication management decisions are based on data collected in relationship to programing for the medication. Any discrepancies will be addressed immediately. Refer to 104.
5. Person Responsible: Program Manager, QIDP, LPN & Program Supervisor.
6. Completion Date: 5/13/2016

W312

1. Individual #4 is no longer residing at the facility.
2. At the next psych clinic meeting the team will discuss the medication reduction plans are accurate to ensure and incorporated in the Individual Program Plan's. During this discussion the team will review data and establish criteria on med reductions plans.
3. A training has been scheduled for the QIDP's at Aspire Human Services. One part of the training will focus on the implementation of individualized medication reduction plan. Aspire Human Services has implemented a QIDP Manual. This will provide guidance to QIDP's to review data during pre-psych meetings. Pre-psych meeting notes will be stored in the case file for each individual. Guidance will include reviewing and discussing med reduction plans. Refer to 104.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review verifies that individualized medication reduction plans are incorporated into each Individual Program Plan when appropriate. Refer to 104.
5. Person Responsible: Program Manager, QIDP & Program Supervisor
6. Completion Date: 5/13/2016

W315

1. Individual #4 is no longer in the facility.
2. The staff in the home are scheduled to be trained on how to identify the side effects of medications for each individual residing in the facility.

3. Aspire Human Services is revising the SAM Observation Form to include showing competency on finding a side effect of a medication for the individuals they serve in the Drug Handbook. Refer to 104.zz
4. Aspire Human Services completes 2 med observations a month. It will be documented on the SAM Observation Form. During this time Direct Support Professionals will be as to the side effects of a medication they pasted. Training will occur immediately if staff are unable to locate the side effect in the Drug Handbook. Refer to 104.
5. Person Responsible: Program Manager, LPN, QIDP & Program Supervisor
6. Completion Date: 5/13/2016

W317

1. Individual #4 is no longer residing in the facility.
2. All files are currently being reviewed to verify that supporting interventions are being implemented to support individuals through medication adjustments.
3. Aspire Human Services currently has a QIDP Manual that specifies the process of a med support reduction plans. The Program Manager will review med support reduction documents to ensure that policies are implemented. In addition Direct Support Professionals will be trained on the Med Support Reduction Plan to ensure staff are providing supportive interventions during a med reduction.
4. Aspire Human Services is making systematic changes to assist in providing oversight on the supportive interventions used during a medication change or reduction. The QIDP's will store their case files in the Program Manager's office. They will be assigned to spend a portion of their time in the office. Refer to 104.
5. Person Responsible: Program Manager, LPN, QIDP & Program
6. Completion Date: 5/13/2016

W326

1. Individual #2 has been scheduled for a bone density screening.
2. All files are currently being reviewed to verify that all recommended screenings have been administered. If screenings are missed appointments will be scheduled immediately.
3. A training has been scheduled for the nursing teams at Aspire Human Services, the training will focus on assuring that all recommended screening occur as scheduled. In addition, at the Boise location an additional nursing aid is being added to the team to assist in assuring all follow up recommendations occur as recommended.
4. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review verifies that all recommended screenings occur. If recommendations are not followed they will be addressed immediately. Refer to 104.
5. Person Responsible: Program Manager, LPN & QIDP.
6. Completion Date: 5/13/2016

W329

1. Individual #4 is no longer residing in the facility.
2. All files are currently being reviewed to verify that initial H & P's have been completed by a physician and not Nurse Practitioners for all new admissions. Cougar Creek has no new admissions

3. A training has been scheduled for the nursing teams at Aspire Human Services, one part of the training will focus on assuring that initial H & P's are completed by a physician and not Nurse Practitioners for all new admissions.
4. The Program Manager will review the admissions checklist ensuring a physician has completed the H & P. Refer to 104.
5. Person Responsible: Program Manager, LPN & QIDP.
6. Completion Date: 5/13/2016

W361

1. Currently individual #3 and #2 are receiving all of their prescribed medications.
2. The med cart at Cougar Creek has been inspection by the facility nurse to verify that all individuals are receiving their medications as ordered and no medications are being missed.
3. Aspire Human Services is revising their MAR to include a weekly inventory to ensure all medication are ordered in a timely manner and available at all times.
4. Direct Support Professionals will complete the weekly inventory reporting to the facility nurse the same day inventory was completed. This will give the facility nurse time to order any low meds to ensure all meds are available over the weekend.
5. Person Responsible: Program Manager, LPN, QIDP, Program Supervisor, and Direct Support Professionals
6. Completion Date: 5/13/2016

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. The Program Manager will maintain a schedule for pharmacy reviews and coordinate to ensure they are not missed.
4. The review will ensure pharmacy reviews are documented after in the nursing files
5. Person Responsible: Facility Nurse & QIDP
6. Completion Date: 5/13/2016

MM080

Please see the responses given under W102, W104 and W111.

MM134

Please see the responses given under W122, W123, W125, W128, W129, W130, W144, W149, W153, W154, W155 and W157.

MM155

Please see the responses given under W159.

MM159

Please see the responses given under W195, W196, W199, W206, W210, W212, W214, W216, W217, W219, W222, W223, W227, W234, W238, W239, W249, W252, W255, W258, W259 and W260.

MM162

Please see the responses given under W266, W278, W285, W288, W289, W311, W312, W315 and W317.

MM166

Please see the responses given under W326 and W362.

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