

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 8, 2012

Jeff Frick, Administrator
Preferred Community Homes - Cornerstone
7091 W Emerald
Boise, ID 83704

RE: Preferred Community Homes - Cornerstone, Provider #13G056

Dear Mr. Frick:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Cornerstone, which was conducted on July 26, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Jeff Frick, Administrator
August 8, 2012
Page 2 of 2

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **August 20, 2012**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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

This request must be received by August 20, 2012. If a request for informal dispute resolution is received after August 20, 2012, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/srm
Enclosures



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FACILITY STANDARDS

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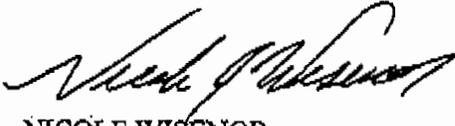
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Sincerely,


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Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
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MN/srm
Enclosures

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

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2012
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - CORNERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2028 EAST 2975 SOUTH WENDELL, ID 83355
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS The following deficiency was cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Jim Trouffetter, QMRP Common abbreviations used in this report are: IDT - Interdisciplinary Team PCLP - Person Centered Lifestyle Plan QIDP - Qualified Intellectual Disability Professional	W 000		
W 207	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Appropriate facility staff must participate in interdisciplinary team meetings. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure appropriate facility staff participated in the IDT meetings for 2 of 3 individuals (Individuals #1 and #3) whose PCLPs were reviewed. This resulted in the potential for a lack of comprehensive information being provided in the development of PCLPs and a lack of opportunities for the IDT members to consult with one another and to exchange information. The findings include: 1. Individual #3's PCLP, dated 5/23/12, documented a 20 year old female diagnosed with profound intellectual disability. Her record did not contain documented evidence of attendees at her PCLP meeting.	W 207	W 207 483.440(c)(2) INDIVIDUAL PROGRAM PLAN The facility will ensure that appropriate facility staff will participate in all resident IPP and IDT meetings and that documentation of the meetings will be obtained. This is the responsibility of the QIDP. The Administrator will ensure that a signature sheet circulates during the meeting and he will also keep a copy of the signature sheet to ensure all of the records contain documented evidence of attendees. Completion Date: 9/30/12 Persons Responsible: Administrator and QIDP	

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Admin	(X6) DATE 8-29-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - CORNERSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2028 EAST 2975 SOUTH WENDELL, ID 83355		
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W 207	<p>Continued From page 1</p> <p>When asked about the meeting, the Administrator stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they could not find the signature sheet.</p> <p>2. Individual #1's PCLP, dated 4/4/12, documented a 36 year old male diagnosed with profound intellectual disability and spastic quadriparesis.</p> <p>His record did not contain documented evidence of attendees at his PCLP meeting.</p> <p>When asked about the meeting, the Regional Director, who was also the acting QIDP, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they could not find the signature sheet.</p> <p>The facility failed to ensure there was documentation of facility staff in attendance for Individuals #1 and #3's PCLPs.</p>	W 207			

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FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED: 07/26/2012
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - CORNER!		STREET ADDRESS, CITY, STATE, ZIP CODE 2028 EAST 2975 SOUTH WENDELL, ID 83355		
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M 000	16.03.11 Initial Comments The following deficiency was cited during the annual licensing survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Jim Troutfetter, QMRP	M 000	MM724 16.03.11.270.01(a) Assessments Refer W207	
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W207.	MM724		

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Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *JH Z...* TITLE Admin (X6) DATE 8.29.12

STATE FORM

0389

CRLW11

If continuation sheet 1 of 1