

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 - Courtyard
7091 W Emerald
Boise, ID 83704

RE: Preferred Community Homes - Courtyard, Provider #13G057

Dear Mr. Frick:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Courtyard, 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.

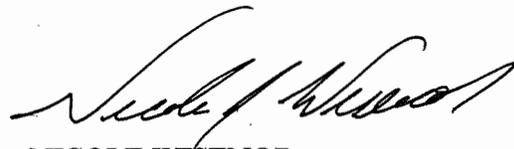
This request must be received by August 20, 2012. If a request for informal dispute resolution is received after August 20, 2012, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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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7091 W Emerald
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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;
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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.

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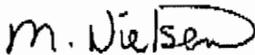
www.icfmr.dhw.idaho.gov

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

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Sincerely,



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Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
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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: 13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactivity Disorder BMP - Behavior Management Plan HRC - Human Rights Committee IDT - Interdisciplinary Team LPN - Licensed Practical Nurse PCLP - Person Centered Lifestyle Plan QIDP - Qualified Intellectual Disability Professional RSC - Residential Service Coordinator	W 000	W 159 483.430.(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Refer to W207, W226, W262, W263, W289, W312, W313, and W436 as it relates to the facilities QIDP's failure to perform certain tasks.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the QIDP provided sufficient monitoring and coordination which directly impacted 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. That failure resulted in individuals not receiving the necessary services, supports, and training required to meet their needs. The findings include: 1. Refer to W207 as it relates to the facility's	W 159		

RECEIVED
AUG 29 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Admin

(X6) DATE

8-29-12

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 159	<p>Continued From page 1</p> <p>failure to ensure the QIDP ensured PCLP attendance was documented.</p> <p>2. Refer to W226 as it relates to the facility's failure to ensure the QIDP ensured a PCLP was completed within 30 days of an individual's admission.</p> <p>3. Refer to W262 as it relates to the facility's failure to ensure the QIDP ensured HRC consent was obtained prior to the use of restrictive interventions.</p> <p>4. Refer to W263 as it relates to the facility's failure to ensure the QIDP ensured parent/guardian consent was obtained prior to the use of restrictive interventions.</p> <p>5. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured behavior plans were developed in a comprehensive manner.</p> <p>6. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured behavior modifying drugs were incorporated into a plan.</p> <p>7. Refer to W313 as it relates to the facility's failure to ensure the QIDP ensured drugs used to control inappropriate behavior were not used without evidence that the severity of the behavior clearly outweighed the risks associated with the drugs.</p> <p>8. Refer to W436 as it relates to the facility's failure to ensure the QIDP ensured a program was developed to encourage the use of eyeglasses for an individual.</p>	W 159			

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W 207	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN</p> <p>Appropriate facility staff must participate in interdisciplinary team meetings.</p> <p>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:</p> <p>1. Individual #1's PCLP, dated 9/27/11, documented a 14 year old male diagnosed with severe intellectual disability, autism, and ADHD. The signature sheet attached to his PCLP documented the meeting was held on 9/27/11 at 11:30 p.m. at a local library, and only the QIDP, the RSC, and the LPN were in attendance.</p> <p>When asked about the meeting, the LPN stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., nobody else attended the meeting and she remembered the previous QIDP saying it just needed to get done.</p> <p>2. Individual #3's PCLP, dated 2/17/12, documented an 11 year old male diagnosed with mild intellectual disability, autism, and ADHD.</p> <p>His record did not contain documented evidence of attendees at his PCLP meeting.</p>	W 207	<p>W 207 483.440 (c)(2) INDIVIDUAL PROGRAM PLAN</p> <p>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.</p> <p>Completion Date: 9/30/12 Persons Responsible: Administrator and QIDP</p>	

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W 207	Continued From page 3	W 207		
W 226	<p>When asked who attended the meeting, the Regional Director, who was also 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 appropriate facility staff were in attendance and documented for Individuals #1 and #3's PCLPs.</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the interdisciplinary team prepared a person centered lifestyle plan (PCLP) within 30 days of admission for 1 of 3 individuals (Individual #3) whose PCLPs were reviewed. The failure to develop and implement Individual #3's PCLP resulted in a delay in identifying, prioritizing, and addressing his needs. The findings include:</p> <p>1. Individual #3's PCLP, dated 2/17/12, documented an 11 year old male diagnosed with mild intellectual disability, autism, and ADHD.</p> <p>However, his record documented he was admitted to the facility on 1/7/12.</p> <p>When asked during an interview on 7/26/12 from 9:10 - 11:00 a.m., the Regional Director, who was</p>	W 226	<p>W226 483.440.(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The facility will ensure that an IPP is developed and implemented for all new residents within 30 days of admittance. Upon admittance, the Program Director will record the date and make weekly calls to ensure that the QIDP is on track for the developing and implementing of the new IPP. This will be done until the completion of the new IPP.</p> <p>Completion Date: 9/30/12 Persons Responsible: Program Director and QIDP</p>	

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W 226	Continued From page 4 also the acting QIDP, stated he was not sure why Individual #3's PCLP was late.	W 226	W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The facility's IDT will hold a meeting to evaluate and discuss all residents' restrictive interventions. HRC approval will be obtained for those restrictive components. All restrictive components will be reviewed quarterly at core team meetings to ensure all restrictive components are appropriate. Changes will be made as needed. The Program Director will audit QIDP books on a quarterly basis to verify that the written informed consents are accurate and updated with the appropriate HRC chairperson signature. Completion Date: 9/30/12 Persons Responsible: Program Director, Administrator, QIDP and RSC.	
W 262	The facility failed to ensure Individual #3's PCLP and programs were prepared and implemented within the required time frame. 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 2 of 3 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's PCLP, dated 9/27/11, documented a 14 year old male diagnosed with severe intellectual disability, autism, and ADHD. a. Individual #1's current behavior modifying drugs included Risperdal (an antipsychotic drug) 3 mg twice a day, Clonidine (an antihypertensive drug) 0.1 mg three times a day, and Strattera (an ADHD drug) 18 mg each day. Individual #1's Medication Reduction Plan, dated	W 262		

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W 262	<p>Continued From page 5</p> <p>4/20/12, documented Risperdal was for hitting and slapping others, Clonidine was for yelling, and Strattera was for falling to the floor.</p> <p>Approval from the facility's HRC could not be found for the use of Risperdal and Clonidine.</p> <p>b. Individual #1's Behavioral Assessment, dated 9/26/11, stated he required 1:1 staff supervision due to his behavior.</p> <p>During observations on 7/23/12, 7/24/12, and 7/25/12 for a cumulative 3 hours 55 minutes, Individual #1 was noted to have a 1:1 staff person with him.</p> <p>However, approval from the facility's HRC for 1:1 supervision could not be found.</p> <p>c. Individual #1's medical record documented he required Diazepam 15-mg 1 hour prior to dental examinations. His dental examination, dated 7/12/12, documented Diazepam was administered prior to the examination.</p> <p>Approval from the facility's HRC could not be found for the use of Diazepam.</p> <p>When asked, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they were unable to find HRC approval for Individual #1's restrictive interventions.</p> <p>2. Individual #2's PCLP, dated 8/30/11, documented a 21 year old male diagnosed with moderate intellectual disability, autism, ADHD, and seizure disorder.</p>	W 262			

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W 262	Continued From page 6 Individual #2's current behavior modifying drugs included Tenex (an antihypertensive drug) 1 mg three times a day. Individual #2's Medication Reduction Plan, dated 4/20/12, documented Tenex was for spitting. However, approval from the facility's HRC could not be found for the use of Tenex. When asked, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they were unable to find HRC approval for Individual #2's Tenex.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for Individuals #1 and #2. The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the parent/guardian for 2 of 3 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior consent for restrictive interventions. The findings include:	W 263	W 263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The facility's IDT will hold a meeting to evaluate and discuss all residents' restrictive interventions. Guardian or parent approval will be obtained for those restrictive components. All restrictive components will be reviewed quarterly at core team meetings to ensure all restrictive components are appropriate. Changes will be made as needed. The Program Director will audit QIDP books on a quarterly basis to verify that the written informed consents are accurate and updated with the appropriate Guardian or parent signature. Completion Date: 9/30/12 Persons Responsible: Program Director, Administrator, QIDP and RSC.	

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W 263	<p>Continued From page 7</p> <p>1. Individual #1's PCLP, dated 9/27/11, documented a 14 year old male diagnosed with severe intellectual disability, autism, and ADHD.</p> <p>a. Individual #1's current behavior modifying drugs included Risperdal (an antipsychotic drug) 3 mg twice a day, Clonidine (an antihypertensive drug) 0.1 mg three times a day, and Strattera (an ADHD drug) 18 mg each day.</p> <p>Individual #1's Medication Reduction Plan, dated 4/20/12, documented Risperdal was for hitting and slapping others, Clonidine was for yelling, and Strattera was for falling to the floor.</p> <p>Consent from Individual #1's state-appointed guardian could not be found for the use of Risperdal and Clonidine.</p> <p>b. Individual #1's Behavioral Assessment, dated 9/26/11, stated he required 1:1 staff supervision due to his behavior.</p> <p>During observations on 7/23/12, 7/24/12, and 7/25/12 for a cumulative 3 hours 55 minutes, Individual #1 was noted to have a 1:1 staff person with him.</p> <p>Consent from Individual #1's state-appointed guardian for 1:1 supervision could not be found.</p> <p>c. Individual #1's medical record documented he required Diazepam 15 mg 1 hour prior to dental examinations. His dental examination, dated 7/12/12, documented Diazepam was administered prior to the examination.</p>	W 263		

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W 263	Continued From page 8 Consent from Individual #1's state-appointed guardian could not be found for the use of Diazepam. When asked, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they were unable to find guardian consent for Individual #1's restrictive interventions. 2. Individual #2's PCLP, dated 8/30/11, documented a 21 year old male diagnosed with moderate intellectual disability, autism, ADHD, and seizure disorder. Individual #2's current behavior modifying drugs included Tenex (an antihypertensive drug) 1 mg three times a day. Individual #2's Medication Reduction Plan, dated 4/20/12, documented Tenex was for spitting. However, approval from Individual #2's legal guardian could not be found for the use of Tenex. When asked, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they were unable to find guardian consent for Individual #2's Tenex. The facility failed to ensure restrictive interventions were implemented only with the written Informed consent of the parent/guardian for Individuals #1 and #2.	W 263			
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be	W 289			

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W 289	<p>Continued From page 9 incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 3 individuals (Individual #2) whose behavior plans were reviewed. This resulted in a lack of interventions being in place to ensure an individual's behavioral needs were met. The findings include:</p> <p>1. Individual #2's PCLP, dated 8/30/11, documented a 21 year old male diagnosed with moderate intellectual disability, autism, ADHD, and seizure disorder.</p> <p>Individual #2's Behavioral Assessment, dated 8/30/11, stated he engaged in assaults (defined as threatening to harm or actually harming another person), property destruction (defined as kicking holes in walls, trying to break items, and throwing items), leaving without permission (defined as leaving the house, store, or activity without permission), spitting, and pulling the fire alarm.</p> <p>Individual #2's BMP, revised 7/20/12, did not contain any instructions to staff on what to do if Individual #2 engaged in the identified target behaviors.</p> <p>When asked, the QIDP, who was also the</p>	W 289	<p>W 289 483.450 (b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The facility's IDT will hold a meeting to discuss all individual's BMP's. All individuals' BMP's will be revised to ensure that techniques and instructions used to manage individuals' maladaptive behaviors are incorporated into the plans. All BMP's will reviewed quarterly at core team meetings to ensure that all BMP's contain comprehensive and specific interventions and instructions to address all identified targeted behaviors. Changes will be made as needed. The QIDP will do weekly observations to verify implementation of behavior management techniques and to ensure continual regulatory compliance. Observation data will be reviewed by the Administrator, Program Director, RSC, and QIDP on a monthly basis to discuss corrective action, adequate staff training, and to ensure that the needs of all individuals are being met.</p> <p>Completion Date: 9/30/12 Persons Responsible: Program Director, Administrator, QIDP and RSC.</p>		

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W 289	Continued From page 10 Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., there were no instructions in Individual #2's BMP and it needed to be revised.	W 289	W 312 483.450(e)(2) DRUG USAGE The IDT will hold a meeting to discuss all individuals' medication reduction plans. All individuals' medication reduction plans will be revised to ensure that all behavior modifying medications are used only as a comprehensive part of an individuals' IPP that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. All medication reductions plans will be reviewed quarterly at core team meetings to ensure that all are accurate, appropriate, and consistent with each other. Changes will be made as needed. Completion Date: 9/30/12 Persons Responsible: Program Director, Administrator, QIDP and RSC.	
W 312	The facility failed to ensure interventions were incorporated in Individual #2's BMP. 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 elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed 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 of and eventual elimination of the behavior for which the drug was employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified the drug usage and how it may change in relation to progress or regression. The findings include: 1. Individual #1's PCLP, dated 9/27/11, documented a 14 year old male diagnosed with severe intellectual disability, autism, and ADHD. Individual #1's medical record documented he required Diazepam 15 mg 1 hour prior to dental	W 312		

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W 312	Continued From page 11 examinations. His dental examination, dated 7/12/12, documented Diazepam was administered prior to the examination.	W 312		
W 313	<p>However, no plan related to the use of Diazepam could be found. When asked, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they were not able to find a plan.</p> <p>The facility failed to ensure a plan related to the use of Diazepam was developed for Individual #1. 483.450(e)(3) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs for 2 of 3 individuals (Individuals #1 and #2) whose restrictive interventions were reviewed. This resulted in the potential for individuals to receive behavior modifying drugs without the necessary justification. The findings include:</p> <p>1. Individual #1's PCLP, dated 9/27/11, documented a 14 year old male diagnosed with severe intellectual disability, autism, and ADHD.</p> <p>His current behavior modifying drugs included Risperdal (an antipsychotic drug) 3 mg twice a</p>	W 313	<p>W 313 483.450(e)(3) DRUG USAGE</p> <p>The IDT will hold a meeting to discuss all individuals' drugs that are used to control inappropriate behavior. Discussions will ensure that it is justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. Quarterly at core team meetings, all behavior modifying drugs will be reviewed to ensure the severity of the maladaptive behavior outweighs the risks associated with the side effects of the drugs.</p> <p>Completion Date: 9/30/12 Persons Responsible: Program Director, Administrator, QIDP and RSC.</p>	

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W 313	<p>Continued From page 12</p> <p>day, Clonidine (an antihypertensive drug) 0.1 mg three times a day, and Strattera (an ADHD drug) 18 mg each day.</p> <p>Individual #1's Behavioral Assessment, dated 9/26/11, stated he engaged in aggression (defined as hitting and slapping others) and uncooperative behavior (defined as yelling and falling to the floor). His Behavioral Assessment stated he hit or slapped staff in order to gain their attention, and he was uncooperative with staff in order to avoid a task.</p> <p>Individual #1's Medication Reduction Plan, dated 4/20/12, documented the behavior modifying drugs were used for maladaptive behaviors, as follows:</p> <p>a. His Plan stated he received Risperdal for hitting and slapping others.</p> <p>The 2012 Nursing Drug Handbook listed multiple potential side effects of Risperdal, which included, but were not limited to headache, insomnia, agitation, anxiety, pain, dizziness, fever, hallucination, tremor, fatigue, depression, nervousness, chest pain, abnormal vision, constipation, nausea, vomiting, abdominal pain, anorexia, dry mouth, diarrhea, urinary incontinence, back pain, leg pain, coughing, and rash.</p> <p>Individual #1's Program Summaries for aggression behavior, dated 10/11 - 6/12, documented the behavior occurred at the following monthly rates:</p> <p>10/11: 0 11/11: 0</p>	W 313		
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W 313	<p>Continued From page 13</p> <p>12/11: 0 1/12: 1 2/12: 2 3/12: 1 4/12: 11 5/12: 9 6/12: 0</p> <p>When asked for evidence that the severity of Individual #1's aggression (defined as hitting and slapping others) clearly outweighed the potentially harmful side effects of Risperdal, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they did not have documented evidence.</p> <p>b. His Plan stated he received Clonidine for yelling.</p> <p>The 2012 Nursing Drug Handbook listed multiple potential side effects of Clonidine which included, but were not limited to drowsiness, dizziness, sedation, weakness, fatigue, malaise (a generalized feeling of discomfort or illness), agitation, depression, bradycardia (slow heart rate), constipation, dry mouth, nausea, vomiting, anorexia (loss of appetite), and urine retention.</p> <p>Individual #1's Program Summaries for yelling behavior, dated 10/11 - 6/12, documented the behavior occurred at the following monthly rates:</p> <p>10/11: 0 11/11: 0 12/11: 8 1/12: 56 2/12: 56 3/12: 21 4/12: 24</p>	W 313		

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W 313	<p>Continued From page 14</p> <p>5/12: 10 6/12: 0</p> <p>When asked for evidence that the severity of individual #1's yelling clearly outweighed the potentially harmful side effects of Clonidine, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they did not have documented evidence.</p> <p>c. His Plan stated he received Strattera for falling to the floor.</p> <p>The 2012 Nursing Drug Handbook listed multiple potential side effects of Strattera, which included, but were not limited to headache, insomnia, dizziness, crying, irritability, mood swings, fatigue, sedation, depression, tremor, early-morning awakening, sleep disorder, abdominal pain, constipation, nausea, vomiting, decreased appetite, dry mouth, urinary retention, cough, and increased sweating.</p> <p>Individual #1's Program Summaries for falling to the floor behavior, dated 10/11 - 6/12, documented the behavior occurred at the following monthly rates: 10/11: 0 11/11: 0 12/11: 0 1/12: 25 2/12: 56 3/12: 21 4/12: 22 5/12: 2 6/12: 0</p> <p>When asked for evidence that the severity of</p>	W 313			

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W 313	<p>Continued From page 15</p> <p>Individual #1's behavior of falling to the floor clearly outweighed the potentially harmful side effects of Strattera, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they did not have documented evidence.</p> <p>2. Individual #2's PCLP, dated 8/30/11, documented a 21 year old male diagnosed with moderate intellectual disability, autism, ADHD, and seizure disorder. He was admitted to the facility on 8/11/11.</p> <p>His current behavior modifying drugs included Adderall XR (a central nervous system stimulant) 30 mg each day, Tenex (an antihypertensive drug) 1 mg three times a day, Lexapro (an antidepressant drug) 10 mg each morning, and Zyprexa (an antipsychotic drug) 20 mg each evening</p> <p>Individual #2's Behavioral Assessment, dated 8/30/11, stated he engaged in assaults (defined as threatening to harm or actually harming another person), property destruction (defined as kicking holes in walls, trying to break items, and throwing items), leaving without permission (defined as leaving the house, store, or activity without permission), spitting, and pulling the fire alarm. His Behavioral Assessment stated he had threatened to hurt staff when he wanted something he could not have, and kicked a couple of holes in the wall when he felt he was being ignored by staff.</p> <p>Individual #2's Medication Reduction Plan, dated 4/20/12, documented the behavior modifying drugs were used for maladaptive behaviors, as</p>	W 313			

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W 313	<p>Continued From page 16 follows:</p> <p>a. His Plan stated he received Adderall for leaving without permission.</p> <p>The website www.drugs.com listed multiple potential side effects of Adderall, which included, but were not limited to constipation, diarrhea, dizziness, dry mouth, headache, loss of appetite, nausea, nervousness, restlessness, stomach pain or upset, trouble sleeping, unpleasant taste, vomiting, weakness, weight loss.</p> <p>Individual #2's Program Summaries for leaving without permission, dated 9/11 - 6/12, documented the behavior occurred at the following monthly rates: 9/11: 1 10/11: 0 11/11: 1 12/11: 0 1/12: 0 2/12: 0 3/12: 0 4/12: 0 5/12: 0 6/12: 0</p> <p>When asked for evidence that the severity of Individual #2's leaving without permission clearly outweighed the potentially harmful side effects of Adderall, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they did not have documented evidence.</p> <p>b. His Plan stated he received Tenex for spitting.</p>	W 313			

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W 313	<p>Continued From page 18</p> <p>vomiting, increased or decreased appetite, dry mouth, flatulence, heartburn, urinary frequency, weight gain or loss, muscle cramps, pain in arms or legs, cough, rash, increased sweating, and flulike symptoms.</p> <p>Individual #2's Program Summaries for assaultive behavior, dated 9/11 - 6/12, documented the behavior occurred at the following monthly rates: 9/11: 4 10/11: 0 11/11: 0 12/11: 2 1/12: 1 2/12: 3 3/12: 8 4/12: 1 5/12: 0 6/12: 0</p> <p>When asked for evidence that the severity of Individual #2's assaultive behavior clearly outweighed the potentially harmful side effects of Lexapro, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they did not have documented evidence.</p> <p>d. His Plan stated he received Zyprexa for property destruction.</p> <p>The 2012 Nursing Drug Handbook listed multiple potential side effects of Zyprexa which included, but were not limited to somnolence, insomnia, dizziness, abnormal gait, personality disorder, tremor, articulation impairment, tardive dyskinesia, fever, chest pain, constipation, dry mouth, increased appetite, increased salivation,</p>	W 313		
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W 313	Continued From page 19 vomiting, thirst, urinary incontinence, weight gain, and joint and back pain. Individual #2's Program Summaries for property destruction, dated 9/11 - 6/12, documented the behavior occurred at the following monthly rates: 9/11: 4 10/11: 0 11/11: 1 12/11: 0 1/12: 0 2/12: 0 3/12: 5 4/12: 5 5/12: 0 6/12: 1 When asked for evidence that the severity of Individual #2's property destruction clearly outweighed the potentially harmful side effects of Zyprexa, the QIDP, who was also the Regional Director, stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they did not have documented evidence. The facility failed to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs for Individual #1 and #2.	W 313		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
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W 436	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure an individual was taught to use and make informed decisions regarding adaptive equipment for 1 of 1 individual (Individual #2) who required adaptive equipment. This resulted in a lack of a plan being developed and implemented related to the use of eyeglasses. The findings include: 1. Individual #2's PCLP, dated 8/30/11, documented a 21 year old male diagnosed with moderate intellectual disability, autism, ADHD, and seizure disorder. Individual #2's vision examination, dated 8/19/11, documented he required and was prescribed eyeglasses. However, during observations on 7/23/12, 7/24/12 and 7/25/12 for a cumulative 3 hours 55 minutes, Individual #2 was not noted to be wearing eyeglasses. When asked, the Administrator stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., Individual #2 had eyeglasses but refused to wear them at times. When asked about a training plan related to wearing eyeglasses, the Administrator stated Individual #2 had no plan. The facility failed to ensure Individual #2 was provided training related to the use of his eyeglasses.	W 436	W 436 483.470 (g)(2) SPACE AND EQUIPMENT The IDT will review all recommendations regarding individuals' needs for specific adaptive equipment. The facility will ensure that all individuals have an opportunity to be taught and formally trained to use and make informed decisions regarding adaptive equipment. At quarterly core team meetings, the IDT will review all recommendations regarding adaptive equipment for all individuals. Changes will be made and formal training plans will be put into place as needed. The QIDP will do weekly observations to verify implementation of formal training programs and to ensure continual regulatory compliance. Observation data will be reviewed by the Administrator, Program Director, RSC, and QIDP on a monthly basis to discuss corrective action, adequate staff training, and to ensure that the needs of all individuals are being met. Completion Date: 9/30/12 Persons Responsible: Program Director, Administrator, QIDP and RSC.		
W 440	483.470(i)(1) EVACUATION DRILLS	W 440			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 815 SECOND AVENUE WEST WENDELL, ID 83355	
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W 440	<p>Continued From page 21</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include:</p> <p>1. The facility's evacuation drills were reviewed and were present for all shifts for the first and second quarter of 2012 (January through June).</p> <p>Third quarter drills for 2012 were present for the swing shift and graveyard shift. However, drills for the morning shift, for 2011 or 2012, could not be found. No drills for 2011 could be found.</p> <p>When asked, the Administrator stated during an interview on 7/26/12 from 9:10 - 11:00 a.m., they were unable to find any drills for 2011.</p> <p>The facility failed to ensure quarterly drills were conducted for all shifts.</p>	W 440	<p>W 440 483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. A Fire and Safety Checklist has been created that includes a checklist that can easily be monitored by the administrator. This checklist includes an entry that the RSC must initial showing that the fire drill was performed each month and an entry showing that the Administrator has checked this list at least quarterly. The RSC will perform the monthly fire drill and record that the drill was completed on the list. The administrator will check the Fire and Safety Checklist at least quarterly and initial that the fire drills have been performed. The Administrator will check this list and initial that the check was performed at least quarterly to ensure the fire drills have been completed. The Administrator will check the Fire and Safety Checklist at least quarterly and will initial showing the check was performed. The Fire and Safety Checklist has already been created and is located in the front of the Fire drill and Disaster Plan book.</p> <p>Completion Date: 9/30/12 Persons Responsible: Administrator and RSC</p>	

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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COURTYA		STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83355		
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MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W313.	MM191	MM191 16.03.11.075.09 (c) Last Resort Refer W313 MM194 16.03.11.075.10 (a) Approval of Human Rights Committee Refer W262	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM196 16.03.11.075.10 (c) Consent of Parent or Guardian Refer W263	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM197 16.03.11.075.10 (d) Written Plans Refer W289 & W312	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289 and W312.	MM197		

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AUG 29 2012
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] TITLE Admin

(X5) DATE 8-29-12

STATE FORM

8160 09V211

If continuation sheet 1 of 3

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MM235	16.03.11.080.03(e) Interdisciplinary Evaluation To be given a written interpretation of the interdisciplinary evaluation that is conducted for each resident within thirty (30) days after admission to the facility and for all subsequent evaluations, such interpretations to be provided by the administrator of the facility; and This Rule is not met as evidenced by: Refer to W226.	MM235	MM235 16.03.11.080.03 (e) Interdisciplinary Evaluation Refer to W226 MM337 16.03.11.110.04(c) Fire Drills Refer to W440	
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337	MM724 16.03.11.270.01(a) Assesments Refer to W207 MM725 16.03.11.270.01(b) QMRP Refer to W159	
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		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan	MM725		

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MM725	Continued From page 2 for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	MM856 16.03.11.270.08(d) Appropriate Training and Habilitation Refer to W436	
MM856	16.03.11.270.08(d) Appropriate Training and Habilitation Appropriate training and habilitation programs must be provided residents with hearing, visual, perceptual, or motor impairments, in cooperation with appropriate staff or service providers. This Rule is not met as evidenced by: Refer to W436.	MM856		