



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

January 31, 2014

Jonathon Daltow, Administrator  
Preferred Community Homes - Fieldstone  
7091 West Emerald Street  
Boise, ID 83704

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Mr. Daltow:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Fieldstone, which was conducted on January 27, 2014.

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

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January 31, 2014  
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 **February 12, 2014**, and keep a copy for your records.

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

[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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

This request must be received by February 12, 2014. If a request for informal dispute resolution is received after February 12, 2014, 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,



TRISH O'HARA  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

TO/pmt  
Enclosures

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

PRINTED: 01/30/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY 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 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey conducted from 1/21/14 - 1/27/14.  The survey was conducted by: Trish O'Hara, RN, Team Leader Michael Case, LSW, QIDP  Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactive Disorder A.O.D. - Administrator on Duty HRC - Human Rights Committee IED - Intermittent Explosive Disorder PCLP - Person Centered Lifestyle Plan PRN - As needed QIDP - Qualified Intellectual Disabilities Professional	W 000	<b>RECEIVED</b>  <b>FEB 12 2014</b>  <b>FACILITY STANDARDS</b>	
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.  This STANDARD is not met as evidenced by: Based on review of the facility's policy for abuse, neglect and mistreatment, review of internal investigations and staff interviews, it was determined the facility failed to sufficiently implement policies related to timely investigation and individual protection during investigations. This directly impacted 2 of 2 individuals (Individuals #1 and #4) for whom significant incidents had occurred, and had the potential to affect all individuals residing at the facility. The findings include:	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tom M... [Signature] TITLE Program Manager (X6) DATE 2/12/14

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 149	<p>Continued From page 1</p> <p>1. The facility's policy, titled Abuse, Neglect, Mistreatment and Injuries of An Unknown Source, updated 5/21/13, defined neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The policy was not implemented as follows:</p> <p>Individual #1's PCLP, dated 7/23/13, stated she was a 22 year old female with diagnoses including severe intellectual disability, depression and IED. Her record documented the following:</p> <p>On 9/25/13, Individual #1 developed extreme swelling of her upper lip. Staff contacted the facility nurse and were told to administer Benadryl (an antihistamine drug) 25 mg. This was given with no improvement in the swelling. The nurse was once again contact and directed staff to take Individual #1 to a local urgent care for treatment. This was done at approximately 5:00 p.m. on 9/25/13. The swelling was diagnosed as an allergic reaction to an unknown substance and Individual #1 was given a prescription for a Medrol DosePak (a steroid drug given to treat severe inflammation) and instructions to go to the Emergency Room if the condition worsened.</p> <p>There was no documentation indicating the prescription had been filled and the medication had been administered to Individual #1 on the evening of 9/25/13.</p> <p>At 6:30 a.m. on 9/26/13, documentation showed Individual #1 was experiencing chest pain and shortness of breath. Staff contacted the facility nurse and were directed to call 911. Individual #1 was subsequently transferred by paramedics to a local hospital emergency room. She was treated for allergic reaction with intravenous steroids and</p>	W 149		

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W 149	Continued From page 2 for anxiety with intravenous benzodiazepines. Hospital discharge instructions included directions to fill the prescription for Medrol DosePak and administer as directed.  In a phone interview on 1/29/14 from 2:30 - 2:45 p.m., the Program Manager confirmed this incident was not investigated as potential neglect and no corrective action had been taken to prevent the reoccurrence of such events.  The facility failed to implement the abuse, neglect and mistreatment policy for Individual #1.	W 149			
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must prevent further potential abuse 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 potential abuse, neglect, and mistreatment were prevented while investigations were in process. This failure directly impacted 1 of 1 individuals (Individual #4) residing at the facility, and had the potential to impact all individuals (Individuals #1 - #5) residing at the facility. This resulted in the	W 155			

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W 155	<p>Continued From page 3</p> <p>potential for individuals being subjected to potential abuse and neglect during the course of an investigation. The findings include:</p> <p>The facility's policy, titled Abuse, Neglect, Mistreatment and Injuries of An Unknown Source, updated 5/21/13, stated "The Administrator, A.O.D., or Regional Representative will take immediate and appropriate action to prevent further potential abuse, neglect, or mistreatment while an investigation is in progress." However, the policy was not implemented, as follows:</p> <p>An investigation, dated 12/30/13, stated an allegation of medical neglect was reported to the City Director on that date. The allegation stated the on call nurse had knowingly taken medication, belonging to another individual, to the facility and instructed staff to administer the medication to Individual #4. Review of the investigation and daily time card records showed the nurse was allowed to have contact with and make medical decisions for individuals at the facility from the date of the allegation, 12/30/13, until she was interviewed and relieved of her duties on 1/9/14 at 2:30 p.m., a period of eleven days during which she worked eight days.</p> <p>In an interview on 1/27/14 from 11:00 - 11:25 a.m., the City Director said when she received the allegation verbally on 12/30/13, she understood all the incorrect medication had been removed. She said she felt it was then a personnel issue and was something that could be addressed at a later date.</p> <p>The facility failed to protect individuals from potential further neglect while an investigation was in progress.</p>	W 155			

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W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures and investigations and staff interview it was determined the facility failed to ensure the results of an investigation were reported within 5 working days for 1 of 1 individuals (Individual #4) for whom a significant incident had occurred. This resulted in appropriate corrective action being delayed. The findings include:</p> <p>1. The facility's policy, titled Abuse, Neglect, Mistreatment and Injuries of An Unknown Source, updated 5/21/13, stated "The results of internal investigations must be reported to the Administrator within 5 working days."</p> <p>Internal investigations were requested from 12/21/12 - 1/21/14. One investigation was provided. This investigation showed it was initiated on 12/30/13 and was concluded on 1/9/14. This time frame included 8 working days.</p> <p>In an interview on 1/27/14 from 11:00 - 11:25 a.m., the City Director confirmed the 5 working day reporting requirement had been exceeded.</p> <p>The facility failed to complete an investigation within the required time frame.</p>	W 156		
W 214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and</p>	W 214		

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W 214	<p>Continued From page 5 behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure behavior assessments contained accurate information for 1 of 3 individuals (Individual #3) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #3's 1/24/13 PCLP stated he was an 18 year old male whose diagnoses included mild intellectual disability, autistic disorder, mood disorder, ADHD, and intermittent explosive disorder.</p> <p>Individual #3's Behavioral Assessment, revised 5/15/13, stated he engaged in the following maladaptive behaviors:</p> <ul style="list-style-type: none"> <li>- Physical Aggression, defined as kicking, grabbing clothes, trying to climb staff, and hitting. The Assessment stated the behavior was related to Individual #3's mood disorder.</li> <li>- Inappropriate Social, defined as picking his nose, eating "boogers," masturbating in public, swearing, jumping on furniture, laying on the kitchen counters, and climbing the walls. The Assessment stated the behavior was related to Individual #3's ADHD.</li> <li>- Destruction of Property, defined as kicking, slamming, punching or throwing objects. The Assessment stated the behavior was related to Individual #3's ADHD and intermittent explosive</li> </ul>	W 214			

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W 214	<p>Continued From page 6 disorder.</p> <p>- Uncooperative, defined as elopement. The Assessment stated the behavior was related to Individual #3's ADHD and intermittent explosive disorder.</p> <p>- Trespassing, defined as trying to get into neighbor's homes or property. The Assessment stated the behavior was related to Individual #3's ADHD.</p> <p>Under the section titled "Analysis of Potential Causes: may elicit or sustain the behavior" the Assessment stated "[Individual #3's] team has identified that he engaged in this behavior because he is bored and needs something to do" under each maladaptive behavior.</p> <p>However, Individual #3's replacement behavior plans included issues of communication, making appropriate choices, using a tissue, and participating in 3 to 5 minutes of structured social time 3 to 4 times a day.</p> <p>With the exception of the structured social time, it was not clear how Individual #3's replacement behavior plans would address his being "bored."</p> <p>When asked if boredom was the actual eliciting and sustaining factor of Individual #3's maladaptive behaviors, during an interview on 1/27/14 from 11:35 a.m. - 12:25 p.m., the QIDP and Program Supervisor both stated it was not. The QIDP stated the assessment was not accurate and needed to be revised.</p> <p>The facility failed to ensure Individual #3's Behavioral Assessment contained accurate</p>	W 214		

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W 214	Continued From page 7	W 214		
W 262	information related to his maladaptive behavior. 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 record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the HRC for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include:  1. Individual #3's 1/24/13 PCLP stated he was an 18 year old male whose diagnoses included mild intellectual disability, autistic disorder, mood disorder, ADHD, and intermittent explosive disorder.  Individual #3's record included a prescription, dated 5/21/13, for Lortab (an analgesic drug) 7.5 mg to be taken one hour before dental appointments.  Individual #3's record included a dental note, dated 5/21/13, which stated "next time we will premed [with] Lortab 7.5, 1 [hour] prior to [appointment]." A subsequent dental note, dated 10/8/13, stated Individual #3 received Lortab 7.5 mg 1 hour prior to the appointment. A	W 262		

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W 262	Continued From page 8 corresponding Nursing Progress Notes stated PRN Lortab was used for pre-sedation.  However, Individual #3's record did not include HRC approval for the use of Lortab as pre-sedation for dental appointments.  During an interview on 1/17/14 from 11:35 a.m. - 12:25 p.m., the QIDP stated HRC approval for the use of Lortab as pre-sedation had not been obtained due to an oversight.  The facility failed to ensure HRC approval was obtained prior to the use of Individual #3's PRN Lortab.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE  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 record review and staff interview, it was determined the facility failed to ensure guardian consent was obtained prior to the implementation of restrictive interventions for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include:  1. Individual #3's 1/24/13 PCLP stated he was an 18 year old male whose diagnoses included mild intellectual disability, autistic disorder, mood disorder, ADHD, and intermittent explosive	W 263		

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W 263	Continued From page 9 disorder.  Individual #3's record included a prescription, dated 5/21/13, for Lortab (an analgesic drug) 7.5 mg to be taken one hour before dental appointments.  Individual #3's record included a dental note, dated 5/21/13, which stated "next time we will premed [with] Lortab 7.5, 1 [hour] prior to [appointment]." A subsequent dental note, dated 10/8/13, stated Individual #3 received Lortab 7.5 mg 1 hour prior to the appointment. A corresponding Nursing Progress Notes stated PRN Lortab was used for pre-sedation.  However, Individual #3's record did not include written guardian consent for the use of Lortab as pre-sedation for dental appointments.  During an interview on 1/17/14 from 11:35 a.m. - 12:25 p.m., the QIDP stated written guardian consent for the use of Lortab as pre-sedation had not been obtained due to an oversight.	W 263		
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 elimination of the behaviors for which the drugs are employed.	W 312		

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W 312	<p>Continued From page 10</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 behavior modifying drugs were used only as a comprehensive part of an individual's PCLP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drug was employed for 1 of 3 individuals (Individual #3) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without plans that identified the drugs usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #3's 1/24/13 PCLP stated he was an 18 year old male whose diagnoses included mild intellectual disability, autistic disorder, mood disorder, ADHD, and intermittent explosive disorder.</p> <p>Individual #3's record included a prescription, dated 5/21/13, for Lortab (an analgesic drug) 7.5 mg to be taken one hour before dental appointments. A Nursing Progress Notes, dated 10/8/13, stated Individual #3's PRN Lortab was used for pre-sedation.</p> <p>However, Individual #3's record did not include a plan related to PRN Lortab, it's use, or what would have to happen for the use of the drug to be reduced or discontinued.</p> <p>During an interview on 1/27/14 from 11:35 a.m. - 12:25 p.m., the QIDP stated Individual #3's PRN Lortab had not been incorporated into a plan, but needed to be.</p> <p>The facility failed to ensure Individual #3's PRN</p>	W 312		

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

PRINTED: 01/30/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/27/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>	
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W 312 W 322	Continued From page 11 Lortab was appropriately incorporated into a plan. 483.460(a)(3) PHYSICIAN SERVICES  The facility must provide or obtain preventive and general medical care.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure general and preventative medical care was provided for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual not receiving the timely administration of prescribed medication resulting in the need for more aggressive and invasive treatment. The findings include:  1. Individual #1's PCLP stated she was a 22 year old female with diagnoses including severe intellectual disability, depression and IED. Her record documented the following:  On 9/25/13, Individual #1 developed extreme swelling of her upper lip. Staff contacted the facility nurse and were told to administer Benadryl (an antihistamine drug) 25 mg. This was given with no improvement in the swelling. The nurse was once again contact and directed staff to take Individual #1 to a local urgent care for treatment. This was done at approximately 5:00 p.m. on 9/25/13. The swelling was diagnosed as an allergic reaction to an unknown substance and Individual #1 was given a prescription for a Medrol DosePak (a steroid drug given to treat severe inflammation) and instructions to go to the Emergency Room if the condition worsened.	W 312 W 322		

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W 322	<p>Continued From page 12</p> <p>There was no documentation indicating the prescription had been filled and the medication had been administered to Individual #1 on the evening of 9/25/13.</p> <p>At 6:30 a.m. on 9/26/13, documentation showed Individual #1 was experiencing chest pain and shortness of breath. Staff contacted the facility nurse and were directed to call 911. Individual #1 was subsequently transferred by paramedics to a local hospital emergency room. She was treated for allergic reaction with intravenous steroids and for anxiety with intravenous benzodiazepines. Hospital discharge instructions included directions to fill the prescription for Medrol DosePak and administer as directed.</p> <p>In an interview on 1/27/14 from 11:25 a.m. - 12:25 p.m., the facility nurse said she did not know why the Medrol DosePak was not filled and administered on the evening of 9/25/13.</p> <p>The facility failed to initiate medication in a timely manner for treatment of an acute condition for Individual #1.</p>	W 322		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 1/21/14 - 1/27/14.  The survey was conducted by: Trish O'Hara, RN, Team Leader Michael Case, LSW, QIDP  Common abbreviations used in this report are: LPN - Licensed Practical Nurse PCLP - Person Centered Lifestyle Plan	M 000		
MM111	16.03.11.050.01(c) Medical History  A medical history and a physical examination must be completed by a physician not more than ninety (90) days before admission. The medical history and the record of the physical examination must include information concerning the resident's activity limitations and the results of a tuberculin skin test or chest x-ray. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate medical history and physical had been completed not more than 90 days prior to admission, and that tuberculin testing and had occurred for, 1 of 1 individuals (Individual #2) admitted to the facility within the past year. This resulted in the potential for an individual's medical needs to be un-assessed. The findings include:  1. Individual #2's PCLP stated he was a 21 year old male whose diagnoses included moderate intellectual disability and seizure disorder. He was admitted to the facility on 10/30/13.  However, Individual #2's record did not include documentation a history and physical had been	MM111		

**RECEIVED**  
**FEB 12 2014**  
**FACILITY STANDARDS**

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Tom M...</i>	TITLE  <i>Program Manager</i>	(X6) DATE  <i>2/2/14</i>
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Bureau of Facility Standards

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MM111	<p>Continued From page 1</p> <p>completed since 4/24/13, and did not include documentation that tuberculin testing had occurred as part of his pre-admission or admission process.</p> <p>During an interview on 1/27/14 from 11:35 a.m. - 12:25 p.m., the LPN stated an updated history and physical had not been completed and tuberculin testing had not taken place due to an oversight.</p> <p>The facility failed to ensure a history and physical had been completed, and appropriate tuberculin testing had taken place, for Individual #2.</p>	MM111		
MM177	<p>16.03.11.075.09 Protection from Abuse and Restraint</p> <p>Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149, W155 and W156.</p>	MM177		
MM194	<p>16.03.11.075.10(a) Approval of Human Rights Committee</p> <p>Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.</p>	MM194		

Bureau of Facility Standards

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MM196	Continued From page 2	MM196		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian	MM196		
	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.			
MM197	16.03.11.075.10(d) Written Plans	MM197		
	Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W312.			
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data	MM730		
	Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.			
MM735	16.03.11.270.02 Health Services	MM735		
	The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by:			

Bureau of Facility Standards

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MM735	Continued From page 3 Refer to W322.	MM735		



February 12, 2014

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

RE: Fieldstone, Provider #13G030

Dear Trish O'Hara:

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

**W 149 Staff Treatment of Clients**

Please see response given for W155 as it relates to ensuring the protection of individuals from further harm and W156 as it relates to ensuring the timeliness of the investigation process. The facility recognizes that the abuse, neglect and mistreatment policy was not implemented as written. The facility has scheduled training for the Program Supervisors (Administrators) on the Abuse Neglect and Mistreatment Policy and Procedure. The training will focus on identifying potential circumstances of abuse, neglect or mistreatment, the timeliness of the investigation, protecting individuals during an investigation as well as the types of corrective action required under the regulations. For future investigations, the Program Manager will be responsible for assuring that the abuse neglect and mistreatment policy is implemented as written.

**Person Responsible:** Program Manager  
**Completion Date:** 2/28/14

**W 155 Staff Treatment of Clients**

The facility recognizes that the abuse, neglect and mistreatment policy was not implemented as written. The facility has scheduled training for the Program Supervisors (Administrators) on the Abuse Neglect and Mistreatment Policy and Procedure. The training will focus on identifying potential circumstances of abuse, neglect or mistreatment, the timeliness of the investigation, protecting individuals during an investigation as well as the types of corrective action required under the regulations. For future investigations, the Program Manager will be responsible for assuring that the abuse neglect and mistreatment policy is implemented as written.

**Person Responsible:** Program Manager  
**Completion Date:** 2/28/14

**W 156 Staff Treatment of Clients**

The facility recognizes that the abuse, neglect and mistreatment policy was not implemented as written. The facility has scheduled training for the Program Supervisors (Administrators) on the Abuse Neglect and Mistreatment Policy and Procedure. The training will focus on identifying potential circumstances of abuse, neglect or mistreatment, the timeliness of the investigation, protecting individuals during an investigation as well as the types of corrective action required under the regulations. For future investigations, the Program Manager will be responsible for assuring that the abuse neglect and mistreatment policy is implemented as written.

**Person Responsible: Program Manager**  
**Completion Date: 2/28/14**

**W214 Individual Program Plan**

The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for the Behavior Assessment. The training will include but will not be limited to assuring that the behavior assessment contains accurate information related to maladaptive behaviors. Aspire Human Services has revised the Peer Review form to include a section for verifying that the behavior assessments contain accurate information. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified and a behavior assessment is not accurate, the team will schedule a meeting at the earliest possible time and make the appropriate revisions to the behavior assessment.

**Person Responsible: Program Manager**  
**Completion Date: 2/28/14**

**W262 Program Monitoring and Change**

The QIDP is currently developing a Written Informed Consent and a Desensitization Program for individual #3's Lortab. After the documents have been created he will be obtaining guardian and then HRC consent for the medication prior to it being utilized again. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has obtained written informed consent from the guardian and HRC before any pre-sedation is utilized. Aspire Human Services has revised the Peer Review form to include a section for verifying that there is informed consent and a desensitization program has been implemented prior to the utilization of pre-sedation medication. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate corrective plans.

**Person Responsible: Program Manager**  
**Completion Date: 2/28/14**

**W263 Program Monitoring and Change**

The QIDP is currently developing a Written Informed Consent and a Desensitization Program for individual #3 as Lortab. After the documents have been created he will be obtaining guardian and then HRC consent for the medication prior to it being utilized again. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has obtained written informed consent from the guardian and HRC before any pre-sedation is utilized. Aspire Human Services has revised the Peer Review form to include a section for verifying that there is informed consent and a desensitization program has been

implemented prior to the utilization of pre-sedation medication. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate corrective plans.

**Person Responsible: Program Manager**  
**Completion Date: 2/28/14**

#### **W312 Drug Usage**

The QIDP is currently developing a Written Informed Consent and a Desensitization Program for individual #3 as Lortab. After the documents have been created he will be obtaining guardian and then HRC consent for the medication prior to it being utilized again. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has obtained written informed consent from the guardian and HRC before any pre-sedation is utilized. Aspire Human Services has revised the Peer Review form to include a section for verifying that there is informed consent and a desensitization program has been implemented prior to the utilization of pre-sedation medication. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate corrective plans.

**Person Responsible: Program Manager**  
**Completion Date: 2/28/14**

#### **W322 Physician Services**

The facility is currently unable to give individual #1 her Medrol because her condition resolved and there is no current order for the medication. The facility recognizes that there was an error and individual #1 should have received her Medrol. Aspire Human Services/Preferred Community Homes has hired a Director of Nursing that will work out of the Boise Office and be available to provide oversight and direction. Per policy he will be conducting quarterly chart reviews to verify that individuals are receiving medical care are prescribed.

**Persons Responsible: Director of Nursing**  
**Completion Date: 3/15/14**

#### **MM111 Medical History**

The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for the admission process. The training will include but will not be limited to assuring that when an individual transfers from one of the Aspire facilities to another that all new assessments and treatments are revised including obtaining a revised history and physical and appropriate tuberculin testing. Aspire Human Services has revised the Peer Review form to include a section for verifying that the charts contain appropriate documentation when individuals are admitted. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and make the appropriate revisions to the plan which could include obtaining a revised history and physical and an appropriate tuberculin test.

**Persons Responsible: Director of Nursing & Program Manager**  
**Completion Date: 3/15/14**

**MM177 Protection of Abuse and Restraint**

Please see response given for W149, W155 and 156 as they relate to Staff Treatment of Clients.

**MM194 Approval of Human Rights Committee**

Please see response given for W 262 as it relates to Program Monitoring and Change.

**MM196 Consent of Parent or Guardian**

Please see response given for W263 as it relates to Program Monitoring and Change.

**MM197 Written Plans**

Please see response given for W312 as it relates to Drug Usage.

**MM730 Diagnosed and Prognostic Data**

Please see response given for W214 as it relates to the Individual Program Plan.

**MM 735 Health Services**

Please see response given for W322 as it relates to Physician Services.

*Tom Moss 2/12/14*

Tom Moss  
Program Manager  
Licensed Social Worker

Jonathon Daltow  
Program Supervisor  
Administrator