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

Rylee Kaercher, Administrator
Preferred Community Homes - Vineyards
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Vineyards, Provider #13G028

Dear Ms. Kaercher:

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

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

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

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G028		01/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE 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: aka - also known as HRC - Human Rights Committee ISP - Individualized Service Plan LPN - Licensed Practical Nurse mg - milligrams NOS - Not Otherwise Specified OCD - Obsessive Compulsive Disorder PCLP - Person Centered Lifestyle Plan PICA - Eating non-edible items QIDP - Qualified Intellectual Disabilities Professional	W 000	RECEIVED FEB 12 2014 FACILITY STANDARDS	
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 2 of 4 individuals (Individuals #1 and #3) whose records were reviewed. This resulted in a lack of accurate information in individuals' records. The findings include:	W 111		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Nuss
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 111	Continued From page 1 1. Individual #1's PCLP, dated 5/7/13, stated she was a 65 year old female with diagnoses including severe intellectual disability, osteoporosis and Parkinson's. Review of her record showed a written informed consent for Valium (a sedative drug) 1 mg to be given one hour prior to dental appointments or mammogram appointments. The consent was signed by Individual #1's guardian on 1/3/14 and approved by HRC on 1/14/14. There was also a written informed consent for Ativan (a sedative drug) 1 mg to be given one hour prior to dental appointments or mammogram appointments. The consent was dated 1/21/14 but was not signed or approved. Further record review showed a medication reduction plan for the Valium. A medication reduction plan for the Ativan could not be found. A Physician's Order for the two drugs was not present in Individual #1's record. There was no documentation in her record that either of the drugs had been given prior to appointments during the last year. In an interview on 1/27/14 from 2:45 - 3:30 p.m., the nurse verified by telephone with the pharmacy that neither of the drugs had been dispensed to Individual #1 during the past year. Additionally, the QIDP, who was present during the interview, said she had pulled consents forward from the previous year and did not verify whether the drugs were actually being given at this time. The Program Manager, who was also present, said he had directed the QIDP to develop medication reduction plans based solely on the consents that	W 111		

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W 111	Continued From page 2 were pulled forward. The facility failed to ensure accurate health care information was kept for Individual #1. 2. Individual #3's 12/16/13 PCLP stated he was a 43 year old male whose diagnoses include profound intellectual disability. Individual #3's record included a Dietary plan, revised 2/1/11, which stated his dietary order was to include "nectar thick liquids" due to swallowing issues. However, Individual #3's Physician's Orders, dated 4/2013, 7/2013, and 10/2013 all stated his diet order included "thin liquids." During an interview on 1/27/14 from 12:30 - 1:30 p.m., the Program Supervisor and LPN both confirmed Individual #3 received nectar thick liquids. The LPN stated the Physician's Orders, created by the facility and signed by the physician, were in error and needed to be revised. The facility failed to ensure Individual #3's Physician's Orders included accurate dietary orders.	W 111		
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	Continued From page 3 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 1 individuals (Individual #4) 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: 1. Individual #4's PCLP, revised 10/15/13, stated he was a 45 year old male whose diagnoses included profound intellectual disability, mood disorder, depression NOS, autism, PICA and OCD. Individual #4's Physician's Order, signed by the physician 12/20/13, stated he received clomipramine (an antidepressant drug) 300 mg, clonazepam (an anticonvulsant drug) 3 mg, imipramine (an antidepressant drug) 50 mg, and olanzapine (an antipsychotic drug) 15 mg. Individual #4's record included a plan for reduction of psychotropic drugs, dated 1/17/14, which stated olanzapine was being discontinued and replaced with imipramine. Individual #4's reduction plan stated imipramine was prescribed for psychomotor agitation, defined as licking his fingers then touching furniture, light switches, and door knobs, then re-licking his fingers, pushing on his abdominal area, and	W 312		

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W 312	Continued From page 4 incontinence of bladder. The plan stated a reduction of imipramine would be discussed when he displayed 20 or fewer incidents of psychomotor agitation per month for 6 consecutive months. Individual #4's behavioral data was reviewed from 7/2013 - 12/2013. The data documented an average of 110 episodes of psychomotor agitation per month during the 6 month period. Individual #4's reduction plan stated Klonopin (aka clonazepam) was prescribed for physical aggression, defined as pushing, pinching, pulling hair, grabbing, elbowing staff in the neck, pressing his body against others, and choking others. The plan stated a reduction of Klonopin would be discussed when he displayed 0 incidents of physical aggression for 6 consecutive months and was no longer taking imipramine. Individual #4's behavioral data was reviewed from 7/2013 - 12/2013. The data documented 2 incidents of physical aggression in September 2013. No other incidents of physical aggression had been documented. As written, Individual #4 could have 0 incidents of physical aggression for well over six months with no discussion related to the reduction of Klonopin given his high number of psychomotor agitation incidents. During an interview on 1/27/14 from 12:30 - 1:30 p.m., the QIDP stated the reduction plan was not realistic and the criteria needed to be revised. The facility failed to ensure Individual #4's psychoactive medications were appropriately	W 312		

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W 312	Continued From page 5 incorporated into a plan.	W 312		
W 322	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 4 individuals (Individuals #2) whose medical records were reviewed. This resulted in an individual not receiving medication as prescribed. The findings include: Individual #2's ISP, dated 2/1/13, stated she was a 56 year old female with diagnoses including profound intellectual disability and osteoporosis. Record review showed she had been discharged from the hospital on 11/10/13. A nurse's note, dated 11/11/13, stated Individual #2 was "all over edematous" and weighed 137 pounds. Edema is the retention of fluid in body tissues. Another nurse's note, dated 11/18/13, stated "[physician's name] had ordered HCTZ on 11/13/13. However, the pharm. [sic] never sent & [Individual #2] was noted to be losing 3 or more pounds/day, so she did not take." HCTZ, (Hydrochlorothiazide) is a diuretic medication that assists the body in removing excess fluid. In an interview on 1/27/14 from 11:00 - 11:25 a.m., the City Director there had been a change of facility nursing personnel on 1/9/14.	W 322		

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W 322	Continued From page 6 In an interview on 1/27/14 from 12:30 - 1:30 p.m., the current facility nurse said she did not know why the HCTZ had not been ordered or given. Further, the Program Supervisor, who was also present during the interview, stated she had accompanied Individual #2 home from the hospital on 11/10/13. She said she was aware that HCTZ had been ordered for Individual #2 when she left the hospital and had asked the former facility nurse several times about the status of the medication. The Program Supervisor provided an e-mail from the former facility nurse, dated 11/18/13, that said because Individual #2 was continuing to lose weigh on a daily basis, she (the nurse) had decided not to pursue the prescribed HCTZ. The facility failed to provide medical care as prescribed for Individual #2.	W 322		

PRINTED: 01/30/2014
FORM APPROVED

Bureau of Facility Standards

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	13G028		01/27/2014

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - VINEYARI

STREET ADDRESS, CITY, STATE, ZIP CODE: 2226 WEST SONOMA DRIVE, MERIDIAN, ID 83642

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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	M 000		
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 W312.	MM197	RECEIVED FEB 12 2014 FACILITY STANDARDS	
MM566	16.03.11.210.04(j) Authorizations and Consents Appropriate authorizations and consents; and This Rule is not met as evidenced by: Refer to W111.	MM566		
MM735	16.03.11.270.02 Health Services 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: Refer to W322.	MM735		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Moss

TITLE: Program Manager

(X6) DATE: 2/12/14

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: Vineyards, Provider #13G028

Dear Trish O'Hara:

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

W111 Client Records

1. The Vineyards team has scheduled a team meeting to discuss medications utilized during medical/dental appointments. During the meeting the team will discuss specifically what medications are needed and then verify that written informed consents are in place only for needed medications. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies, regulations and processes outlined for medications utilized for medical/dental appointments. The training will include but will not be limited to when pre-sedation consents are required and the importance of discussing with the team anytime pre-sedation is utilized. Aspire Human Services has revised the Peer Review form to include a section for verifying that consents are obtained only for services or medication being utilized. 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 plans.

2. The Physicians order for individual #3 has been revised and the record currently states that his diet order is "Nector thick liquids". The LPN is currently in the process of verifying that all Physician's Orders are accurate for all individuals residing in the home. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies, regulations and processes outlined for Physicians Orders. The training will include but will not be limited to assuring the accuracy of Physician's orders. For future Physician's orders the LPN will forward the orders to the QIDP and the Program Supervisor (Administrator) for their review. In the event that a Physician's order is found to be inaccurate the LPN will contact the Physician and make the appropriate revisions.

Persons Responsible: Program Manager, Program Supervisor, QIP & LPN
Completion Date: 2/28/14

W312 Drug Usage
The Vineyards team has scheduled a team meeting to discuss individual #4's medication reduction plan. At the meeting the team will review individual #4's behavior data and make revisions to individual #4's medication reduction plan assuring that the reduction criteria is realistic. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies, regulations and processes outlined for medication reduction plans. The training will include but will not be limited to set realistic medication reduction plans for each individual that utilizes a behavior modifying medication. Aspire Human Services has revised the Peer Review form to include a section for verifying that Medication Reduction plans are realistic. 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 plans.

Persons Responsible: Program Manager
Completion Date: 2/28/14

322 Physician Services
The facility is currently unable to give individual #2 her HCTZ because her Edema has been resolved and there is no current order for the medication. The facility recognizes that there was an error and individual #2 should have received her HCTZ on 11/10/13. 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

MM 197 Written Plans
Please see the response given for W312 as it relates to Drug Usage.

MM 566 Authorizations and Consents
Please see the response given for W111 as it relates to Client Records.

MM 735 Health Services
Please see the response given for W322 as it relates to Physician Services.

Tom Moss 2/12/14

Tom Moss
Program Manager
Licensed Social Worker

Rylee Kaercher
Program Supervisor
Administrator