

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

**CERTIFIED MAIL: 7000 1670 0011 3315 1880**

March 21, 2014

Tony Franklin, Administrator  
Preferred Community Homes - Courtyard  
12553 West Explorer Drive Suite 190  
Boise, ID 83713

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

Dear Mr. Franklin:

Based on the Complaint survey completed at Preferred Community Homes - Courtyard on March 14, 2014, we have determined that Preferred Community Homes - Courtyard is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) Condition of Participation of **Client Protections (42 CFR 483.420)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

Tony Franklin  
March 21, 2014  
Page 2 of 4

**It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed.

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

**Such corrections must be achieved and compliance verified by this office, before April 28, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than April 14, 2014.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 3, 2014.**

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

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Courtyard ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective March 14, 2014, through July 12, 2014. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Tony Franklin  
March 21, 2014  
Page 3 of 4

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

Be advised that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **April 18, 2014**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

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

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

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

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

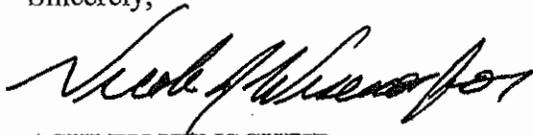
Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by April 3, 2014. If a request for informal dispute resolution is received after April 3, 2014 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

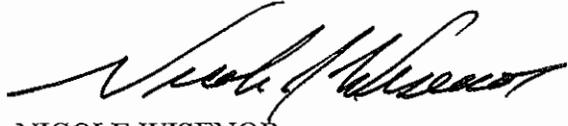
Tony Franklin  
March 21, 2014  
Page 4 of 4

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

Sincerely,



ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/nw  
Enclosures

COPY



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3232 Elder Street  
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March 21, 2014

Tony Franklin, Administrator  
Preferred Community Homes - Courtyard  
12553 West Explorer Drive Suite 190  
Boise, ID 83713

Provider #13G057

Dear Mr. Franklin:

On **March 14, 2014**, a complaint survey was conducted at Preferred Community Homes - Courtyard. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00006394**

**Allegation #1:** Management staff have failed to protect individuals by not investigating and taking appropriate corrective action in response to all allegations of abuse and neglect.

**Findings #1:** An unannounced on-site complaint survey was conducted from 3/7/14 - 3/14/14. During that time, observations, record review and staff interviews were conducted with the following results:

The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13, was reviewed. The policy stated "...Employees must not use physical, verbal, sexual or psychological abuse or punishment..."

The policy stated, "The Company and/or Administrator will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are thoroughly investigated and ensure the prevention of further abuse or injury while the investigation is taking place, as reported and established by the following procedures."

The policy stated staff who had reasonable cause to believe that anyone had committed any type

Tony Franklin, Administrator

March 21, 2014

Page 2 of 6

of abuse, neglect or mistreatment were to immediately report the incident to the Administrator or the Administrator on duty (AOD). The policy stated the Administrator, AOD or Regional Representative was to begin an investigation immediately, regardless of when the incident occurred, including outside of normal business hours. The policy stated "This includes designating an 'investigator' as outlined in the Investigation policy and taking any immediate actions to protect the resident's health and safety."

On 3/7/14 observations were conducted at the facility for no less than a cumulative 1 hour and 25 minutes. Staff did not demonstrate abusive behavior during the observations. However, facility staff, including 11 direct care staff, the Licensed Practical Nurse, the Trainer, the Administrator and the City Director were interviewed on 3/7/14. Facility staff statements included allegations of abuse, neglect, and mistreatment which had been immediately reported to the Administrator and/or City Director but had not been investigated. Allegations included, but were not limited to, the following:

- Direct care staff made fun of individuals, yelled at individuals and were vulgar around individuals.
- Direct care staff had an individual sit on the couch and did not give him dinner.
- Direct care staff took an individual to his bedroom when he was engaging in maladaptive behaviors. They linked arms with the individual, pulled him to his room, and closed the door. When the individual came out of his room he had red marks on his face.
- Direct care staff left an individual alone during a seizure and in a second incident an individual who was not able to stand well independently was left alone standing.
- Staff held someone on the couch, with their arms across their chest, for refusing to participate.
- Direct care staff laughed at individuals and made fun of them in Spanish.
- Direct care staff on the p.m. shift made one individual do all of the housework. The individual had to clean, take out the garbage, clean up the table and put away dishes. Staff stated it had been reported to the Administrator before and the Administrator stated "I know it needs to stop."

Facility staff stated the allegations had been reported to the City Director and/or Administrator. However, investigations regarding the incidents could not be found.

Additionally, 3 individuals were interviewed on 3/7/14. The individuals alleged concerns similar to those expressed by the facility staff. However, only one of the individuals had reported her concern to the Administrator. The individual stated once direct care staff talked about his

Tony Franklin, Administrator  
March 21, 2014  
Page 3 of 6

"private areas" in front of her. The individual told the direct care staff that it made her uncomfortable and she did not think his behavior was appropriate. The individual also reported the incident to the Administrator.

However, investigations related to the allegations which had been reported could not be found.

The facility's Administrator was interviewed on 3/7/14 at 4:05 p.m. The Administrator stated the allegations of abuse, neglect and mistreatment were reported to the City Director. The Administrator stated staff had reported to him on a few occasions and he had instructed the staff to call the City Director.

The City Director was interviewed on 3/7/14 at 4:49 p.m. The City Director stated he investigated all allegations of abuse, neglect and mistreatment. When asked if he had ever received allegations of staff calling the individuals names or staff making fun of the individuals in Spanish, the City Director stated yes. However, he stated the allegations were not investigated. The City Director stated he did not remember who reported the allegations. The reporting staff stated other staff were saying (in Spanish) that an individual wanted to have sex with a boy at school. The City Director determined that it was not inappropriate and it did not need to be investigated. The City Director further stated another facility staff had talked to him about concerns reported to her by direct care staff during orientation, but nothing that was abuse.

No documentation related to the incidents, including the City Director's reasoning for not investigating, could be found in the facility's records.

The facility failed to ensure steps were taken to ensure individuals were protected and that all reported allegations of abuse, neglect and mistreatment were thoroughly investigated.

Additionally, the facility's Investigations policy, revised 2/15/12, stated investigations were to include the following:

- Interviews with the complainant, accused, witnesses (including individuals as appropriate) and those who created relevant documents.
- Witnesses' statements were to be submitted in writing with their signature and date.
- Available documentation was to be reviewed, including time cards, personnel files, disciplinary action, individuals' program documentation, etc. The policy stated "You should always review disciplinary records, employee evaluations, and employee logs to determine if they contain a recorded history of the same violation."
- Other evidence, such as pictures of bruises, etc.

Tony Franklin, Administrator

March 21, 2014

Page 4 of 6

However, the facility's investigations did not include all information as specified in the Investigations policy. For example, on 2/1/14, an allegation of neglect, was reported. The investigation included a handwritten statement from a direct care staff dated 2/1/14. The statement documented another direct care staff who was assigned to the individual while she was on suicide watch, was sleeping during the night shift. The allegation was immediately reported to the City Director. The handwritten statement documented the reporting staff "...also noticed that {direct care staff's name} had a small of {sic} beer." The reporting direct care staff documented she "did not tell {City Director's name} about the alcohol because I thought he {the City Director} was going to find out when he came..."

An email from the City Director to the Idaho State Director, dated 2/3/14 and timed 9:03 a.m., documented he had responded to the report by going to the facility and found the accused direct care staff awake, but seated on the floor with a pillow behind his head and a blanket tucked behind his back.

A subsequent email, from the City Director to the Idaho State Director, dated 2/3/14 and timed 11:06 a.m., documented that the direct care staff accused of sleeping "...says he never sleeps, and the reporting staff says she saw him lying down on a mat and that he then also fell asleep. I {the City Director} have her {the reporting staff} statement, he {the staff accused of sleeping} has not completed one yet..." The email documented the direct care staff accused of sleeping was immediately suspended and the City Director had collected "...about 1/2 the staff statements from staff in the house and none of the staff report seeing any staff sleeping..."

The email also stated the reporting direct care staff stated the direct care staff accused of sleeping told her watching people at night was not required. The reporting direct care staff also told the City Director that accused direct care staff smelled of alcohol. The City Director's email documented "This is not the first time staff have reported that {direct care staff's name} smelled of alcohol..."

A third email to the Idaho State Director, dated 2/5/14 and timed 11:54 a.m., stated he and the Human Resources Representative had spoke with the direct care staff accused of sleeping. The email documented the direct care staff denied sleeping and being under the influence of drugs or alcohol while on shift. However, the direct care staff did say he had gone to watch television when he should have been watching the individual on suicide watch and agreed he should not have been laying on the floor. The email documented the direct care staff wrote a short statement and left the facility.

The email stated it was the City Director's belief the direct care staff was likely sleeping, but he did not have evidence beyond the reporting direct care staff's allegation.

Tony Franklin, Administrator  
March 21, 2014  
Page 5 of 6

Beyond the email and the reporting direct care staff's handwritten allegation, documentation of thorough investigation into the incident could not be found. The staff accused of sleeping's handwritten statement was not present, statements collected from other staff members were not present, a review of documentation related to the report of smelling alcohol was not present and information related to a review of accused direct care staff's personnel file, including other disciplinary action, performance evaluations, etc. in accordance with the facility's Investigations policy was not present.

Further, the City Director's documentation did not include evidence that the individual on suicide watch had been interviewed regarding the incident. When asked, during an interview on 3/7/14 at 4:49 p.m., the City Director stated he did not ask the individual about the incident as it was his understanding she was sleeping throughout the incident.

However, the individual's 11/26/13 Behavior Intervention Plan for suicidal ideation was reviewed. The plan stated she was "...very honest about her thoughts and feelings and will express them when asked..."

The individual was interviewed by survey staff on 3/7/14 at 2:49 p.m. When asked if anyone had ever slept in her room, she stated yes. The individual stated 3 different direct care staff had slept, including the staff on the night shift.

The facility failed to ensure all potential witnesses had been interviewed related to the 2/1/14 investigation.

On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the Qualified Intellectual Disabilities Professional (QIDP) and the Registered Nurse (RN). When asked if additional information related to the investigation had been found, the Pocatello City Director stated no.

The facility failed to ensure thorough investigations, on which to base corrective action decisions, had been conducted.

Further, the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy stated, in "The Documentation Process" section, that the "...Administrator or designee will complete the Investigation Report on the back of the Incident/Accident Form, to include witness statement review, record review, conclusions, corrective action taken and notification documentation."

The facility's Investigation Reports were reviewed. The Investigation Reports documented corrective action which had not actually occurred. For example, an Incident/Accident report,

Tony Franklin, Administrator  
March 21, 2014  
Page 6 of 6

dated 2/22/14, documented an allegation that staff had pulled an individual's hair while redirecting her away from the refrigerator. An attached Investigation Report, completed by the City Director on 2/28/14, stated in the Corrective Action section that "The staff...will be retrained to follow the behavior plan as it is written... The staff that was accused of pulling {individual name's} hair will receive specific instruction and individual training."

On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked for documentation that the corrective action had been taken, the Pocatello City Director stated none had been found.

The facility failed to ensure corrective action had been taken.

The facility failed to investigate all reported allegations of abuse, neglect and mistreatment. The facility also failed to ensure thorough investigations were conducted and that appropriate corrective actions had been taken. The cumulative effect of these systemic failures resulted in individuals being placed at risk of serious and immediate harm due to ongoing abuse, neglect, and mistreatment. Therefore, the allegation was substantiated and Federal and State deficient practices were cited.

**Conclusion #1:** Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/nw

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

PRINTED: 03/21/2014  
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  C 03/14/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83366	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint survey conducted from 3/7/14 to 3/14/14.</p> <p>The survey was conducted by: Ashley Henscheld, QIDP, Team Leader Michael Case, LSW, QIDP Trish O'Hara, RN, CNN Jim Troutfetter, QIDP Nicole Wisenor, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ADHD - Attention Deficit Hyperactivity Disorder AOD - Administrator on Duty LPN - Licensed Practical Nurse PT - Physical Therapy QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse</p> <p>Immediate Jeopardy was identified at W127 and the facility was notified on 3/7/14 at 6:50 p.m. The facility submitted an Immediate Plan of Correction on 3/7/14 at 11:10 p.m. On-site verification of the plan's implementation was completed on 3/8/14 at 12:10 a.m. and follow-up interviews were completed with all direct care staff across all shifts from 3/8/14 at 6:00 a.m. to 3/10/14 at 6:00 a.m. Additionally, the facility submitted training logs signed by direct care staff on 3/10/14 at 1:19 p.m. and the Immediate Jeopardy was abated.</p>	W 000		
W 122	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p>	W 122		

**RECEIVED**  
APR 15 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *M. Halliday* TITLE: *City Director* (X5) DATE: *4/10/14*

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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(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 122	Continued From page 1  This <b>CONDITION</b> is not met as evidenced by: Based on review of the facility's policies and procedures, investigations, incident reports and individual and staff interviews, it was determined the facility failed to ensure steps were taken to protect 7 of 7 individuals (Individuals #1 - #7) for whom abuse, neglect and mistreatment was alleged. This resulted in a lack of notification, investigation and corrective action being taken in response to allegations of abuse, neglect and mistreatment, which placed individuals at risk of being subjected to ongoing abuse, neglect and/or mistreatment. The findings include:  1. Refer to W149 as it relates to the facility's failure to ensure written policies and procedures that prohibited abuse, neglect and mistreatment were adequately developed, implemented and monitored.	W 122	POC W122 483.420 <b>CLIENT PROTECTIONS</b>  Courtyard will ensure that specific client protections requirements are met.  Refer to W149  Monitor: Refer monitoring for W149	4/14/14	
W 125	483.420(a)(3) <b>PROTECTION OF CLIENTS RIGHTS</b>  The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.  This <b>STANDARD</b> is not met as evidenced by: Based on record review and individual and staff interviews, it was determined the facility failed to ensure mechanisms were in place to ensure individuals were not subjected to reprisal as a	W 125			

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 815 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 125	<p>Continued From page 2</p> <p>result of reporting a complaint. This failure directly impacted 1 of 1 individual (Individual #1) who reported inappropriate staff interactions to the Administrator and had the potential to impact all individuals (Individuals #1 -#7) residing at the facility. This resulted in an individual failing to report allegations of abuse, neglect and mistreatment. The findings include:</p> <p>1. Individual #1 was a 16 year old female who was admitted to the facility in October 2013. Her 11/26/13 Behavior Intervention Plan for suicidal ideation was reviewed. The plan stated Individual #1 was "...very honest about her thoughts and feelings and will express them when asked..."</p> <p>Individual #1 was interviewed by survey staff on 3/7/14 at 2:49 p.m. During the interview, Individual #1 stated once Direct Care Staff B talked about his "private areas" in front of her. Individual #1 told Direct Care Staff B that it made her uncomfortable and she did not think his behavior was appropriate around a 16 year old girl. She also reported the incident to the Administrator. Individual #1 stated after the incident Direct Care Staff B stopped speaking to her for a week and as a result, she never reported anything again.</p> <p>Individual #1 also stated the following which she had not reported:</p> <p>- Direct Care Staff H and Direct Care Staff C were "smart asses." Individual #1 stated Direct Care Staff F was not as disrespectful as Direct Care Staff C and direct care staff spoke in Spanish around her all the time. Individual #1 stated it made her uncomfortable as she did not know if staff were talking about her.</p>	W 125	<p>POC W125 483.420(a)(3) <b>PROTECTION OF CLIENTS RIGHTS</b></p> <p>Courtyard will ensure the rights of all clients. Courtyard will allow and encourage individuals to exercise their rights as individuals to file complaints, and the right to due process.</p> <p>The Abuse, Neglect, Mistreatment policy will be revised to include specific instructions to ensure individuals are not subject to reprisal or intimidation as a result of reporting a complaint. The policy will also be revised to show a clear chain of command for reporting incidents of reprisal or intimidation.</p> <p>A staff training on the new policy will be completed with all staff and individuals and/or the guardian/advocate. In addition, it will be reviewed by the Human Rights Committee. A copy of this policy will also be available in the home for staff and individuals to reference.</p> <p>Responsible Parties: Nursing Department, Program Supervisors, QIDP, and City Director</p> <p>Monitor: The City Director and/or Program Supervisor will train all employees on the Abuse policy and the changes with regarding reprisal and intimidation. Periodic interviews will be conducted weekly with both the staff and individuals to ensure intimidation and reprisal is not occurring to</p>	4/14/14	

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W 125	Continued From page 3  - Direct Care Staff C had slept on her bedroom floor, on her roommate's (Individual #2's), seizure mat and Direct Care Staff H had also slept on the bedroom floor during the morning shift. Individual #1 stated Direct Care Staff B had slept on her bedroom floor during a night shift. Individual #1 stated all 3 sleeping staff incidents were in January or February.  - Direct Care Staff H, Direct Care Staff C and Direct Care Staff F treated Individual #6 "like a slave." Individual #1 stated Individual #6 was required to do everything, such as getting up from the dinner table and retrieving items for staff.  - She had seen Direct Care Staff H hit Individual #3 on the forehead in January or February.  The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13 was reviewed. The policy did not include information related to protection of individuals from reprisal or intimidation as a result of reporting a complaint or grievance.  On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked what mechanisms were in place to ensure individuals were not subjected to reprisal as a result of reporting a complaint the Program Manager stated there were none. The Idaho State Director concurred.  The facility failed to ensure mechanisms were in place to ensure individuals were not subjected to	W 125	the individuals. This will be done by the QIDP, Program Supervisor, and the City Director.		

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

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OMB NO. 0938-0301

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  C 03/14/2014
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 125	Continued From page 4	W 125	POC W127 483.420(a)(5)		
W 127	reprisal or intimidation as a result of reporting a complaint. 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.  This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews, it was determined the facility failed to ensure all allegations of abuse, neglect and mistreatment were immediately reported to the Administrator and other authorities in accordance with State Law and that all allegations which were reported to the Administrator were accurately identified and investigated as abuse, neglect and mistreatment for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. The failure to report and identify allegations of abuse, neglect and mistreatment resulted in the facility's failure to investigate allegations, failure to ensure that individuals were protected during the course of the investigations and failure to take appropriate corrective actions necessary to ensure individuals were safe. The cumulative effect of these systematic failures placed individuals at risk of experiencing serious and immediate harm as a result of ongoing abuse, neglect and mistreatment. The findings include:  The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 6/21/13 stated "...Employees must not use	W 127	PROTECTION OF CLIENT RIGHTS  Courtyard will ensure the rights of all clients. Courtyard will ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.  Courtyard will ensure the Abuse, Neglect, Mistreatment policy will be revised to include specific methods for ensuring that the facilities are free from abuse, neglect or mistreatment. Training will be completed with all staff on the new policy and the expectation of reporting.  Responsible Parties: Nursing Department, Program Supervisors, QIDP, and City Director  Monitor: The City Director and/or Program Supervisor will work with each department to ensure proper notification has been made. The City Director and/or Program Supervisor will ensure that Child Protective Services/Adult Protection Services is notified based on the reporting requirements. The City Director/Program Supervisor will complete periodic interviews to ensure individuals rights are being protected.  Refer to W125 Refer to W127 Refer to W148 Refer to W153 Refer to W154 Refer to W157	4/14/14	

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

PRINTED: 03/21/2014  
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  C 03/14/2014
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W 127	<p>Continued From page 5</p> <p>physical, verbal, sexual or psychological abuse or punishment.." and included the following definitions:</p> <ul style="list-style-type: none"> <li>- Abuse: "The infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish whether purposeful, or due to carelessness, inattentiveness or omission of the perpetrator..."</li> <li>- Physical Abuse: "Any physical motion or action (e.g. hitting, slapping, kicking, pinching, etc.) by which bodily pain, harm or trauma occurs..."</li> <li>- Verbal Abuse: "...any use of oral, written or gestured language by which abuse occurs. This includes pejorative and derogatory terms to describe individuals with disabilities whom we serve."</li> <li>- Emotional or Psychological Abuse: "The verbal or nonverbal infliction of anguish, pain, or distress that results in mental or emotional suffering. Includes, but is not limited to humiliation, harassment and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma."</li> <li>- Misuse of Restraints: "Chemical or physical control of the individual receiving services beyond physicians [sic] orders or not in accordance with accepted professional practice."</li> <li>- Neglect: "Is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."</li> <li>- Physical Neglect: "The deprivation of goods and</li> </ul>	W 127			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 816 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)	(X6) COMPLETION DATE	
W 127	<p>Continued From page 6</p> <p>services necessary to maintain physical or mental health. This includes but is not limited to withholding food, fluids, clothing, shelter, help, or other essentials included in an implied or contractual agreement of responsibility to an individual receiving services..."</p> <p>- Medical Neglect: "Failure to provide care for existing medical problems..."</p> <p>The policy stated, "The Company and/or Administrator will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are thoroughly investigated and ensure the prevention of further abuse or injury while the investigation is taking place, as reported and established by the following procedures."</p> <p>The policy stated staff who had reasonable cause to believe that anyone had committed any type of abuse, neglect or mistreatment were to immediately report the incident to the Administrator or AOD. The policy stated the Administrator, AOD or Regional Representative was to begin an investigation immediately, regardless of when the incident occurred, including outside of normal business hours. The policy stated "This includes designating an 'investigator' as outlined in the investigation policy and taking any immediate actions to protect the resident's health and safety."</p> <p>The facility's investigations policy, revised 2/15/12, stated a form would be used as a checklist to verify and establish documentation that a proper investigation had been conducted. The policy stated "It is always preferable to have one person designated as the investigator and</p>	W 127			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83365		
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W 127	<p>Continued From page 7</p> <p>the Administrator or designee designated as the decision maker."</p> <p>The facility's Administrator was interviewed on 3/7/14 at 4:05 p.m. The Administrator stated the allegations of abuse, neglect and mistreatment were reported to the City Director. The Administrator stated staff had reported to him on a few occasions and he had instructed the staff to call the City Director.</p> <p>The City Director was interviewed on 3/7/14 at 4:49 p.m. The City Director stated he investigated all allegations of abuse, neglect and mistreatment.</p> <p>However, interviews with facility staff were conducted across shifts on 3/7/14. Facility staff stated abuse, neglect and mistreatment were occurring. Staff statements included allegations of abuse, neglect, and mistreatment which had been immediately reported to the Administrator or City Director but had not been investigated. Further, staff statements also included allegations which were not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <p>1. Facility staff stated allegations had been reported to the City Director for individuals #1 - #7. However, investigations for the allegations could not be found as follows:</p> <p>a. The facility Trainer stated she had emailed the Administrator and the City Director on 1/23/14 to report concerns Direct Care Staff A had expressed during training. The Trainer stated Direct Care Staff A reported other direct care staff made fun of individuals, yelled at individuals and</p>	W 127			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
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W 127	<p>Continued From page 8</p> <p>were vulgar around individuals. Direct Care Staff A also reported an incident when other direct care staff thought an individual may have faked a seizure. In response, the other direct care staff had the individual sit on the couch and did not give him dinner.</p> <p>Investigations regarding the allegations could not be found.</p> <p>b. The Trainer stated she had emailed the Administrator and the City Director on 9/13/13 to report concerns that Direct Care Staff D had expressed to her. The Trainer stated Direct Care Staff D stated other direct care staff left an individual alone during a seizure and in a second incident an individual who was not able to stand well independently was left alone standing.</p> <p>The Trainer's email to the City Director, the Administrator and the LPN, dated 9/13/13, stated she had instructed Direct Care Staff D to share her concerns with the Administrator and the LPN.</p> <p>No additional information, including an investigation into the allegations, could be found.</p> <p>c. The Trainer was interviewed on 3/7/14 at 5:55 p.m. The Trainer stated she had verbally reported incidents to the City Director. The Trainer stated a direct care staff had reported other direct care staff were forcing individuals' mouths open to brush their teeth when the individuals refused to open their mouths with prompting. She also stated staff held someone on the couch, with their arms across their chest, for refusing to participate.</p> <p>Individual #1 - #7's dental hygiene programs,</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 127	<p>Continued From page 9</p> <p>dated 11/28/13 for Individual #1, dated 11/21/13 for Individual #2, revised 1/2/14 for Individual #3, revised 9/6/13 for Individual #4, revised 7/5/13 for Individual #5, revised 2/14/14 for Individual #6, and revised 9/3/13 for Individual #7 were reviewed. The programs did not include forcing the individuals' mouths open as an approved intervention technique.</p> <p>No additional information, including an investigation into the allegations, could be found.</p> <p>The City Director was interviewed on 3/7/14 at 4:49 p.m. When asked, the City Director stated the Trainer had talked to him about concerns reported to her by direct care staff during orientation, but nothing that was abuse.</p> <p>No documentation related to the incidents, including the City Director's reasoning for not investigating, could be found in the facility's records.</p> <p>The facility failed to ensure all reported allegations of abuse, neglect and mistreatment were thoroughly investigated.</p> <p>2. Facility staff stated the following incidents had occurred for individuals #1 - #7. However, the incidents were not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <p>a. Direct Care Staff E stated she had heard staff call the individuals "perra," a Spanish word similar to "bitch." She further stated Direct Care Staff C yelled at the residents. Direct Care Staff E stated she had not reported because she knew the City Director and the Administrator personally and was</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 127	<p>Continued From page 10 not comfortable reporting to them.</p> <p>b. Direct Care Staff G stated she witnessed other direct care staff say things to the individuals such as, "You know what you're supposed to be doing. Don't act dumb." She further stated Direct Care Staff C and Direct Care Staff H called the individuals names such as "stupid" and "fucker" and they spoke about the individuals in Spanish. Direct Care Staff G stated she had witnessed Direct Care Staff F yell at individuals and she felt like clients were uncomfortable and that staff covered for each other. Direct Care Staff G stated she had not recently reported to the Administrator or City Director, but was in the process of writing a letter to the facility's corporate office and still planned to do so.</p> <p>c. The LPN stated direct care staff had reported to her that verbal abuse occurred "mostly on p.m. shift" and that direct care staff did not respect the individuals. The LPN stated she had not reported the allegations to the Administrator or the City Director. The LPN stated when direct care staff reported allegations, the City Director and the Administrator blamed staff for trying to cause trouble, which resulted in staff not reporting. When asked about her (the LPN's) failure to report the allegations, the LPN stated "I should have but I will get written up for it."</p> <p>The facility failed to ensure all allegations of abuse, neglect and mistreatment were immediately reported to the Administrator and other authorities in accordance with State Law.</p> <p>3. Individual #1 was a 16 year old female.</p> <p>a. Facility staff stated an allegation, specific to</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 SECOND AVENUE WEST WENDELL, ID 83366</b>		
(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 127	<p>Continued From page 11</p> <p>Individual #1, had been reported to the City Director. However, an investigation for the allegation could not be found as follows:</p> <p>- Direct Care Staff A stated Direct Care Staff C and Direct Care Staff F spoke in Spanish about Individual #1, making fun of her and saying she liked both boys and girls and liked to masturbate. Direct Care Staff A stated Individual #1 did not know Spanish but Direct Care Staff C and Direct Care Staff F's non-verbal cues, like facial expressions and body language, were very clear and Direct Care Staff A thought Individual #1 knew when she was being made fun of. Direct Care Staff A stated when Direct Care Staff C and Direct Care Staff F worked together they were awful.</p> <p>Direct Care Staff A stated Individual #1 had gotten upset by the behavior of Direct Care Staff C and Direct Care Staff F and told Direct Care Staff A it made her (Individual #1) uncomfortable. Direct Care Staff A stated she had talked to the Trainer and the LPN and she had given statements to the City Director. However, she felt the City Director did not believe her.</p> <p>Investigations regarding the allegations could not be found.</p> <p>The City Director was interviewed on 3/7/14 at 4:49 p.m. When asked if he had ever received allegations of staff calling the individuals names or staff making fun of the individuals in Spanish, the City Director stated yes. However, he stated the allegations were not investigated. The City Director stated he did not remember who reported the allegation. The reporting staff stated other staff were saying (in Spanish) that Individual</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 SECOND AVENUE WEST WENDELL, ID 83355</b>		
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W 127	<p>Continued From page 12</p> <p>#1 wanted to have sex with a boy at school. The City Director determined that it was not inappropriate and it did not need to be investigated. The City Director stated he thought the accused staff were Direct Care Staff C and Direct Care Staff I, but he could not remember.</p> <p>No documentation related to the incidents, including the City Director's reasoning for not investigating, could be found in the facility's records.</p> <p>b. Facility staff stated the following incident, specific to Individual #1, had occurred. However, the incident was not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <p>- Direct Care Staff G stated she knew that Individual #1 was uncomfortable with staff. However, Direct Care Staff G stated she had not reported her concerns to the Administrator.</p> <p>The facility failed to ensure all allegations were immediately reported to the Administrator and other authorities in accordance with State Law.</p> <p>c. On 2/1/14, an allegation of neglect, specific to Individual #1, was reported. However, a thorough investigation of the allegation was not conducted as follows:</p> <p>- The investigation included a handwritten statement from Direct Care Staff A, dated 2/1/14. The statement documented Direct Care Staff A had reported to the City Director that Direct Care Staff B, who was assigned to Individual #1 while she was on suicide watch, was sleeping during the night shift.</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 127	<p>Continued From page 13</p> <p>An email from the City Director to the Idaho State Director, dated 2/3/14 and timed 9:08 a.m., documented he had responded to the report by going to the facility and found Direct Care Staff B awake, but seated on the floor with a pillow behind his head and a blanket tucked behind his back.</p> <p>A subsequent email, from the City Director to the Idaho State Director, dated 2/5/14 and timed 11:54 a.m., stated he and a Human Resources Representative had spoken with Direct Care Staff B. The email stated it was the City Director's belief the staff was likely sleeping, but he did not have evidence beyond the reporting staff's allegation.</p> <p>The City Director's documentation did not include evidence that Individual #1 had been interviewed regarding the incident. When asked, during an interview on 3/7/14 at 4:49 p.m., the City Director stated he did not ask Individual #1 about the incident as it was his understanding she was sleeping throughout the incident.</p> <p>Individual #1's 11/26/13 Behavior Intervention Plan for suicidal ideation was reviewed. The plan stated Individual #1 was "...very honest about her thoughts and feelings and will express them when asked..."</p> <p>Individual #1 was interviewed by survey staff on 3/7/14 at 2:49 p.m. When asked if anyone had ever slept in her room, Individual #1 stated yes. Individual #1 stated Direct Care Staff C had slept on her bedroom floor, on her roommate's (Individual #2's) seizure mat and Direct Care Staff H had also slept on the bedroom floor during the</p>	W 127			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2014</b>
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W 127	<p>Continued From page 14</p> <p>morning shift. Individual #1 stated Direct Care Staff B had slept on her bedroom floor during a night shift. Individual #1 stated all 3 sleeping staff incidents were in January or February.</p> <p>The facility failed to ensure all potential witnesses had been interviewed related to the 2/1/14 investigation. Additionally, the allegations of Direct Care Staff C and Direct Care Staff H sleeping had not been immediately reported to the Administrator.</p> <p>d. An Incident/Accident Report, dated 2/24/14, documented Individual #1 had scratched herself multiple times with a paperclip. The attached investigation report, completed by the City Director on 3/3/14 stated Individual #1 had a bad day at school and "...felt like she was not getting enough attention from staff. She said she felt invisible..."</p> <p>Individual #1 was interviewed by survey staff on 3/7/14 at 2:49 p.m. At that time, it was noted she had marks on her upper and lower left arm. When asked about the marks, Individual #1 stated they were from cutting last Wednesday. She stated she felt left out and disrespected, like she was not part of the group. Individual #1 stated she had been on suicide watch quite a bit since being admitted to the facility (in October 2013).</p> <p>Individual #1's monthly Behavior Tracking data from 11/13 through 1/14 was reviewed. The data documented the following:</p> <p>11/13: 2 incidents of suicidal ideation and 0 incidents of self injury.          12/13: 2 incidents of suicidal ideation and 0</p>	W 127			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
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 127	<p>Continued From page 15</p> <p>incidents of self injury. 1/14; 3 incidents of suicidal ideation and 0 incidents of self injury.</p> <p>Individual #1 stated "staff treat me like I am not there" and she felt left out at school too. She stated Direct Care Staff H and Direct Care Staff C were "smart asses." Individual #1 stated Direct Care Staff F was not as disrespectful as Direct Care Staff C and direct care staff spoke in Spanish around her all the time. Individual #1 stated it made her uncomfortable as she did not know if staff were talking about her.</p> <p>Beyond the information that was documented in the 3/3/14 investigation report, (Individual #1 feeling like she was not getting enough attention from staff and feeling invisible), Individual #1 had not reported the allegations to the Administrator or the City Director.</p> <p>Individual #1 also stated once Direct Care Staff B talked about his "private areas" in front of her. Individual #1 told Direct Care Staff B that it made her uncomfortable and she did not think his behavior was appropriate around a 16 year old girl. She also reported the incident to the Administrator. However, an investigation related to the incident could not be found. Individual #1 stated after the incident Direct Care Staff B stopped speaking to her for a week and as a result she never reported anything again.</p> <p>The facility failed to ensure Individual #1 was not subjected to reprisal in response to reporting Direct Care Staff B's inappropriate conversation.</p> <p>4. Individual #2 was a 15 year old female.</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/14/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 615 SECOND AVENUE WEST WENDELL, ID 83365		
(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 127	<p>Continued From page 16</p> <p>a. Facility staff stated the following incidents, specific to Individual #2, had occurred. However, the incidents were not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <ul style="list-style-type: none"> <li>- Direct Care Staff E stated Individual #2 needed to use the restroom and Direct Care Staff C would not help her because she was trying to fix the TV. However, Direct Care Staff E stated she had not reported her concerns to the Administrator.</li> <li>- The LPN stated direct care staff had reported that Direct Care Staff C had her legs over Individual #2's lap. The direct care staff who reported the incident to the LPN was unsure if Direct Care Staff C was trying to hold Individual #2 down with her legs or not. The LPN also stated direct care staff had reported to her that Individual #2 had her plate taken away and was given a fork to eat with instead of a spoon.</li> </ul> <p>Individual #2's self-feeding training program, dated 11/21/13, included the use of both a fork and a spoon. The program did not include taking her meal or removing her food as an approved intervention technique. However, the LPN stated she had not reported the allegations to the Administrator.</p> <p>The facility failed to ensure all allegations were immediately reported to the Administrator and other authorities in accordance with State Law.</p> <p>5. Individual #3 was a 12 year old male.</p> <p>a. Facility staff stated an allegation, specific to Individual #3, had been reported to the City</p>	W 127			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
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 127	<p>Continued From page 17</p> <p>Director. However, an investigation for the allegation could not be found as follows:</p> <p>- Direct Care Staff A stated it was apparent in Individual #3's face that he was scared of Direct Care Staff C and Direct Care Staff F. Direct Care Staff A stated Direct Care Staff C and Direct Care Staff F took Individual #3 to his bedroom when he was engaging in maladaptive behaviors. They linked arms with Individual #3, pulled him to his room, and closed the door. When Individual #3 came out of his room he had red marks on his face. The direct care staff attributed the redness to head hits. Direct Care A stated Direct Care C and Direct Care Staff F each did this one time.</p> <p>Individual #3's Behavior Intervention Plans for physical aggression, destruction of property and inappropriate social behavior, all revised 11/4/13, were reviewed. The plans did not include taking Individual #3 to his room when he engaged in maladaptive behavior as an approved intervention strategy. Further, his Behavior Intervention Plan for ADHD symptoms, revised 11/4/13, stated if he continued to have difficulty remaining focused, staff "will offer him to take [sic] a break in his room for a 5 minutes [sic] to clear his mind of distractions..." The plan did not include a physical escort, including linking arms with Individual #3, as an approved intervention strategy.</p> <p>Direct Care Staff A stated she had talked to the Trainer and the LPN and she had given statements to the City Director. However, she felt the City Director did not believe her.</p> <p>Investigations regarding the allegation could not be found.</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 015 SECOND AVENUE WEST WENDELL, ID 83355		
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W 127	<p>Continued From page 18</p> <p>The facility failed to ensure all reported allegations of abuse, neglect and mistreatment were thoroughly investigated.</p> <p>b. Facility staff stated the following incident, specific to Individual #3, had occurred. However, the incident was not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <p>- Direct Care Staff E stated Direct Care Staff C went into Individual #3's room with him. When Individual #3 came out of his room, both sides of his face, from his forehead to his cheeks, were bright red. Direct Care Staff C told the other direct care staff Individual #3 had hit the wall in his bedroom.</p> <p>Incident/Accident reports related to Individual #3 hitting his head while displaying maladaptive behaviors were reviewed. An Incident/Accident report which included head hits while both Direct Care Staff E and Direct Care Staff C were on shift could not be found.</p> <p>Additionally, Individual #1 was interviewed on 3/7/14 at 2:49 p.m. Individual #1 stated she had seen Direct Care Staff H hit Individual #3 on the forehead in January or February. Individual #1 stated she did not report the incident to the Administrator.</p> <p>The facility failed to ensure all allegations were immediately reported to the Administrator and other authorities in accordance with State Law.</p> <p>6. Individual #4 was a 24 year old female.</p>	W 127			

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 815 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 127	<p>Continued From page 19</p> <p>a. Facility staff stated an allegation, specific to Individual #4, had been reported to the City Director. However, an investigation for the allegation could not be found as follows:</p> <ul style="list-style-type: none"> <li>- Direct Care Staff A stated when she began employment another direct care staff had put a low-cut shirt on Individual #4. Direct Care Staff C and Direct Care Staff F laughed at Individual #4 and made fun of her in Spanish for the shirt she was wearing. Direct Care Staff A stated she had talked to the Trainer and the LPN and she had given statements to the City Director. However, she felt the City Director did not believe her.</li> </ul> <p>An investigation regarding the allegation could not be found.</p> <p>The facility failed to ensure all reported allegations of abuse, neglect and mistreatment were thoroughly investigated.</p> <p>b. Individual #2 was interviewed on 3/7/14 at 4:10 p.m. Individual #2 stated when Individual #4 screams she gets sent to her room.</p> <p>Individual #4's Behavior Intervention Plan, revised 11/4/13, stated she demonstrated anxiety by sitting on the floor while screaming and bouncing up and down. The plan did not include sending Individual #4 to her room as an approved intervention for screaming.</p> <p>The facility failed to ensure all reported allegations of abuse, neglect and mistreatment were thoroughly investigated.</p> <p>7. Individual #5 was a 22 year old male.</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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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 127	<p>Continued From page 20</p> <p>a. Facility staff stated the following incident, specific to Individual #5, had occurred. However, the incident was not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <p>- The LPN reported direct care staff had reported to her that Individual #5 wanted something to eat and was told he could have it if he ran up and down the hall a couple of times. The LPN stated direct care staff could have been implementing a PT program, she did not know.</p> <p>Individual #5's PT service program dated 9/12/13, was reviewed. The program did not include running as an exercise Individual #5 was to complete. However, the LPN stated she had not reported her concerns to the Administrator.</p> <p>The facility failed to ensure all allegations were immediately reported to the Administrator and other authorities in accordance with State Law.</p> <p>8. Individual #6 was a 22 year old male.</p> <p>a. Facility staff stated allegations, specific to Individual #6, had been reported to the Administrator or City Director. However, investigations for the allegations could not be found as follows:</p> <p>- Direct Care Staff G stated other direct care staff on the p.m. shift, particularly Direct Care Staff C, made Individual #6 do all of the housework, Individual #6 had to clean, take out the garbage, clean up the table and put away dishes. Direct Care Staff G stated she had reported it to the Administrator before and the Administrator stated "I know it needs to stop."</p>	W 127		

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 616 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 127	<p>Continued From page 21</p> <p>An investigation related to the incident could not be found.</p> <p>- Direct Care Staff A stated Direct Care Staff C asked Individual #6 if he wanted a girlfriend. When Individual #6 responded "yes," Direct Care Staff C asked why. Individual #6 talked about dating. Direct Care Staff C and Direct Care Staff F laughed at Individual #6 and began making fun of Individual #6 in Spanish, stating he wanted a girlfriend to have sex with. Direct Care Staff A stated she had talked to the Trainer and the LPN and she had given statements to the City Director. However, she felt the City Director did not believe her.</p> <p>An investigation related to the incident could not be found.</p> <p>b. Facility staff stated the following incidents, specific to Individual #6, had occurred. However, the incidents were not immediately reported to the Administrator and other authorities in accordance with State Law as follows:</p> <p>- Direct Care Staff E stated Individual #6 wanted to do something and Direct Care Staff C said if he did it he would not be allowed to eat. However, Direct Care Staff E stated she had not reported her concerns to the Administrator.</p> <p>- The LPN stated direct care staff had reported to her that direct care staff make Individual #6 do everything. However, the LPN stated she had not reported her concerns to the Administrator.</p> <p>Additionally, Individual #1 was interviewed on 3/7/14 at 2:49 p.m. Individual #1 stated Direct</p>	W 127			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 616 SECOND AVENUE WEST WENDELL, ID 83366		
(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 127	<p>Continued From page 22</p> <p>Care Staff H, Direct Care Staff C and Direct Care Staff F treated Individual #6 "like a slave." Individual #1 stated Individual #6 was required to do everything, such as getting up from the dinner table and retrieving items for staff.</p> <p>Individual #2 was interviewed on 3/7/14 at 4:10 p.m. Individual #2 stated staff tell Individual #6 to clean. She stated he did the dishes and vacuuming.</p> <p>Individual #6 was interviewed on 3/7/14 at 4:04 p.m. Individual #6 stated he did do housework, such as vacuuming and dishes, and did not always want to. He stated he had been asked to do more work than he wanted. Individual #6 also stated Direct Care Staff C threatened to and took away his food all the time.</p> <p>Individual #6's Active Treatment Schedule, revised 10/14/13, was reviewed. The schedule included cleaning up after meals and stated formal programs included clothing care. However, additional specific information related to the time allotted to formal or informal household chores training (such as vacuuming, cleaning, etc.) was not included in the schedule.</p> <p>Additionally, Individual #6's Behavior Intervention Plans for psychomotor agitation, ADHD symptoms and obsessive behavior, all revised 2/14/14, were reviewed and his self-feeding training program, revised 7/15/13, was reviewed. None of the plans included taking Individual #6's meals as an approved intervention technique.</p> <p>The facility failed to ensure all allegations were immediately reported to the Administrator and other authorities in accordance with State Law.</p>	W 127			

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 SECOND AVENUE WEST WENDELL, ID 83355</b>		
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W 127	<p>Continued From page 23</p> <p>The City Director was interviewed on 3/7/14 at 4:40 p.m. When asked about immediately reporting allegations of abuse, neglect and mistreatment during non-business hours, the City Director stated staff were to call the AOD, which would be the City Director or the Administrator. When asked how staff were to immediately report allegations against the City Director or Administrator for incidents which occurred after normal business hours, the City Director stated there was no way for staff to report after normal business hours other than calling the police or child/adult protection.</p> <p>However, "The Notification Process" section of the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy stated the Administrator, AOD or City Director was responsible for all notifications (e.g. Adult and Child Protective Services, police, etc.).</p> <p>The policy did not include information which directed staff to call other facility officials or State authorities in accordance with State Law, when allegations against the City Director or Administrator occurred after normal business hours and/or if staff were uncomfortable reporting to the City Director or Administrator.</p> <p>The facility failed to ensure systems for the prevention and detection of abuse, neglect and mistreatment were adequately developed, implemented and monitored necessary to ensure individuals were safe. The cumulative effect of these systematic failures placed individuals at risk of experiencing serious and immediate harm as a result of ongoing abuse, neglect and mistreatment.</p>	W 127			

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

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FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>616 SECOND AVENUE WEST WENDELL, ID 83355</b>		
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W 127	Continued From page 24  Note: The facility was notified of the Immediate Jeopardy on 3/7/14 at 6:50 p.m. The facility submitted an Immediate Plan of Correction on 3/7/14 at 11:10 p.m. which stated the following:  - The City Director, Administrator, LPN and 5 Direct Care Staff were placed on Administrative leave and an investigation into the allegations was initiated.  - The Regional Representative was serving as the AOD and another LPN was serving as the nurse on duty (NOD). A memo was developed by the Idaho State Director notifying staff of the changes in the AOD and NOD. The memo further stated if the staff did not feel the Regional Representative was responsive, the staff were to call the Idaho State Director. Contact numbers for the AOD, NOD, Regional Representative and Idaho State Director were included on the memo.  - All remaining staff were to be re-trained on the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy including identification, documentation and the immediate reporting, prior to working their next scheduled shift.  On-site verification of the plan's implementation was completed on 3/8/14 at 12:10 a.m., and follow-up interviews, to ensure training occurred, were completed with all direct care staff across all shifts from 3/8/14 at 6:00 a.m. to 3/10/14 at 6:00 a.m. Additionally, the facility submitted training logs signed by direct care staff on 3/10/14 at 1:19 p.m. and the Immediate Jeopardy was abated.	W 127			
W 148	483.420(c)(6) COMMUNICATION WITH	W 148			

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

PRINTED: 03/21/2014  
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W 148	<p>Continued From page 25 CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</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 parents/guardians were promptly notified of significant events. This failure directly impacted 2 of 7 individuals (Individuals #1 and #5) for whom significant events were reported and had the potential to impact all individuals (Individuals #1 - #7) residing at the facility. This resulted in a potential lack of advocacy for individuals by their parents/guardians. The findings include:</p> <p>1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13, stated The Administrator, AOD or City Director "must notify the client's parents, family or guardians immediately" of significant incidents which included sexual, physical or verbal abuse, death, serious physical injury or illness, hospitalization and any other cause as outlined or requested by the guardian/parent in writing.</p> <p>The facility used Parent/Guardian Notification Forms which listed multiple types of incidents such as falls, ingestion of non-edibles, calls to child/adult protection, lacerations, head injuries, etc. The forms were to be given to each individual's parents/legal guardians. The parents/legal guardians were to mark which incidents they wished to be informed of and</p>	W 148	<p>POC W148 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS</p> <p>Courtyard will ensure prompt notification to the client, parents, or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accidents, death, abuse, or unauthorized absence.</p> <p>All notification regarding past incident/accidents have been reported to parents/guardians. A review of all behavior documentation was completed prior to notification. In addition, all conversations have been documented.</p> <p>Courtyard will update the Guardian Contact Sheets for each individual based on the events the parent/guardians are requesting to be notified on. In addition, training will be done with each professional on what and when they are responsible for reporting significant incidents or changes. Training will also be done with the departments to ensure they are filling out Family/Guardian Contact Forms when contacting Guardians on significant events.</p> <p>In addition, if the allegation or complaint is received or made via email, letter, verbally, etc, those allegations will be summaries on an Incident/Accident form to ensure the date and time of guardian/advocate notification is recorded and completed.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 618 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 148	<p>Continued From page 26</p> <p>document any other information they would like, which was not listed on the form.</p> <p>However, neither the policy nor the form included significant events including all forms of abuse, neglect and mistreatment as defined in the facility's policy (e.g. emotional and psychological abuse, exploitation, medical neglect, misuse of restraints, etc.).</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked about the policy and the parent/guardian notification forms, the Idaho State Director stated it was something that would need to be looked at.</p> <p>The facility failed to ensure the policy was sufficiently developed.</p> <p>2. Facility records did not demonstrate parents/legal guardians had been notified of significant incidents as follows:</p> <p>a. Individual #5's record included a Parent/Guardian Notification Form, signed by Individual #5's parent/legal guardian on 10/25/13. The form documented Individual #5's parent/legal guardian wanted to be notified of unknown scratches and bruises or possible bruises, even if they did not require medical attention.</p> <p>An Incident/Accident Report, dated 2/16/14, documented Individual #5 had 2 small abrasions in the middle of his chest. The report stated the cause of the injuries was unknown. However, documentation that Individual #5's parent/legal</p>	W 148	<p>Responsible Parties: Nursing Department, Program Supervisors, QIDP, City Director, and Regional Director.</p> <p>Monitor: The City Director and/or Program Supervisor will work with each department to ensure proper notification has been made. The City Director and/or Program Supervisor will ensure the date and time of notification is documented on the Incident/Accident or in a Family Contact Form and a copy will be placed with the Incident/Accidents Forms. Until all guardian notifications have been obtained, Courtyard will report all incidents of abuse, neglect, and mistreatment or injury to the guardians/advocates. Weekly the City Director will review all Incident/Accident, significant changes, and guardian notification forms to ensure all notifications were made. While the professional staff are in training weekly chart audits will be completed on documentation. Once the professional staff are proficient in identify when contact is necessary, the parameters will change to monthly. Quarterly the Regional Director will review all Incident/Accidents to ensure proper notification was made.</p>	4/14/14	

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

PRINTED: 03/21/2014  
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  G 03/14/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 616 SECOND AVENUE WEST WENDELL, ID 83355		
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W 148	<p>Continued From page 27</p> <p>guardian had been notified of the abrasions was not present.</p> <p>b. A Parent/Guardian Notification Form, signed by Individual #1's parent/guardian could not be found in her record. However, Individual #1's record documented significant incidents as follows:</p> <ul style="list-style-type: none"> <li>- An Incident/Accident Report, dated 2/24/14, documented Individual #1 was placed on suicide watch on 2/26/14 due to harming herself with a paperclip on 2/24/14. The report documented she had used the paperclip to scratch her left arm multiple times.</li> </ul> <p>The attached investigation included a section for notifications. "NA" meaning not applicable was written in the box for "Relative/Guardian" notification.</p> <ul style="list-style-type: none"> <li>- A handwritten statement, dated 2/1/14, from Direct Care Staff A, documented Direct Care Staff A had reported to the City Director that Direct Care Staff B, who was assigned to Individual #1 while she was on suicide watch, was sleeping during the night shift.</li> </ul> <p>Documentation that Individual #1's parent/legal guardian had been notified of the suicide watch or the potential staff neglect could not be found.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked about Individual #1's Parent/Guardian Notification Form, the Program Manager stated the facility was in the process of obtaining one for Individual #1 as a previously</p>	W 148			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 148	Continued From page 28 completed form could not be found. When asked if the incidents documented above should have been reported to Individual #1's parent/guardian, the Program Manager stated yes.	W 148			
W 149	The facility failed to ensure parents/guardians were promptly notified of significant events. 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 policy review, record review and individual and staff interviews, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of notification, investigation and corrective action being taken in response to allegations of abuse, neglect and mistreatment. The findings include:  1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13, stated "...Employees must not use physical, verbal, sexual or psychological abuse or punishment..." The policy stated "An incident/accident form will be completed by the employee immediately after reporting the occurrence to the Administrator, AOD, or Regional Representative..."  However, Incident/Accident reports for all	W 149			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 149	<p>Continued From page 29</p> <p>allegations which had been reported to the Administrator and City Director could not be found. Examples included, but were not limited to, the following:</p> <p>a. The City Director was interviewed on 3/7/14 at 4:49 p.m. When asked if he had ever received allegations of staff calling the individuals names or staff making fun of the individuals in Spanish, the City Director stated yes. However, the City Director stated the allegations were not investigated. The City Director stated he did not remember who reported the allegation. The reporting staff stated other staff were saying (in Spanish) that Individual #1 wanted to have sex with a boy at school. The City Director determined that was not inappropriate and did not need to be investigated. The City Director stated he thought the accused staff were Direct Care Staff C and Direct Care Staff I, but he could not remember.</p> <p>A related Incident/Accident report could not be found.</p> <p>b. The Trainer was interviewed on 3/7/14 at 5:55 p.m. The Trainer stated she had emailed the Administrator and the City Director on 9/13/13 to report concerns that Direct Care Staff D had expressed to her. The Trainer stated Direct Care Staff D stated other direct care staff left an individual alone during a seizure and in a second incident an individual who was not able to stand well independently was left alone standing.</p> <p>The Trainer's email to the City Director, the Administrator and the LPN, dated 9/13/13, stated she had instructed Direct Care Staff D to share her concerns with the Administrator and the LPN.</p>	W 149	<p>POC W149 483.420(d)(1)</p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p>Courtyard will ensure development and implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of the clients.</p> <p>The policy revisions will include expectations that phone numbers are posted in the home for the individual on-call, Adult Protection, and Child Protection. In addition, the policy revisions will include methods for interviewing staff and individuals regarding concerns of abuse, neglect, and mistreatment. The policy is also being revised to include who to contact in the event that allegations are not handled appropriately.</p> <p>Courtyard will provide training to all staff on the new policy. In addition, the policy changes will be shared with both the individuals and their guardians. The policy will be available in the home for staff or individuals to reference.</p> <p>Person Responsible: QIDP, Program Supervisor, LPN, and City Director</p> <p>Monitor: Daily incident/accidents/behavior logs will be turned in. The City Director and/or Program Supervisor will ensure the date and time of notification is documented on the Incident/Accident or in a Family Contact Form and a copy will be placed with the Incident/Accidents Forms. The Program Supervisor will review them each business</p>		

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 149	<p>Continued From page 30</p> <p>However, Incident/Accident reports completed by either the Trainer or Direct Care Staff D could not be found.</p> <p>An interview was conducted with the Idaho State Director, Regional Representative, Program Manager and Pocatello City Director on 3/11/14 from 12:30 - 1:25 p.m. When asked, the Idaho State Director stated it was the expectation that Incident/Accident reports be completed for all allegations in accordance with the facility's policy.</p> <p>The facility failed to ensure the policy was implemented.</p> <p>2. Refer to W125 as it relates to the facility's failure to ensure mechanisms were in place to ensure individuals were not subjected to reprisal as a result of reporting a complaint.</p> <p>3. Refer to W127 as it relates to the facility's failure to ensure systems for the prevention and detection of abuse and neglect were sufficiently developed, implemented and monitored to ensure individuals were not subjected to ongoing abuse and neglect.</p> <p>4. Refer to W148 as it relates to the facility's failure to ensure parents/guardians were promptly notified of significant events, including abuse.</p> <p>5. Refer to W153 as it relates to the facility's failure to ensure all allegations of abuse were immediately reported to the Administrator and other officials in accordance with State law.</p> <p>6. Refer to W154 as it relates to the facility's failure to ensure thorough investigations were</p>	W 149	<p>day. The QIDP will review them weekly and adjust programming as necessary. Weekly the City Director will review the tracking information to ensure Abuse, Neglect, Mistreatment, Injuries of Unknown Source are being appropriately documented and tracked.</p> <p>Refer to W125 Refer to W127 Refer to W148 Refer to W153 Refer to W154 Refer to W157</p>	4/14/14	

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 149	Continued From page 31 conducted for all allegations of abuse and neglect.	W 149			
W 163	7. Refer to W157 as it relates to the facility's failure to ensure appropriate corrective action was taken in response to allegations of abuse and neglect.  483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on policy review, record review and staff interviews, it was determined the facility failed to ensure all allegations of abuse were immediately reported to the Administrator and other officials in accordance with State Law for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for ongoing abuse to occur without appropriate corrective action being taken. The findings include:  1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13, stated "...Employees must not use physical, verbal, sexual or psychological abuse or punishment..." The policy was not sufficiently developed as follows:  a. The Investigation Process section of the policy stated staff who had reasonable cause to believe that anyone had committed any type of abuse,	W 163			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 153	<p>Continued From page 32</p> <p>neglect or mistreatment were to immediately report the incident to the Administrator or AOD. If staff were alleging the Administrator was committing abuse, neglect or mistreatment, staff were to immediately report the incident to the Regional Representative. However, the Notification Process section of the policy stated if staff were alleging the Administrator committed any abuse, neglect or mistreatment, staff were to report immediately to the City Director.</p> <p>The policy was not consistent in identifying who staff were to report to when alleging the Administrator committed abuse, neglect and/or mistreatment.</p> <p>When asked about the policy, on 3/10/14 at 1:53 p.m., the Idaho State Director stated the intent of the policy was to always have someone the staff could report to but the policy needed to be looked at.</p> <p>The facility's policy was not clear regarding who staff were to report to.</p> <p>b. The facility's Administrator was interviewed on 3/7/14 at 4:05 p.m. The Administrator stated allegations of abuse, neglect and mistreatment were reported to the City Director. The Administrator stated staff had reported to him on a few occasions and he had instructed the staff to call the City Director.</p> <p>The City Director was interviewed on 3/7/14 at 4:49 p.m. The City Director stated he investigated all allegations of abuse, neglect and mistreatment. When asked about immediately reporting allegations of abuse, neglect and mistreatment during non-business hours, the City</p>	W 153	<p>abuse, neglect, mistreatment allegations are completed. The QIDP will conduct monthly audits on the incident/accidents and behavior logs.</p>	4/14/14	

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

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W 153	<p>Continued From page 33</p> <p>Director stated staff were to call the AOD, which would be the City Director or the Administrator. When asked how staff were to immediately report allegations against the City Director or Administrator for incidents which occurred after normal business hours, the City Director stated there was no way for staff to report after normal business hours other than calling the police or child/adult protection.</p> <p>However, the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy stated in "The Investigation Process" section that "The Administrator, AOD or Regional Representative will ensure that all proper authorities, Legal Guardians, Parents, children, residents, or family members are notified as required by state law and the notification policy in the Company policy and procedure manual."</p> <p>"The Notification Process" section of the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy stated the Administrator, AOD or City Director was responsible for all notifications (e.g. Adult and Child Protective Services, police, etc.).</p> <p>The policy did not include information which directed staff to call other facility officials or State authorities, in accordance with State Law, when allegations against the City Director or Administrator occurred after normal business hours and/or if staff were uncomfortable reporting to the City Director or Administrator.</p> <p>The facility failed to ensure the policy was sufficiently developed.</p> <p>2. The facility's Abuse, Neglect, Mistreatment and</p>	W 153			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 153	<p>Continued From page 34</p> <p>Injuries of An Unknown Source policy stated staff who had reasonable cause to believe that anyone had committed any type of abuse, neglect or mistreatment were to immediately report the incident to the Administrator or AOD. The reporting requirements of the policy were not implemented as follows:</p> <p>a. Direct Care Staff E was interviewed on 3/7/14 at 2:16 p.m. Direct Care Staff E stated she had witnessed incidents of abuse. When asked if she had reported the incidents she stated she had not reported because she knew the City Director and the Administrator personally and was not comfortable reporting to them. Direct Care Staff E stated the following:</p> <ul style="list-style-type: none"> <li>- She had heard staff call the individuals "perra," a Spanish word similar to "bitch."</li> <li>- Individual #6 wanted to do something and Direct Care Staff C said if he did it he would not be allowed to eat.</li> <li>- Individual #2 said she needed to use the restroom and Direct Care Staff C would not help her because she was trying to fix the TV.</li> <li>- Direct Care Staff C yelled at the residents.</li> <li>- Direct Care Staff C went into Individual #3's room with him. When Individual #3 came out of his room, both sides of his face, from his forehead to his cheeks, were bright red. Direct Care Staff C told the other direct care staff Individual #3 had hit the wall in his bedroom.</li> </ul> <p>Incident/Accident reports related to Individual #3 hitting his head while displaying maladaptive</p>	W 153			

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

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FORM APPROVED  
OMB NO. 0938-0391

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W 153	<p>Continued From page 35</p> <p>behaviors were reviewed. An Incident/Accident report which included head hits while both Direct Care Staff E and Direct Care Staff C were on shift could not be found.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if there were other Incident/Accident reports documenting Individual #3's head hits, the Pocatello City Director stated no.</p> <p>The facility failed to ensure all allegations of abuse, neglect and mistreatment were immediately reported to the Administrator.</p> <p>b. Direct Care Staff G was interviewed on 3/7/14 at 2:36 p.m. Direct Care Staff G stated the following:</p> <ul style="list-style-type: none"> <li>- She witnessed other direct care staff say things to the individuals such as, "You know what you're supposed to be doing. Don't act dumb."</li> <li>- Direct Care Staff C and Direct Care Staff H called the individuals names such as "stupid" and "fucker." They spoke about the individuals in Spanish.</li> <li>- She witnessed Direct Care Staff F yell at individuals.</li> <li>- She felt like clients were uncomfortable and that staff covered for each other. Direct Care Staff G stated she knew that Individual #1 was uncomfortable with staff.</li> <li>- She stated she had not recently reported to the</li> </ul>	W 153			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 153	<p>Continued From page 36</p> <p>Administrator or City Director, but was in the process of writing a letter to the facility's corporate office and still planned to do so.</p> <p>The facility failed to ensure all allegations of abuse, neglect and mistreatment were immediately reported to the Administrator.</p> <p>c. The LPN was interviewed on 3/7/14 at 2:25 p.m. The LPN stated direct care staff had reported allegations of abuse to her, which included the following:</p> <ul style="list-style-type: none"> <li>- Verbal abuse occurred "mostly on p.m. shift"</li> <li>- Individual #2 had her plate taken away and was given a fork to eat with instead of a spoon.</li> </ul> <p>Individual #2's self feeding training program, dated 11/21/13, included the use of both a fork and a spoon. However, the program did not include taking her meal or removing her food as an approved intervention technique.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if temporary food removal was an approved intervention technique for Individual #2, the Pocatello City Director stated no.</p> <ul style="list-style-type: none"> <li>- Direct Care Staff C had her legs over Individual #2's lap. The direct care staff who reported the incident to the LPN was unsure if Direct Care Staff C was trying to hold Individual #2 down with her legs or not</li> <li>- Individual #5 wanted something to eat and was</li> </ul>	W 153			

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

PRINTED: 03/21/2014  
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	<p>Continued From page 37</p> <p>told he could have it if he ran up and down the hall a couple of times. The LPN stated direct care staff could have been implementing a PT program, she did not know.</p> <p>Individual #5's PT service program dated 9/12/13, was reviewed. The program did not include running as an exercise that Individual #5 was to complete.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if running was part of Individual #5's PT program, the Program Manager stated no.</p> <p>- Direct care staff do not respect the individuals. Direct care staff made Individual #8 do everything.</p> <p>When asked, the LPN stated she had not reported the allegations to the Administrator or the City Director. The LPN stated when direct care staff reported allegations, the City Director and the Administrator blamed staff for trying to cause trouble, which resulted in staff not reporting. When asked about her (the LPN's) failure to report the allegations, the LPN stated "I should have but I will get written up for it."</p> <p>An interview was conducted with the Idaho State Director, Regional Representative, Program Manager and Pocatello City Director on 3/11/14 from 12:30 - 1:25 p.m. When asked, the Program Manager stated it was the expectation that anyone with knowledge immediately report. The Program Manager stated if the staff was uncomfortable, the LPN should have offered to</p>	W 153			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
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W 153	<p>Continued From page 38 make the reporting call with the direct care staff.</p> <p>The facility failed to ensure the LPN immediately reported all allegations of abuse, neglect and mistreatment to the Administrator.</p> <p>3. The "The Notification Process" section of the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy stated the Administrator, AOD or City Director were to notify Adult Protection for "Any staff to client abuse, neglect, or exploitation." For individuals under the age of 18, the Administrator, AOD or City Director were to notify Child Protection for "Any staff to client abuse, neglect, or exploitation."</p> <p>On 3/10/14 at 1:19 p.m. the individuals' ages were provided by the facility as follows:</p> <p>Individual #4 was 24 years old, and Individuals #5 and #6 were 22 years old requiring reporting to Adult Protection.</p> <p>Individual #1 was 16 years old, Individuals #2 and #7 were 15 years old, and Individual #3 was 12 years old, requiring reporting to Child Protection.</p> <p>The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy reporting requirements were not implemented as follows:</p> <p>a. The Trainer was interviewed on 3/7/14 at 5:55 p.m. The Trainer stated she had emailed the Administrator and the City Director on 9/13/13 to report concerns that Direct Care Staff D had expressed to her. The Trainer stated Direct Care Staff D stated other direct care staff left an individual alone during a seizure and in a second incident an individual who was not able to stand</p>	W 153			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 153	<p>Continued From page 39 well independently was left alone standing.</p> <p>The Trainer's email to the City Director, the Administrator and the LPN, dated 9/13/13, stated she had instructed Direct Care Staff D to share her concerns with the Administrator and the LPN.</p> <p>However, no additional information, including documentation that Child and/or Adult Protection had been notified of the allegations, could be found.</p> <p>b. The Trainer was interviewed on 3/7/14 at 6:55 p.m. The Trainer stated she had verbally reported incidents to the City Director. The Trainer stated a direct care staff had reported other direct care staff were forcing individuals' mouths open to brush their teeth when the individuals refused to open their mouths with prompting. She also stated staff held someone on the couch, with their arms across their chest, for refusing to participate.</p> <p>Individual #1 - #7's dental hygiene programs, dated 11/26/13 for Individual #1, dated 11/21/13 for Individual #2, revised 1/2/14 for Individual #3, revised 9/6/13 for Individual #4, revised 7/5/13 for Individual #5, revised 2/14/14 for Individual #6 and revised 9/3/13 for Individual #7 were reviewed. The programs did not include forcing the individuals' mouths open as an approved intervention technique.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if forcing individuals' mouths open was a part of an approved intervention technique,</p>	W 153			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 153	Continued From page 40 for the individuals, the Idaho State Director stated no.  However, no additional information, including documentation that Child and Adult Protection had been notified of the allegations, could be found.  The facility failed to ensure all allegations of abuse, neglect and mistreatment were reported in accordance with State Law.	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on review of the facility's abuse policy, record review and individual and staff interviews, it was determined the facility failed to ensure thorough investigations were conducted for 7 of 7 individuals (Individuals #1 -#7) residing at the facility. This resulted in a lack of protection being provided to individuals and a lack of sufficient information being collected on which to base corrective action decisions. The findings include:  1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13, stated upon receiving an allegation of abuse, neglect or mistreatment, the Administrator, AOD or Regional Representative was to begin an investigation immediately, regardless of when the incident occurred, including outside of normal business hours. The policy stated "This includes designating an 'investigator' as outlined in the investigation policy	W 154			

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

PRINTED: 03/21/2014  
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  C 03/14/2014
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W 154	<p>Continued From page 41 and taking any immediate actions to protect the resident's health and safety."</p> <p>The facility's "Investigations" policy, revised 2/15/12, stated a form would be used as a checklist to verify and establish documentation that a proper investigation has been conducted. The policy stated "It is always preferable to have one person designated as the investigator and the Administrator or designee designated as the decision maker." The policy further stated "After the Administrator or designee is done reviewing all the evidence and the credibility determinations, they must determine what did or did not happen and whether the conduct violates any company policy..."</p> <p>However, the facility's Administrator was interviewed on 3/7/14 at 4:05 p.m. The Administrator stated the allegations of abuse, neglect and mistreatment were reported to the City Director. The Administrator stated staff had reported to him on a few occasions and he had instructed the staff to call the City Director.</p> <p>The City Director was interviewed on 3/7/14 at 4:49 p.m. The City Director stated he investigated all allegations of abuse, neglect and mistreatment.</p> <p>The Administrator and/or an investigator was not involved in investigations of allegations of abuse, neglect and mistreatment as specified in the facility's policy.</p> <p>The facility failed to ensure the policy was implemented.</p> <p>2. Facility staff were interviewed on 3/7/14. Staff</p>	W 154	<p>POC W154 483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>Courtyard will ensure all alleged violations are thoroughly investigated.</p> <p>All past identified allegations have been investigated. Follow through based on the outcome of the investigations has been or is being implemented.</p> <p>A new data based will be used to track all incidents of Abuse, Neglect, Mistreatment, and Injuries of Unknown Source and the outcome of all allegations.</p> <p>Person Responsible: QIDP, Program Supervisor, LPN, and City Director</p> <p>Monitor: Each business day incident/accidents/behavior logs will be taken to the main office and given to the Program Supervisor. The Program Supervisor will enter those incidents into the data tracking system. The Program Supervisor will review them each business day.. The QIDP will review them weekly and adjust programming as necessary. Weekly the City Director will review the tracking and all investigation information to ensure Abuse, Neglect, Mistreatment, Injuries of Unknown Source are being appropriately investigated, documented and tracked. When an allegation is reported, the Program Supervisor will complete a</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2014  
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W 154	<p>Continued From page 42</p> <p>stated allegations of abuse and neglect had been reported to the facility Administrator and/or the City Director. However, investigations related to the allegations could not be found as follows:</p> <p>a. Individual #1 was interviewed by survey staff on 3/7/14 at 2:49 p.m. During the interview, Individual #1 stated once Direct Care Staff B talked about his "private areas" in front of her, Individual #1 told Direct Care Staff B that it made her uncomfortable and she did not think his behavior was appropriate around a 16 year old girl. She also reported the incident to the Administrator.</p> <p>However, an investigation related to the incident could not be found.</p> <p>b. Direct Care Staff G was interviewed on 3/7/14 at 2:36 p.m. Direct Care Staff G stated other direct care staff on the p.m. shift, particularly Direct Care Staff C, made Individual #6 do all of the housework. Individual #6 had to clean, take out the garbage, clean up the table and put away dishes.</p> <p>When asked about reporting, Direct Care Staff G stated she had reported it to the Administrator before and the Administrator stated "I know it needs to stop."</p> <p>An investigation related to the incident could not be found.</p> <p>c. Direct Care Staff A was interviewed on 3/7/14 at 2:25 p.m. Direct Care Staff A stated the following:</p> <p>- When she began employment another direct</p>	W 154	<p>thorough investigation. Once the corrective action is identified, the Program Supervisor will notify the City Director of the outcome and proceed with the recommendation or corrective measures. If the allegation involved clients, the QIDP will also be involved in the implementation of the corrective measures.</p>	4/14/14	

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 43</p> <p>care staff had put a low-cut shirt on Individual #4. Direct Care Staff C and Direct Care Staff F laughed at Individual #4 and made fun of her in Spanish for the shirt she was wearing.</p> <p>- Direct Care Staff C asked Individual #6 if he wanted a girlfriend. When Individual #6 responded "yes," Direct Care Staff C asked why. Individual #6 talked about dating. Direct Care Staff C and Direct Care Staff F laughed at Individual #6 and began making fun of Individual #6 in Spanish, stating he wanted a girlfriend to have sex with.</p> <p>- Direct Care Staff C and Direct Care Staff F spoke in Spanish about Individual #1, making fun of her and saying she liked both boys and girls and liked to masturbate. Direct Care Staff A stated Individual #1 did not know Spanish but Direct Care Staff C and Direct Care Staff F's non-verbal cues, like facial expressions and body language, were very clear and Direct Care Staff A thought Individual #1 knew when she was being made fun of. Direct Care Staff A stated when Direct Care Staff C and Direct Care Staff F worked together they were awful.</p> <p>- It was apparent in Individual #3's face that he was scared of Direct Care Staff C and Direct Care Staff F. Direct Care Staff A stated Direct Care Staff C and Direct Care Staff F took Individual #3 to his bedroom when he was engaging in maladaptive behaviors. They linked arms with Individual #3, pulled him to his room, and closed the door. When Individual #3 came out of his room he had red marks on his face. The direct care staff attributed the redness to head hits. Direct Care A stated Direct Care C and Direct Care Staff F each did this one time.</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 44</p> <p>Individual #3's Behavior Intervention Plans for physical aggression, destruction of property and inappropriate social behavior, all revised 11/4/13, were reviewed. The plans did not include taking Individual #3 to his room when he engaged in maladaptive behavior as an approved intervention strategy. Further, his Behavior Intervention Plan for ADHD symptoms, revised 11/4/13, stated if he continued to have difficulty remaining focused, staff "will offer him to take [sic] a break in his room for a 5 minutes [sic] to clear his mind of distractions..." The plan did not include a physical escort (e.g. linking arms with Individual #3) as an approved intervention strategy.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if the escort to his room was an approved intervention technique for Individual #3, the Program Manager stated no.</p> <p>- Individual #1 had gotten upset by the behavior of Direct Care Staff C and Direct Care Staff F and told Direct Care Staff A it made her, Individual #1, uncomfortable.</p> <p>When asked if she had reported the incidents, Direct Care Staff A stated she had talked to the Trainer and the LPN and she had given statements to the City Director. However, she felt the City Director did not believe her.</p> <p>The Trainer was interviewed on 3/7/14 at 5:55 p.m. She stated she had emailed the Administrator and the City Director on 1/23/14 to report concerns Direct Care Staff A had</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 45</p> <p>expressed during training. The Trainer stated Direct Care Staff A reported other direct care staff made fun of individuals, yelled at individuals and were vulgar around individuals. Direct Care Staff A also reported an incident when other direct care staff thought an individual may have faked a seizure. In response, the other direct care staff had the individual sit on the couch and did not give him dinner.</p> <p>However, investigations regarding the allegations could not be found.</p> <p>d. The Trainer was interviewed on 3/7/14 at 5:55 p.m. The Trainer stated she had emailed the Administrator and the City Director on 9/13/13 to report concerns that Direct Care Staff D had expressed to her. The Trainer stated Direct Care Staff D stated other direct care staff left an individual alone during a seizure and in a second incident an individual who was not able to stand well independently was left alone standing.</p> <p>The Trainer's email to the City Director, the Administrator and the LPN, dated 9/13/13, stated she had instructed Direct Care Staff D to share her concerns with the Administrator and the LPN.</p> <p>However, no additional information, including an investigation into the allegations, could be found.</p> <p>e. The Trainer was interviewed on 3/7/14 at 5:55 p.m. The Trainer stated she had verbally reported incidents to the City Director. The Trainer stated a direct care staff had reported other direct care staff were forcing individuals' mouths open to brush their teeth when the individuals refused to open their mouths with prompting. She also stated staff held someone</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 46</p> <p>on the couch, with their arms across their chest, for refusing to participate.</p> <p>Individual #1 - #7's dental hygiene programs, dated 11/26/13 for Individual #1, dated 11/21/13 for Individual #2, revised 1/2/14 for Individual #3, revised 9/6/13 for Individual #4, revised 7/5/13 for Individual #5, revised 2/14/14 for Individual #6 and revised 9/3/13 for Individual #7 were reviewed. The programs did not include forcing the individuals' mouths open as an approved intervention technique.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if forcing individuals' mouths open was a part of an approved intervention technique for the individuals, the Idaho State Director stated no.</p> <p>However, no additional information, including an investigation into the allegations could be found.</p> <p>f. The City Director was interviewed on 3/7/14 at 4:49 p.m. When asked if he had ever received allegations of staff calling the individuals names or staff making fun of the individuals in Spanish, the City Director stated yes. However, he stated the allegations were not investigated. The City Director stated he did not remember who reported the allegation. The reporting staff stated other staff were saying (in Spanish) that Individual #1 wanted to have sex with a boy at school. The City Director determined that it was not inappropriate and it did not need to be investigated. The City Director stated he thought the accused staff were Direct Care Staff C and</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/14/2014
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W 154	<p>Continued From page 47</p> <p>Direct Care Staff I, but he could not remember. The City Director further stated the Trainer had talked to him about concerns reported to her by Direct Care Staff during orientation, but nothing that was abuse.</p> <p>No documentation related to the incidents, including the City Director's reasoning for not investigating could be found in the facility's records.</p> <p>3. The facility's "Investigations" policy, revised 2/15/12, stated investigations were to include the following:</p> <ul style="list-style-type: none"> <li>- Interviews with the complainant, accused, witnesses (including individuals as appropriate) and those who created relevant documents.</li> <li>- Witnesses' statements were to be submitted in writing with their signature and date.</li> <li>- Available documentation was to be reviewed, including time cards, personnel files, disciplinary action, individuals' program documentation, etc. The policy stated "You should always review disciplinary records, employee evaluations, and employee logs to determine if they contain a recorded history of the same violation."</li> <li>- Other evidence, such as pictures of bruises, etc.</li> </ul> <p>An interview was conducted with the Idaho State Director, Regional Representative, Program Manager and Pocatello City Director on 3/11/14 from 12:30 - 1:25 p.m. When asked about documentation and thorough investigations (including written staff statements, review of personnel files, review of prior incidents,</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 48</p> <p>Interviews with individuals, etc.) the Program Manager stated investigations were to be thorough in accordance with the facility's policy. The Idaho State Director concurred.</p> <p>However, the facility's investigations did not include all information as specified in the Investigations policy as follows:</p> <p>a. A handwritten statement from Direct Care Staff A, dated 2/1/14, stated Direct Care Staff B were working together on the night shift. The handwritten statement documented Direct Care Staff A had spoken to the City Director to verify Individual #1 was on suicide watch.</p> <p>The handwritten statement documented Direct Care Staff A was cleaning and Direct Care Staff B was assigned the suicide watch for Individual #1. The handwritten statement documented that at approximately 11:30 p.m., Direct Care Staff A observed Direct Care Staff B lying down in the bedroom shared by Individuals #1 and #2. Direct Care Staff A told Direct Care Staff B that the instructions given by the City Director regarding Individual #1's suicide watch needed to be followed. Direct Care Staff B responded stating "...nobody was doing what [City Director's name] had said, he [Direct Care Staff B] mentioned that I [Direct Care Staff A] was the only one doing this because I [Direct Care Staff A] was new..."</p> <p>The handwritten statement from Direct Care Staff A further documented an hour later Direct Care Staff B was still "lying down or sleeping" in the bedroom shared by Individuals #1 and #2. Direct Care Staff A called the City Director who "...gave instructions on how to handle this situation." Specific information regarding the City Director's</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>015 SECOND AVENUE WEST WENDELL, ID 83355</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 154	<p>Continued From page 48</p> <p>Instructions was not included in Direct Care Staff A's handwritten statement.</p> <p>The handwritten statement from Direct Care Staff A also documented during the second time she observed Direct Care Staff B lying down, she "...also noticed that [Direct Care Staff B's name] had a small of [sic] beer." Direct Care Staff A documented she "did not tell [City Director's name] about the alcohol because I [Direct Care Staff A] thought he [the City Director] was going to find out when he [the City Director] came and talk [sic] to [Direct Care Staff B's name]."</p> <p>An investigation form, as specified in the facility's Investigations policy could not be found. However, an email from the City Director to the Idaho State Director, dated 2/3/14 and timed 9:03 a.m., documented the following:</p> <p>Direct Care Staff A called the City Director to report Direct Care Staff B was sleeping during the shift. Direct Care Staff B was allegedly lying down on a PT mat while he was watching Individual #1 who was on suicide watch. The email stated Direct Care Staff A made Direct Care Staff B sit up and go out in the hall. Direct Care Staff A reported Direct Care Staff B was sleeping in the hallway. The City Director documented he instructed Direct Care Staff A to go watch Individual #1 who was on suicide watch to ensure she was safe. The City Director documented he arrived at the facility less than 5 minutes later and found Direct Care Staff B awake, but seated on the floor with a pillow behind his head and a blanket tucked behind his back.</p> <p>A subsequent email, from the City Director to the Idaho State Director, dated 2/3/14 and timed</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - COURTYARD			STREET ADDRESS, CITY, STATE, ZIP CODE 815 SECOND AVENUE WEST WENDELL, ID 83255		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 154	<p>Continued From page 50</p> <p>11:06 a.m., documented that Direct Care Staff B "...says he never sleeps, and the reporting staff [Direct Care Staff A] says she saw him lying down on a mat and that he [Direct Care Staff B] then also fell asleep. I [the City Director] have her [Direct Care Staff A's] statement, he [Direct Care Staff B] has not completed one yet..." The email documented Direct Care Staff B was immediately suspended and the City Director had collected "...about 1/2 the staff statements from staff in the house and none of the staff report seeing any staff sleeping..."</p> <p>The email stated Direct Care Staff A stated Direct Care Staff B told her watching people at night was not required. Direct Care Staff A also told the City Director that Direct Care Staff B smelled of alcohol. The City Director's email documented "This is not the first time staff have reported that [Direct Care Staff B's name] smelled of alcohol..."</p> <p>A third email to the Idaho State Director, dated 2/5/14 and timed 11:54 a.m., stated he and a Human Resources Representative had spoken with Direct Care Staff B. The email documented Direct Care Staff B denied sleeping and being under the influence of drugs or alcohol while on shift. However, Direct Care Staff B did say he had gone to watch television when he should have been watching the individual on suicide watch and agreed he should not have been laying on the floor. The email documented Direct Care Staff B wrote a short statement and left the facility.</p> <p>The email stated it was the City Director's belief Direct Care Staff B was likely sleeping, but he did not have evidence beyond Direct Care Staff A's allegation.</p>	W 154			

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

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W 154	<p>Continued From page 51</p> <p>Beyond the email and Direct Care Staff A's handwritten allegation, documentation of thorough investigation into the incident could not be found. Direct Care Staff B's handwritten statement was not present, statements collected from other staff members were not present, a review of documentation related to Direct Care Staff A reporting the smell of alcohol was not present and information related to a review of Direct Care Staff B's personnel file, including other disciplinary action, performance evaluations, etc. in accordance with the facility's Investigations policy was not present.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if additional information related to the investigation had been found, the Pocatello City Director stated no.</p> <p>Further, Individual #1's 11/26/13 Behavior Intervention Plan for suicidal ideation was reviewed. The plan stated Individual #1 was "...very honest about her thoughts and feelings and will express them when asked..."</p> <p>Individual #1 was interviewed by survey staff on 3/7/14 at 2:49 p.m. When asked if anyone had ever slept in her room, Individual #1 stated yes. Individual #1 stated Direct Care Staff C had slept on her bedroom floor, on her roommate's (Individual #2's) seizure mat and Direct Care Staff H had also slept on the bedroom floor during the morning shift. Individual #1 stated Direct Care Staff B had slept on her bedroom floor during a night shift. Individual #1 stated all 3 sleeping staff</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 52 Incidents were in January or February.</p> <p>However, documentation related to the 2/1/14 allegation of Direct Care Staff B sleeping did not include evidence that Individual #1 had been interviewed regarding the incident.</p> <p>When asked, during an interview on 3/7/14 at 4:49 p.m. the City Director stated he did not ask Individual #1 about the incident as it was his understanding she was sleeping throughout the incident.</p> <p>b. An Incident/Accident report, dated 2/16/14 documented Individual #5 had 2 small abrasions in the middle of his chest. The cause of the injuries was documented as unknown. An attached Investigation Report, completed by the City Director on 2/21/14 stated "None of the staff interviewed report witnessing any incidents..."</p> <p>However, only one staff written statement was included with the report. No additional information regarding which staff had been interviewed was present with the investigation.</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if additional information related to the investigation had been found, the Pocatello City Director stated no.</p> <p>c. An Incident/Accident report, dated 2/17/14, documented Individual #4 had multiple bruises on her right and left upper and lower arms. The cause of the injuries was documented as unknown. An attached Investigation Report,</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	<p>Continued From page 53</p> <p>completed by the City Director on 2/24/14 stated "The staff report that [Individual #4] had an incident where she grabbed a gallon of milk and dumped it out onto the floor. This might not seem to explain the bruises, but it very likely is the reason for the bruises...The bruises occur to her left arm in three ways. The first was is that she will drag her arm over the lid to spin the cap off. Second, she will then 'hug' the object tightly against her with both arms as she squeezes the liquid out. The third way is if staff attempt to block an attempt to dump out or to get to an object to dump out, she can be bruised from the contact with the staff..."</p> <p>However, no staff written statements were included with the report. No additional information regarding the milk dumping incident, such as the date and time of the incident and what actually occurred to cause the bruising (e.g. If she actually rubbed the lid on her arms during the incident, if she actually hugged the milk container during the incident, if staff actually touched or bumped her arms when redirecting or a combination of the possible causes) was included with the report.</p> <p>Individual #4's Behavior Intervention Plan for Food Stealing, revised 10/9/13, stated she would grab food and drinks which did not belong to her. She would sometimes consume the items and other times she would dump the items out on the floor. The plan did not include information related to her rubbing items on her arms or hugging them. Further, the plan stated "if possible staff will remove the food item from [Individual #4]." However, the plan did not include instructions regarding how staff were to remove the items.</p>	W 154			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 154	Continued From page 54 On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked if additional information related to the investigation had been found, the Pocatello City Director stated no.	W 154			
W 167	483.420(d)(4) STAFF TREATMENT OF CLIENTS  If the alleged violation is verified, appropriate corrective action must be taken.  This STANDARD is not met as evidenced by: Based on review of investigations, policy review and staff interviews, it was determined the facility failed to ensure appropriate corrective action was taken, which directly impacted 3 of 7 individuals (Individuals #4, #5 and #7) for whom an investigation had been completed, and had the potential to impact all individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of sufficient corrective action being implemented. The findings include:  1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, revised 5/21/13, stated "...Employees must not use physical, verbal, sexual or psychological abuse or punishment..."  The policy stated "This includes designating an 'investigator' as outlined in the investigation policy and taking any immediate actions to protect the	W 167			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 157	<p>Continued From page 55 resident's health and safety."</p> <p>The facility's "Investigations" policy, revised 2/15/12, stated a form would be used as a checklist to verify and establish documentation that a proper investigation had been conducted. The policy stated "It is always preferable to have one person designated as the investigator and the Administrator or designee designated as the decision maker." The policy further stated "After the Administrator or designee is done reviewing all the evidence and the credibility determinations, they must determine what did or did not happen and whether the conduct violates any company policy..."</p> <p>However, the facility's Administrator was interviewed on 3/7/14 at 4:05 p.m. The Administrator stated the allegations of abuse, neglect and mistreatment were reported to the City Director. The Administrator stated staff had reported to him on a few occasions and he had instructed the staff to call the City Director.</p> <p>The City Director was interviewed on 3/7/14 at 4:49 p.m. The City Director stated he investigated all allegations of abuse, neglect and mistreatment.</p> <p>The Administrator was not involved in decision-making or corrective action in response to allegations of abuse, neglect and mistreatment as specified in the facility's policy.</p> <p>The facility failed to ensure the policy was implemented.</p> <p>2. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy stated, in</p>	W 157	<p>POC W157 483.420(d)(4) <b>STAFF TREATMENT OF CLIENTS</b></p> <p>Courtyard will ensure alleged violations are verified and appropriate corrective action is taken.</p> <p>All past identified allegations have been investigated. Follow through based on the outcome of the investigations has been or is being implemented.</p> <p>Training is being completed with the professional staff regarding the investigation process and the appropriate corrective action that will be taken based on the outcome of the investigation.</p> <p>Person Responsible: QIDP, Program Supervisor, LPN, and City Director</p> <p>Monitor: When an allegation is reported, the Program Supervisor will complete a thorough investigation. Once the corrective action is identified, the Program Supervisor will notify the City Director of the outcome and proceed with the recommendation or corrective measures. If the allegation involved clients, the QIDP will also be involved in the implementation of the corrective measures. Daily incident/accidents/behavior logs will be taken to the main office and given to the Program Supervisor. The Program Supervisor will enter those incidents into the data tracking system. The Program Supervisor will review them each business day. The QIDP will review them weekly</p>		

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

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W 157	<p>Continued From page 56</p> <p>"The Documentation Process" section that the "...Administrator or designee will complete the Investigation Report on the back of the Incident/Accident Form, to include witness statement review, record review, conclusions, corrective action taken and notification documentation."</p> <p>The facility's Investigation Reports were reviewed. The Investigation Reports documented corrective action which had not actually occurred as follows:</p> <p>a. An Incident/Accident report, dated 2/16/14, documented individual #5 had 2 small abrasions in the middle of his chest. The cause of the injuries was documented as unknown. An attached investigation Report, completed by the City Director on 2/21/14, stated in the Corrective Action section that "The incident will be discussed at the next Core Team Meeting."</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked for documentation that the corrective action had been taken, the Program Manager stated none had been found. When asked if a Core Team Meeting had been held, the Program Manager stated having weekly or every other week meetings had been a best practice at the facility, but he was unsure of whether the practice was occurring.</p> <p>b. An Incident/Accident report, dated 1/11/14, documented individual #7 had multiple bruises on his legs. A subsequent Incident/Accident report, dated 1/14/14, documented he had a bruise on</p>	W 157	<p>and adjust programming as necessary. Weekly the City Director will review the tracking information and investigations to ensure Abuse, Neglect, Mistreatment, injuries of Unknown Source are being appropriately investigated, documented and tracked.</p>	4/14/14	

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

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W 157	<p>Continued From page 57</p> <p>his left buttock. The cause of the injuries was documented as unknown. Investigation Reports, completed by the City Director on 1/16/14, were attached to both Incident/Accident Reports. The Investigation Reports documented that it was thought the bruising was caused by Individual #7 engaging in maladaptive behaviors while at school. The Corrective Action section of both Investigation Reports stated "...will follow up with a visit next week with a visit to the school [sic]. This incident will also be discussed at the next Core team meeting."</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked for documentation that the corrective action had been taken, the Pocatello City Director stated none had been found.</p> <p>c. An Incident/Accident report, dated 2/4/14, documented Individual #7 had multiple bruises on his legs. The cause of the injuries was documented as unknown. An Investigation Report, completed by the City Director on 2/11/14, was attached to the Incident/Accident Report. The Investigation Report documented that it was thought the bruising was caused by Individual #7 engaging in maladaptive behaviors while at school. The Corrective Action section of the Investigation Report stated "...will be providing another training for the school on 2/19/14. This incident will also be discussed at the next Core team meeting."</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager,</p>	W 157			

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

PRINTED: 03/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

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W 157	<p>Continued From page 58</p> <p>the Pocatello City Director, the QIDP and the RN. When asked for documentation that the corrective action had been taken, the Pocatello City Director stated none had been found.</p> <p>d. An Incident/Accident report dated 2/17/14 documented Individual #4 had multiple bruises on her right and left upper and lower arms. The cause of the injuries was documented as unknown. An attached Investigation Report, completed by the City Director on 2/24/14 stated in the Corrective Action section that "The team decided that we would have formal training for all...staff on how and when to fill out Incident reports and focus attention on [Individual #4] so the staff do not get comfortable seeing bruises on her body...[Individual #4's] bruises are discussed at every Core Team meeting just for this reason..."</p> <p>On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked for documentation that the corrective action had been taken, the Pocatello City Director stated none had been found.</p> <p>e. An Incident/Accident report, dated 2/22/14, documented an allegation that staff had pulled Individual #4's hair while redirecting her away from the refrigerator. An attached Investigation Report, completed by the City Director on 2/28/14 stated in the Corrective Action section that "The staff...will be retrained to follow the behavior plan as it is written while working with [Individual #4]. The staff that was accused of pulling [Individual #4's] hair will receive specific instruction and individual training."</p>	W 157			

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

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W 157	Continued From page 59  On 3/14/14 at 10:30 a.m., an interview was conducted with the Idaho State Director, the Regional Representative, the Program Manager, the Pocatello City Director, the QIDP and the RN. When asked for documentation that the corrective action had been taken, the Pocatello City Director stated none had been found.  The facility failed to ensure corrective action was taken.	W 157			

Bureau of Facility Standards

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  C 03/14/2014
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NAME OF PROVIDER OR SUPPLIER  
**PREFERRED COMMUNITY HOMES - COURTYA**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**616 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) COMPLETE DATE
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the complaint survey conducted from 3/7/14 to 3/14/14.  The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Michael Case, LSW, QIDP Trish O'Hara, RN, CNN Jim Troufetter, QIDP Nicole Wisenor, QIDP	M 000		
MM170	16.03.11.075.07(b)(ii) Method for Investigating Grievances  The facility must have a written procedure for registering and resolving grievances and recommendations by residents or any individual or group designated by the resident as his representative. The procedure must ensure protection of the resident from any form of reprisal or intimidation. The written procedure must include: A method for investigating and assessing the validity of a grievance or recommendation; and	MM170	Refer to Response W125	4/14/14
MM177	16.03.11.075.09 Protection from Abuse and Restraint  This Rule is not met as evidenced by: Refer to W125.  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	MM177	Refer to Response W122, W127, W149, W153, W154 and W157	4/14/14

**RECEIVED**

APR 15 2014

**FACILITY STANDARDS**

Bureau of Facility Standards

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

*M. Halladay*

TITLE

*City Director*

(X6) DATE

*4/10/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G057</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - COURTYA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>618 SECOND AVENUE WEST WENDELL, ID 83355</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
MM177	Continued From page 1 resident from injury to himself or to others (See also Subsection 075.10).  This Rule is not met as evidenced by: Refer to W122, W127, W149, W153, W154 and W157.	MM177			
MM231	16.03.11.080.03(a) Informed of Activities  To be informed of activities related to the resident that may be of interest to them or of significant changes in the resident's condition; and This Rule is not met as evidenced by: Refer to W148.	MM231	POC MM231 16.03.11.080.03(a) Informed of Activities  Refer to W148	4/14/14	