



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

April 8, 2014

Wanda Huber, Administrator  
Preferred Community Homes - Elk Run  
12553 W Explorer Dr Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Elk Run, Provider #13G041

Dear Ms. Huber:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Elk Run, which was conducted on April 3, 2014.

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

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

Wanda Huber, Administrator  
April 8, 2014  
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being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **April 20, 2014**, and keep a copy for your records.

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

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

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

This request must be received by April 20, 2014. If a request for informal dispute resolution is received after April 20, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/03/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - ELK RUN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2273 SOUTH GULL COVE PLACE MERIDIAN, ID 83642</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey conducted from 3/31/14 - 4/3/14.  The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Jim Troutfetter, QIDP  Common abbreviations used in this report are:  DCS - Direct Care Staff ICD - Impulse Control Disorder IED - Intermittent Explosive Disorder LPN - Licensed Practical Nurse MAR - Medication Administration Record NOS - Not Otherwise Specified PCLP - Person Centered Lifestyle Plan PRN - As Needed QIDP - Qualified Intellectual Disability Professional SIV - Self Induced Vomiting	W 000		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 2 of 3 individuals (Individuals #1 and #2), and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This failure resulted in a lack of	W 159		

**RECEIVED**  
**APR 21 2014**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wanda Huber</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-21-14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of assessments, programing, and monitoring. The findings include:  1. Refer to W212 as it relates to the facility's failure to ensure the QIDP ensured evaluation data was available to support an individual's psychiatric diagnoses.  2. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' behavioral and developmental assessments contained comprehensive information.  3. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured individuals' medications to control maladaptive behavior were appropriately incorporated into plans.	W 159		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure that evaluation data was available to support the diagnoses for 1 of 3 individuals (Individual #1) whose records were reviewed. This resulted in the potential for an individual to receive unnecessary interventions based on inaccurate diagnoses. The findings include:  1. Individual #1's 2/7/14 PCLP stated he was a 58 year old male whose diagnoses included severe	W 212		

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W 212	Continued From page 2 mental retardation, schizoaffective disorder - bipolar type, IED, and ICD.  Individual #1's record included Psychiatric Update forms, dated 6/12/13, 7/18/13, 8/15/13, 9/19/13, 11/14/13, 1/30/14, and 2/27/14, all of which included the diagnosis of schizoaffective disorder - bipolar type.  However, Individual #1's record did not include documentation related to how the diagnosis was determined (i.e., evidence of hallucination, delusions, disorganized speech, major depressive or manic episodes, etc.). Additionally, Individual #1's PCLP did not include an objective to track signs and symptoms of schizoaffective disorder.  Relevant, objective, accurate data on which to base Individual #1's diagnosis could not be found in his record.  During an interview on 4/3/14 from 8:30 - 10:20 a.m., the QIDP stated Individual #1 had the diagnosis of schizoaffective disorder for several years. The QIDP stated he did not know what the diagnosis was based on and stated he did not know if there was evaluation data to support the diagnosis.  The facility failed to ensure that evaluation data was available to support Individual #1's diagnosis of schizoaffective disorder - bipolar type.	W 212			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.	W 214			

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W 214	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained accurate and comprehensive information for 2 of 3 individuals (Individuals #1 and #2) whose behavioral interventions were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #1's 2/7/14 PCLP stated he was a 58 year old male diagnosed with severe mental retardation, schizoaffective disorder - bipolar type, IED, ICD, and obstructive sleep apnea.</p> <p>Individual #1's Behavioral Assessment, dated 2/5/14, stated he engaged in maladaptive behaviors which included disruptive behavior, self-abuse, destruction to property and was hurtful to others. However, the Behavior Assessment did not include accurate, comprehensive information as follows:</p> <p>a. Individual #1's Behavioral Assessment listed his diagnoses as schizoaffective disorder - bipolar type, severe intellectual disability, IED and ICD. The assessment did not contain additional information regarding how or if Individual #1's diagnoses impacted his demonstrated maladaptive behaviors.</p> <p>b. Individual #1's Behavioral Assessment stated he "also takes psychotropic medications, used in conjunction with the formal behavior support plan." The assessment did not contain any additional information related to how his psychotropic medications impacted his behavior.</p>	W 214			

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W 214	<p>Continued From page 4</p> <p>c. Individual #1's record contained a Written Informed Consent, dated 4/8/13, which documented he received melatonin 3 mg (a hormonal supplement) each evening for sleep. The consent documented Individual #1 needed "a good night's rest to assist in preventing maladaptive behaviors during the day." However, his Behavioral Assessment did not include information related to how his maladaptive behavior was impacted by his sleep, how much sleep was needed, etc.</p> <p>d. The "related restriction of rights" section of his Behavioral Assessment documented Individual #1 "has a PRN that is available for his use during difficult times." However, the assessment did not include information related to what "difficult times" were, how or when the medication was used or how it affected his behavior.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 p.m., the QIDP stated there was no additional information related to how Individual #1's psychiatric diagnoses impacted his maladaptive behavior, and that the impact of sleep had not included in the assessment. The QIDP stated the assessment needed to be revised.</p> <p>The facility failed to ensure Individual #1's Behavioral Assessment contained comprehensive information on which to base program decisions.</p> <p>2. Individual #2's 11/21/13 PCLP documented a 48 year old male whose diagnoses included moderate intellectual disability, atypical bulimia, bipolar disorder - depressed type, IED, and ICD.</p>	W 214			

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W 214	<p>Continued From page 5</p> <p>His record contained a Behavioral Assessment, dated 11/19/13, which documented he engaged in food stealing, drink stealing, and SIV.</p> <p>The sections of the assessment labeled Food Stealing and Drink Stealing both stated "[Individual #2] is diagnosed with Atypical Bulimia where he will drink or eat large quantities to assist him to purge."</p> <p>The section of the assessment labeled SIV documented "[Individual #2] often eats at a rapid pace. He will 'shovel food' not pausing between bites. This may cause digestive problems or increased possibility of choking as well as when he eats quickly he may self-induce vomiting after his meal quicker [sic]. [Individual #2] is diagnosed with a history of Atypical Bulimia (self-induced vomiting)."</p> <p>His Behavioral Assessment also had a section labeled SIV, Food/Drink Stealing which documented "[Individual #2's] team identified that he engages in self induced vomiting (SIV) and food/drink stealing a depressive type symptoms [sic]. [Individual #2] has a diagnosis of Bipolar Disorder, Depressed Type [sic]. [Individual #2] will engage in these behaviors as a result of this diagnosis."</p> <p>However, the Depressive Type Symptoms section of the assessment did not contain references to SIV, food stealing, or drink stealing.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 a.m., the QIDP stated Individual #2's behavior assessment needed to be revised.</p> <p>The facility failed to ensure Individual #2's</p>	W 214		

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W 214	Continued From page 6 behavior assessment contained accurate information.	W 214			
W 312	483.450(e)(2) DRUG USAGE  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' PCLPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 3 individuals (Individuals #1 and #2) whose behavior modifying drugs were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs' usage and how it may change in relation to progress or regression. The findings include:  1. Individual #2's 11/21/13 PCLP documented a 48 year old male whose diagnoses included moderate intellectual disability, atypical bulimia, bipolar disorder - depressed type, IED, and ICD.  His record contained a Psychiatric Update, dated 2/27/14, documenting he was receiving Zyprexa (an antipsychotic drug) 10 mg at bedtime, Zyprexa 5 mg PRN, and Prozac (an antidepressant drug) 40 mg in the morning for food stealing, drink stealing, and SIV related to	W 312			

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W 312	<p>Continued From page 7 bipolar disorder - depressed type.</p> <p>His record also contained a medication reduction plan, dated 3/17/14, stating "The team will discuss a reduction to [Individual #2's] Zyprexa after he is no longer taking Prozac and he displays SIV 0 times per month and food stealing 0 times per month, and drink stealing 0 times per month, each for 3 consecutive months."</p> <p>His medication reduction plan also stated "The team will discuss a reduction to [Individual #2's] Zyprexa PRN after he is no longer taking Prozac and Zyprexa (routine) and he displays SIV 0 times per month and food stealing 0 times per month, and drink stealing 0 times per month, each for 3 consecutive months."</p> <p>However, Individual #2's MARs were reviewed and documented he had received Zyprexa 5 mg PRN on 11/13/13, 11/25/13, and 12/5/13 for assaultive behavior.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 a.m., the QIDP stated the Zyprexa and Zyprexa PRN should have been listed as used for aggression on the medication reduction plan and that the medication reduction plan was inaccurate and need to be revised.</p> <p>The facility failed to ensure Individual #2's medication reduction plan was accurate.</p> <p>2. Individual #1's 2/7/14 PCLP stated he was a 58 year old male whose diagnoses included severe mental retardation, schizoaffective disorder - bipolar type, IED, ICD and obstructive sleep apnea.</p>	W 312			

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W 312	<p>Continued From page 8</p> <p>His Physician's Orders, dated 12/19/13, stated he received Seroquel (an antipsychotic drug) 100 mg PRN "for extreme agitation repeat 2 [times] daily 4-6 [hours] apart."</p> <p>Individual #1's record included a document titled "Guidelines for PRN Medication," signed by the QIDP on 2/6/14. The guidelines did not provide sufficient criteria for the PRN usage, as follows:</p> <ul style="list-style-type: none"> <li>- The Guidelines stated "Possible pre-indicators include but not limited to: any assaults to peers and/or staff; any slamming of furniture, bolt board, doors, or his elbows/ head [sic] banging; any destruction of property."</li> </ul> <p>It was not clear if the "pre-indicators" were the maladaptive behaviors for which the PRN was to be requested, or at what point it was to be requested.</p> <ul style="list-style-type: none"> <li>- The Guidelines stated "It is important to contact the Program Supervisor or PSOD [Program Supervisor On Duty] when it is thought that [Individual #1] might need his PRN."</li> </ul> <p>However, no additional information related to what maladaptive behavior, what frequency of behavior, or what duration of behavior had to occur before the PRN was requested was included in the guidelines.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 p.m., the QIDP stated too much discretion had been left to direct care staff and the PRN guidelines needed to be revised and clarified.</p> <p>The facility failed to ensure Individual #1's PRN was sufficiently incorporated into a plan.</p>	W 312		

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W 336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure nursing reviews had been completed on a quarterly basis for 2 of 3 individuals (Individuals #2 and #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include:</p> <p>1. Individual #2 and #3's records were reviewed and documented the following:</p> <p>a. Individual #2's 11/21/13 PCLP documented a 48 year old male whose diagnoses included moderate intellectual disability, atypical bulimia, bipolar disorder - depressed type, IED, and ICD.</p> <p>Individual #2's record documented quarterly nursing reviews were completed on 6/18/13 and 12/23/13. There were no completed assessments for the first quarter (January, February, March) of 2014 and third quarter (July, August, September) of 2013.</p> <p>b. Individual #3's 1/16/14 PCLP documented a 61 year old male whose diagnoses included profound intellectual disability, seizure disorder and IED.</p> <p>Individual #3's record documented quarterly</p>	W 336		

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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 336	Continued From page 10 nursing reviews were completed on 10/24/13, 6/8/13, and 1/27/14. There was no completed assessment for the third quarter (July, August, September) of 2013.  During an interview on 4/3/14 from 8:30 - 10:20 a.m., the LPN stated the reviews had been missed.  The facility failed to ensure nursing reviews had been completed on a quarterly basis.	W 336		
W 369	483.460(k)(2) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 4 individuals (Individual #3) observed to take medications. This resulted in an individual's laxative medication being improperly administered. The findings include:  1. Individual #3's 1/16/14 PCLP stated he was a 61 year old male whose diagnoses included profound mental retardation, seizure disorder, depressive disorder NOS, and IED. His Physician's Order, dated 2/4/14, stated he received Miralax (an laxative drug) 17 grams daily.  An observation was conducted at the facility on 4/1/14 from 6:30 - 9:15 a.m. During that time, Individual #3 was observed to participate in a self	W 369		

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W 369	<p>Continued From page 11 administration of medication program.</p> <p>At 8:20 a.m., Individual #3 entered the medication administration area. DCS C, who was assisting Individual #3, obtained a medication cup and poured polyethylene glycol (generic for Miralax) into the cup up to the 30 cc line. DCS C then poured the polyethylene glycol into a glass of milk and handed it to Individual #3 who drank the mixture.</p> <p>When asked about the dose, DCS C stated she had always given Individual #3 a 30 cc dose of polyethylene glycol. DCS C reviewed the MAR and noted the dose indicated was 17 grams. When asked if 17 grams was the same as 30 cc, DCS C stated she did not know.</p> <p>The polyethylene glycol container stated 17 grams was approximately equivalent to 1 heaping tablespoon. However, 30 cc is equal to 2 tablespoons. DCS C stated she had given Individual #3 too much polyethylene glycol.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 a.m., the LPN stated all medications should be given as ordered by the physician. The LPN stated the dose of polyethylene glycol given by DCS C to Individual #3 was in error.</p>	W 369			
W 382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility failed to ensure Individual #3's polyethylene glycol was accurately administered.</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p>	W 382			

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W 382	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:</p> <p>1. An observation was conducted at the facility on 4/1/14 from 6:30 - 9:15 a.m. During that time, Individual #5 was observed to participate in a medication administration program.</p> <p>At 8:00 a.m., Individual #5 entered the medication administration area. DCS C punched Nexium (an antiulcer drug) 40 mg into a small bowl of applesauce. DCS C provided hand over hand assistance to help Individual #5 scoop the pill onto the spoon. Individual #5 dropped the pill from the spoon to the table.</p> <p>DCS C scooped the dropped pill into a medication cup and set it on the counter.</p> <p>At 8:10 a.m., DCS C and Individual #5 left the medication administration area. The dropped pill remained, unlocked and sitting on the counter.</p> <p>At 8:16 a.m., Individual #4 and DCS D entered the medication administration area. The dropped pill remained on the counter.</p> <p>At 8:20 a.m., Individual #3 entered the medication administration area with DCS C. Individual #3 and DCS C left the medication administration</p>	W 382			

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W 382	Continued From page 13 area at 8:43 a.m. The dropped pill remained on the counter.  At 8:45 a.m., DCS C contacted the LPN regarding the dropped pill, at which time DCS C locked the pill in a cabinet in the medication administration area.  When asked during the observation, at 9:05 a.m., DCS C stated all medications were to remain locked at all times. DCS C stated the dropped pill should have been locked up and not left on the counter when she left the medication administration area.  During an interview on 4/3/14 from 8:30 - 10:20 a.m., the LPN stated no medications should be left unlocked and sitting on the counter.	W 382			
W 383	483.460(I)(2) DRUG STORAGE AND RECORDKEEPING  Only authorized persons may have access to the keys to the drug storage area.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure only authorized persons had access to the key for the drug storage area for 6 of 6 individuals (Individuals #1- #6) residing at the facility. This resulted in the potential for unauthorized persons to access individuals' drugs. The findings include:	W 383			

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W 383	<p>Continued From page 14</p> <p>1. Observations were conducted at the facility on 3/31/14 and 4/1/14. During those times, the keys to the drug storage area were observed to be unsecured, as follows:</p> <p>a. During an observation on 3/31/14 from 3:21-4:45 p.m., Individual #4 was noted to come out of the medication administration area after receiving his medications. DCS A, who had assisted Individual #4, was observed to place a set of keys in the drawer of an unlocked plastic container sitting on the kitchen counter.</p> <p>When asked about the keys during the observation, DCS A stated the keys were to the medication cabinet.</p> <p>Also during the observation, the facility's maintenance staff was observed in and out of the kitchen as he worked on patching a section of wall.</p> <p>b. During an observation on 4/1/14 from 6:30 - 9:15 a.m., DCS C was observed to assist individuals with their medication administration programs. At 8:45 a.m., DCS C was observed to lock the medication cabinets, place the keys on the counter in the medication administration area and leave the area. DCS C returned to retrieve the keys at 8:50 a.m.</p> <p>When asked about the keys during the observation, DCS C stated the keys were to remain with the medication staff. DCS C stated she should not have left the keys unattended on the counter.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 a.m., the LPN and Program Supervisor both</p>	W 383			

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W 383	Continued From page 15 stated the keys to the medication cabinet should not have been placed or left in unsecured locations.	W 383			
W 455	The facility failed to ensure only authorized persons had access to the keys to the medication storage area. <b>483.470(l)(1) INFECTION CONTROL</b>  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. This failure directly impacted 4 of 6 individuals (Individuals #2 - #5) residing at the facility and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:  1. Observations were conducted on 3/31/14 and 4/1/14. During those times, the following infection control issues were noted:  a. An observation was conducted on 3/31/14 from 3:20 - 4:10 p.m. At 3:35 p.m., Individual #4 was observed sitting in a chair in the kitchen. Staff stated they were going to work on his physical therapy program for reaching above his head.  DCS A was observed to wash her hands and	W 455			

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W 455	<p>Continued From page 16</p> <p>obtain a banana. DCS A peeled the banana and broke off a small piece with her bare hand and held it above Individual #4's head. Individual #4 reached up, took the piece of banana from DCS A and ate it. The process was repeated until Individual #4 finished the banana.</p> <p>The Program Supervisor, who was present during the observation, stated the bare hand contact with the banana was okay as DCS A washed her hands first.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 a.m., the LPN stated staff should not be using bare hand contact with individuals' food.</p> <p>b. An observation was conducted on 4/1/14 from 6:30 - 9:15 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- At 6:44 a.m., Individual #4 was observed to use his hands to propel his wheelchair to the kitchen to obtain a cup of coffee. At 7:05 a.m., DCS C verbally cued Individual #4 to the medication administration area. Individual #4 wheeled himself to the medication area. At 7:15 a.m., Individual #4 entered the medication area with DCS C and participated in his medication administration program.</li> <li>Neither Individual #4 nor DCS C were observed to wash their hands prior to the medication administration program. DCS C did wash her hands once the program was complete and Individual #4 left the medication administration area.</li> <li>- At 7:30 a.m., Individual #2 was observed to enter the kitchen from his bedroom. DCS B</li> </ul>	W 455			

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W 455	<p>Continued From page 17</p> <p>asked Individual #2 to assist with breakfast. Individual #2 was observed to assist placing slices of bread in a toaster.</p> <p>Individual #2 was not observed to wash his hands.</p> <p>- At 7:45 a.m., DCS C verbally cued Individual #2 to the medication administration area. Individual #2 obtained a glass of juice from the kitchen and took it to the medication area with DCS C. Individual #2 participated in a medication administration program.</p> <p>Neither Individual #2 nor DCS C were observed to wash their hands prior to the medication administration program.</p> <p>- At 8:00 a.m., DCS C verbally cued Individual #5 to the medication administration area. DCS C obtained a small bowl of applesauce from the kitchen and took it to the medication administration area with Individual #5. Individual #5 participated in a medication administration program.</p> <p>During the program, Individual #5 dropped a pill to the counter. DCS C donned a pair of gloves, used two medication cups to scoop up the pill, and then wiped the table with a sanitizing wipe. DCS C removed the gloves and disposed of them, then continued to assist Individual #5 with his medication administration program.</p> <p>Neither Individual #5 nor DCS C were observed to wash their hands prior to the medication administration program. Additionally, DCS C was not observed to wash her hands after removing her gloves.</p>	W 455			

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W 455	<p>Continued From page 18</p> <p>- At 8:13 a.m., DCS C was observed in the kitchen. DCS C donned a pair of gloves and spread peanut butter on a 3 inch square of bread. DCS C removed the gloves and carried the peanut butter bread and a glass of milk to the medication administration area. DCS C was not observed to wash her hands. She then returned to the kitchen and verbally cued Individual #3 to the medication administration area.</p> <p>At 8:20 a.m., DCS C and Individual #3 entered the medication area where DCS C assisted Individual #3 with his medication administration program. Neither DCS C nor Individual #3 was observed to wash their hands. Additionally, after punching Individual #3's medications from their blister packs, DCS C poured the pills onto the peanut butter bread and used her bare hands to fold the bread while pushing the pills into the folded bread with her bare finger. Individual #3 then ate the folded bread.</p> <p>During an interview on 4/1/14 at 9:05 a.m., DCS C stated staff were to wash their hands between medication pass, when cooking, and after using the restroom. DCS C stated since she washed after the medication pass she did not wash at the being of the next medication pass. DCS C stated she should have washed her hands after removing gloves.</p> <p>During an interview on 4/3/14 from 8:30 - 10:20 a.m., the LPN stated staff should be washing hands prior to medication administration even if they washed at the end of the previous one. The LPN stated staff were to have individuals wash their hands prior to medication administration, and should also wash their hand after removing</p>	W 455			

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W 455	<p>Continued From page 19 gloves.</p> <p>c. During an environmental review on 4/1/14 from 10:10 - 10:30 a.m., scoops were noted to be in dry food items including, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>- A large plastic container of ground coffee</li> <li>- A 10.9 ounce container of strawberry milk mix</li> <li>- A 40.7 ounce container of chocolate milk mix</li> <li>- A large container of powdered lemonade drink mix</li> <li>- A small plastic container or Thick-It</li> <li>- A large container of Thick-It</li> </ul> <p>All of the scoops located in the containers were noted to have the handles submerged in the powdered product. It would not be possible to remove the scoops without touching the product. Additionally, any bare hand contact with the scoop handle would potentially contaminate the food product.</p> <p>The Program Supervisor, who was present during the environmental review, stated staff did not always wear gloves prior to removing the scoops from the containers.</p> <p>The facility failed to ensure infection control procedures were sufficiently implemented.</p>	W 455			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  
**PREFERRED COMMUNITY HOMES - ELK RUN**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2273 SOUTH GULL COVE PLACE  
MERIDIAN, ID 83642**

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 3/31/14 - 4/3/14.  The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Jim Troutfetter, QIDP	M 000		
MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W312.	MM197		
MM725	16.03.11.270.01(b) QMRP  The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement.  This Rule is not met as evidenced by: Refer to W159.	MM725		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data  Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W212 and W214.	MM730		

**RECEIVED**  
**APR 21 2014**  
**FACILITY STANDARDS**

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Wanda Huber*

TITLE  
*Administrator*

(X6) DATE  
*4-21-14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/03/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - ELK RUN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2273 SOUTH GULL COVE PLACE MERIDIAN, ID 83642</b>
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MM753	Continued From page 1	MM753		
MM753	16.03.11.270.02(f)(i) Locked Area  All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: refer to W382 and W383.	MM753		
MM759	16.03.11.27.02(f)(v) Medication Error  Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W369.	MM759		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio  Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769		



April 20, 2014

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

**RECEIVED**  
**APR 21 2014**  
**FACILITY STANDARDS**

RE: Elk Run, Provider #13G041

Dear Mr. Case:

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

**W159**

1. Please refer to the responses given under W212 as they relate to the facility's failure to ensure the QIDP ensured evaluation data was available to support an individual's psychiatric diagnosis.
2. Please refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' behavioral and developmental assessments contained comprehensive information.
3. Please refer to W312 as it relates to the facility's medications to control maladaptive behavior were appropriately incorporated into plans.

**W212**

1. Individual #1 is scheduled to have a revised complete Psychiatric evaluation completed which will clarify all of his diagnosis. After the completion of the revised evaluation the IDT will meet and revise his behavior assessment, IPP, BMP and consents accordingly.
2. Aspire Human Services is revising the policy and procedures to include having a full Psychiatric evaluation completed annually for all individuals in the home. Aspire Human Services is in the process of obtaining contract with an outside agency to have the evaluations completed. With the revised evaluation each individual will annually have their Psychiatric Diagnosis evaluated for accuracy.
3. After the Contract is secured, each individual will have an updated Psychiatric evaluation annually to assure that all diagnoses reflect the current status of each individual.

4. After the contract is secured and annual Psychiatric evaluations are being completed, this item will be added to the QIDP peer review sheet. Quarterly QIDP peer reviews will be completed to assure that annual Psychiatric Evaluations are completed for each individual.
5. Person Responsible: Program Manager & Program Supervisor  
Completion Date: 6/15/14

#### **W214**

1. Individual #1 and individual #2 are scheduled to have a revised complete Psychiatric evaluation completed which will clarify all of their diagnosis and which behaviors relate to which specific maladaptive behaviors that are displayed. The assessments will also clarify exactly how much sleep might be required for individual #1. After the completion of the revised evaluations the IDT will meet and revise the behavior assessments, IPP's, BMP's and consents accordingly.
2. Aspire Human Services is revising the policy and procedures to include having a full Psychiatric evaluation completed annually for all individuals in the home. Aspire Human Services is in the process of obtaining contract with an outside agency to have the evaluations completed. With the revised evaluation each individual will annually have their Psychiatric Diagnosis evaluated for accuracy.
3. After the Contract is secured, each individual will have an updated Psychiatric evaluation annually to assure that all diagnoses reflect the current status of each individual.
4. After the contract is secured and annual Psychiatric evaluations are being completed, this item will be added to the QIDP peer review sheet. Quarterly QIDP peer reviews will be completed to assure that annual Psychiatric Evaluations are completed for each individual.
6. Person Responsible: Program Manager & Program Supervisor  
Completion Date: 6/15/14

#### **W312**

1. The medication reduction plan for individual #2 has been revised to specify that his medications Zyprexa and Zyprexa PRN are used for aggression. Individual #1's PRN guidelines are being revised to include more specific instructions including the frequency of behavior and duration of behavior that will be displayed before a PRN can be given.
2. All files at the facility are being reviewed for accuracy by the Program Manager to verify accuracy as they relates to PRN guidelines and medication reduction plans. If any discrepancies are found immediate revisions will be made to the program plans.
3. Aspire Human Services in currently working with the contracted physician to change the format of psych clinic discussions. The goal is to extend the duration of psych clinic meetings so there is more time to discuss the specifics of medication plans including medication reduction plans and PRN guidelines.
4. The QIDP peer review form has been revised to include review of the mediation reduction plans and PRN guidelines. Specifically that the medication plans are accurate and that PRN guidelines include specific instructions for verifying frequency and duration of behavior is specified in all PRN guidelines.
5. Person Responsible: Program Manager & Program Supervisor

Completion Date: 6/15/14

**W336**

1. The LPN is currently in the process of completing the quarterly assessments for individuals #2 and #3.
2. All files at the facility are being reviewed to verify that quarterly nursing reviews are completed. Any nursing quarterly evaluations that are not current will be completed and put into the individual files.
3. In addition, the nursing policy is being revised to include a definition quarters defined by the calendar year. Any individual that needs a quarterly nursing evaluation will have one completed by the facility LPN at the earliest possible time
4. The facility is implementing a nursing peer review form which will be completed quarterly. The form will include specific instructions for documenting that quarterly reviews are in each individuals file.
5. Person Responsible: Director of Nursing & LPN  
Completion Date: 6/15/14

**W369**

1. The home has been given specific measuring devices to assure that Individual #3's polyethylene glycol is ~~not~~ being accurately administered.  
*Pen + vial correction by M. Case, LSW on 4.25.14 @ direction of Program Manager*
2. All individuals that receive similar medications have been reviewed and specific measuring devices are available to staff in the homes to assure that medications are given as ordered.
3. The LPN's are scheduled to receive training from the Director of Nursing in regards to assuring that appropriate measuring devices are available to all staff when giving medications that require a gram to CC conversion.
4. The facility is implementing a nursing peer review form which will be completed quarterly. The form will include specific review for assuring that staff are given the appropriate measuring devices needed for distributing medications.
5. Person Responsible: Director of Nursing & LPN  
Completion Date: 6/15/14

**W382**

1. The home has scheduled a training for all staff to give the expectation that medications are kept locked at all times.
2. The scheduled training will specifically cover the expectation that all medications are to be kept locked in the event that the staff assigned to give the medications leave the medication area and that in the event a medication is dropped or left on the counter it will be kept in a locked area until it is properly disposed of.
3. The Program Supervisor/Administrator along with the home Lead Worker will be conducting at least monthly observations in the home during medication passes to verify that all medications are kept locked up at appropriate times.

4. The Program Supervisor/Administrator and Lead Worker will document their observations and any training that are provided to prevent further instances of medications being left unlocked.
5. Person Responsible: Program Manager & Program Supervisor  
Completion Date: 6/15/14

#### **W383**

1. The home has scheduled a training for all staff to give the expectation that medication keys are always kept in the possession of the medication assigned to pass the medications.
2. To protect all individuals in the home, the staff training will specifically cover the expectation that only the staff assigned to pass the medications will possess the medication keys and that the keys will stay in the possession of the medication passer at all times.
3. The Program Supervisor/Administrator along with the home Lead Worker will be conducting at least monthly observations in the home to verify that medication keys are kept only with the medication passer and that the medication passer keeps the keys in their possession at all times.
4. The Program Supervisor/Administrator and Lead Worker will document their observations and any training that are provided to prevent further instances of the medication keys being left unattended.
5. Person Responsible: Program Manager & Program Supervisor  
Completion Date: 6/15/14

#### **W455**

1. The home has scheduled a training for all staff to help everyone that works in the facility the expectations as they relate to infection control.
2. The scheduled training will specifically cover the expectation for hand washing, glove use and scooping food when using coffee, lemonade etc.
3. The Program Supervisor/Administrator along with the home Lead Worker will be conducting at least monthly observations in the home during medication passes to verify that all infection control procedures are completed appropriately.
4. The Program Supervisor/Administrator and Lead Worker will document their observations and any training that are provided to prevent further instances of infection control concerns. .
5. Person Responsible: Program Manager & Program Supervisor  
Completion Date: 6/15/14

#### **MM197**

Please see response given under W312 as it relates to Written Plans.

#### **MM725**

Please see response given under W159.

**MM730**

Please see responses given under W212 and W214.

**MM753**

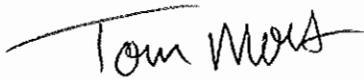
Please see responses given under W382 and W383.

**MM759**

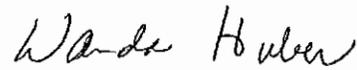
Please see response given under W369.

**MM769**

Please see response given under W455.



Tom Moss  
Program Manager  
Licensed Social Worker



Wanda Huber  
Program Supervisor  
Administrator