



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 15, 2014

Cathy Morales, Administrator
Preferred Community Homes - Milliken
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Milliken, Provider #13G053

Dear Ms. Morales:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Milliken, which was conducted on April 11, 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

Cathy Morales, Administrator
April 15, 2014
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **April 28, 2014**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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

This request must be received by April 28, 2014. If a request for informal dispute resolution is received after April 28, 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: 04/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MILLIKEN	STREET ADDRESS, CITY, STATE, ZIP CODE 7904 ARLINGTON DRIVE NAMPA, ID 83686
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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 4/7/14 - 4/11/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Jim Troutfetter, QIDP Karen Marshall, MS, RD, LD Common abbreviations used in this report are: DCS - Direct Care Staff IED - Intermittent Explosive Disorder PCLP - Person Centered Lifestyle Plan QIDP - Qualified Intellectual Disability Professional SIB - Self Injurious Behavior	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 #2 and #3) and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This failure resulted in a lack of sufficient QIDP monitoring and oversight of a newly admitted individual's programing and of an individual's behavior modifying drugs. The findings include:	W 159		

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APR 28 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cathy Meraldo Administrator</i>	TITLE	(X6) DATE <i>4/25/14</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	<p>Continued From page 1</p> <p>1. Individual #3's 12/24/13 PCLP stated he was a 17 year old male whose diagnoses included moderate intellectual disability, IED and autism. He was admitted to the facility on 11/24/13.</p> <p>The facility utilized a QIDP Tracking Form, in combination with a monthly Program Summaries form, to monitor individuals' program implementation and progress. Individual #3's record included a QIDP Tracking Form for January and February of 2014. The form documented summary data for SIB, restraint use, and sleep. However, all other programs (i.e., grooming, eating, money management, occupational therapy, physical therapy, showering, toileting, oral care, etc.) stated "No data."</p> <p>Additionally, Individual #3's record contained Program Summaries for February 2014, signed 3/13/14 by the former QIDP, which stated "No data noted for this month" under each category. No other Program Summaries or documentation related to QIDP oversight were noted in Individual #3's record.</p> <p>Individual #3's raw program data was requested and reviewed. Program data had been collected from 2/4/14 - 2/26/14 and from 3/21/14 - 3/31/14. However, this data was not reflected in the Program Summaries or on the QIDP Tracking Form.</p> <p>During an interview on 4/10/14 from 12:05 - 1:00 p.m., the Program Supervisor stated programs had been implemented when Individual #3's PCLP was completed at the end of December 2013. The Program Supervisor stated she</p>	W 159			

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W 159	Continued From page 2 reviewed data weekly and placed the data in the QIDP's box. She stated she had no connection with the data once it was placed in the QIDP's box. The Program Manager was the acting QIDP and was also present during the interview. The Program Manager stated the former QIDP should have completed summary information based upon Individual #3's data. The Program Manager stated he was not sure what happened to the missing data, but believed programs had been implemented and data collected as stated in the programs. The Program Manager stated the QIDP oversight that had been provided was not sufficient. The facility failed to ensure Individual #3 received appropriate program monitoring and oversight.	W 159		
W 312	2. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured drugs to control maladaptive behaviors were appropriately incorporated into an individual's plan. 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 a behavior modifying drug was used only as a	W 312		

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W 312	<p>Continued From page 3</p> <p>comprehensive part of an individual's PCLP that was directed specifically towards the reduction of and eventual elimination of the behavior for which the drug was employed for 1 of 3 individuals (Individual #2) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified the drug usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #2's 7/30/13 PCLP documented a 17 year old male whose diagnoses included mild intellectual disability, autism, and IED.</p> <p>Individual #2's record contained a medication reduction plan, dated 2/5/14, documenting he received Clonidine (an antihypertensive drug) 0.1 mg for sleep. The "Med [sic] Reduction Criteria" section stated Individual #2's Clonidine would be discontinued when he slept an average of 8.5 hours per night for 3 consecutive months.</p> <p>However, his record contained a Behavioral Assessment, dated 2/5/14, documenting he was currently averaging 9 hours of sleep per night.</p> <p>Additionally, the Written Informed Consent for the use of Clonidine, dated 2/14/14, documented Individual #2 was currently averaging 9 hours of sleep per night</p> <p>When asked on 4/10/14 from 12:05 - 1:00 p.m., the QIDP stated the medication reduction plan was inaccurate.</p> <p>The facility failed to ensure Individual #2's medication reduction plan was accurate.</p>	W 312			

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W 440 W 440	Continued From page 4 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. The facility's evacuation drills were reviewed and documented the following: The facility was missing an evacuation drill for the overnight shift (10:00 p.m. to 6:00 a.m.) during the 2nd quarter (April, May, and June) of 2013. During an interview on 4/10/14 from 12:05 - 1:00 p.m., the Program Supervisor stated the evacuation drills were done at shift change and should have been completed before 6:00 a.m. but were missed. The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440 W 440			
W 478	483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by:	W 478			

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W 478	<p>Continued From page 5</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals were provided a variety of foods at each meal for 1 of 3 individuals (Individual #3) observed to eat the evening meal. This resulted in an individual not being offered substitutions for primary meal items. The findings include:</p> <p>The facility's menu for Summer Week 1 was reviewed and documented the evening meal was to include the following:</p> <ul style="list-style-type: none"> - Broiled Pork Chop - Brown Rice Pilaf - Spinach Salad with dressing - Pineapple - Ice Cream - Milk <p>An observation was conducted at the facility on 4/7/14 from 5:25 - 6:10 p.m., during which time the evening meal was served. When offered, Individual #3 refused the spinach salad and the fruit. DCS A was not observed to offer Individual #3 an equivalent substitution for the salad or the fruit.</p> <p>During an interview on 4/10/14 from 12:05 - 1:00 p.m., the Program Supervisor stated Individual #3 should have been offered an equivalent substitution item when a meal item was refused.</p> <p>The facility failed to ensure Individual #3 was offered an equivalent substitution for the spinach salad and fruit menu items.</p>	W 478			
W 488	483.480(d)(4) DINING AREAS AND SERVICE	W 488			

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W 488	<p>Continued From page 6</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual ate in a manner consistent with their developmental level which directly impacted 3 of 3 individuals (Individuals #1, #3 and #5) who were observed during mealtime, and had the potential to impact all individuals residing at the facility. This failure impacted individuals' ability to learn appropriate dining skills and master the social skills involved in dining. The findings include:</p> <p>1. An observation was conducted at the facility on 4/7/14 from 5:25 - 6:10 p.m. During that time, dinner was observed. The dinner menu included broiled pork chop, brown rice pilaf, spinach salad, pineapple, ice cream and milk.</p> <p>The dining room included 2 tables. Individual #1 sat at the first table with DCS A. Individuals #3 and #5 sat at the second table with DCS B and DCS C.</p> <p>At 5:30 p.m., Individual #3 was observed to carry salad dressing from the kitchen and place it on the first table. He then placed a napkin holder on each of the tables.</p> <p>At 5:35 p.m., Individual #3 placed a plate, cup, and spoon on the second table where he sat. Individual #1 entered the dining area and sat at his place at the first table. Individual #5 sat at the second table with DCS B.</p>	W 488		

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W 488	<p>Continued From page 7</p> <p>At 5:40 p.m., DCS A placed serving dishes on the first table and took Individual #1 to the kitchen to wash his hands and obtain a plate, cup and fork. Once back at the table, DCS A placed a pork chop on Individual #1's plate. Individual #1 was not encouraged to assist in serving himself.</p> <p>At 5:45 p.m., DCS A walked between the two tables and from person to person serving pork chops, rice pilaf, spinach salad, and pears (the fruit substitution for the pineapple). No attempt was made to encourage or assist individuals to serve themselves.</p> <p>At 5:55 pm., Individual #3 completed his meal and independently cleared his place setting to the kitchen. Individual #3 returned with two cookies on a plate, ate them, then cleared the plate to the kitchen sink. DCS A offered and served Individual #1 a second pork chop. No attempt was made to have Individual #1 assist with serving his food.</p> <p>At 6:05 p.m., Individual #1 and Individual #5 cleared their place settings to the kitchen with staff assistance.</p> <p>No attempts were made to encourage individuals to engage in dining tasks such as passing serving dishes or serving themselves from the serving dishes.</p> <p>During an interview on 4/10/14 from 12:05 - 1:00 p.m., the Program Supervisor and the Program Manager both stated individuals and staff should be seated at the table, serving dishes should be passed, and individuals should be assisted to serve themselves during meals.</p>	W 488		

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W 488	Continued From page 8 The facility failed to ensure individuals were provided an opportunity to participate in independent dining skills.	W 488			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: **PREFERRED COMMUNITY HOMES - MILLIKEN**
 STREET ADDRESS, CITY, STATE, ZIP CODE: **7904 ARLINGTON DRIVE
 NAMPA, ID 83606**

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 4/7/14 - 4/11/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Jim Troutfetter, QIDP Karen Marshall, MS, RD, LD	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		
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337		
MM686	16.03.11.250.08(f) Substitutions If a resident refuses the food served, appropriate substitutions are to be offered. This Rule is not met as evidenced by: Refer to W478.	MM686		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the	MM725		

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MAY 05 2014

FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

Anthony Marcelles

Administrator

5/5/14

Bureau of Facility Standards

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MM725	<p>Continued From page 1</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to W159.</p>	MM725		



April 28, 2014

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

RECEIVED

APR 28 2014

FACILITY STANDARDS

RE: Milliken Heights, Provider #13G053

Dear Mr. Case:

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

W159

Please refer to the responses given under W312.

1. All of the existing data for individual #3 is currently being revised and program adjustments are being made based on the data collected by the direct care staff. In addition, individual #3's program plan is currently up to date and being implemented at his home.
2. All of the individuals living at the Milliken Heights home has a current Individual Program Plan and data is being collecting daily, summarized monthly and program adjustments are being made monthly based on current data.
3. Aspire Human Services is currently in the process of hiring a new QIDP and anticipates the position being filled within the next few weeks. Upon hire the new QIDP will have an assigned Mentor which will be completing a Mentor Checklist and also be available to offer support and assistance in regards to implementing program plans.
4. Aspire Human Services currently completes peer reviews to verify that QIDP books are up to date and accurate. The peer review form has been revised to include verifying that Program Plans are implemented as soon as plans are developed.
5. Person Responsible: Program Manager & QIDP
Completion Date: 6/15/14

W312

1. Individual #2's IDT has scheduled a meeting to discuss his medication Clomidine, specifically the criteria set on his medication reduction plan. The team will weigh the risk and benefits of reducing the medication compared to revising the medication reduction plan.
2. The IDT for the Milliken Heights home has scheduled a meeting to review each of the medication reduction plans to verify their accuracy. In the event that any discrepancies are identified, immediate revisions will be implemented.
3. 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 as well as helping the team set appropriate reduction criteria for any behavior modifying medications.
4. After the contract is secured and annual Psychiatric evaluations are being completed and appropriate reduction criteria is identified, 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

W440

1. Currently the Program Supervisors at Aspire Human Services are scheduling and conducting quarterly evacuation drills for each shift.
2. Aspire Human Services has a monthly checklist which is completed by the homes supervisor. The checklist has been revised to include a tracking system to document when an evacuation drill occurs.
3. In addition the monthly checklist is given to the Program Manager monthly to verify the evacuation drills are current and scheduled appropriately.
4. The Program Manager will also be tracking evacuation drills on a separate spreadsheet to avoid missing scheduled drills.
5. Person Responsible: Program Manager & Program Supervisor
Completion Date: 6/15/14

W478

1. The Program Supervisor has provided additional training to the staff in the home and currently individual #3 is being offered substitutions when he refuses items from his menu.
2. The Supervisor clarified for the staff that all individuals will be offered equivalents for salad and fruit items during meals in the event that those items are refused.
3. Additional information sheets are being created for the staff to utilize at the home to give ideas for meal substitutions. With the information the staff will have the information they need to offer appropriate substitutions during meals.

4. Currently the home is assigned a Lead Worker which assist with providing direction and oversight for the staff in the home. The Lead Worker has been assigned to perform a weekly meal observation to assure that substitutions are offered in the event that an individual refuses anything from the menu.
5. Person Responsible: Lead Worker & Program Supervisor
Completion Date: 6/15/14

W488

1. The Program Supervisor has provided additional training to the staff in the home and currently individuals #1, #3 & #5 are being offered the opportunity to participate in independent dining skills.
2. The Supervisor clarified for the staff that all individuals living in the home will be offered the opportunity to participate in independent dining skills.
3. The Program Manager and Program Supervisor are currently in the process of creating a meal observation sheet that can be utilized to verify that meals are being provided according to regulations including verifying that all individuals are being offered the opportunity to participate in independent dining skills.
4. Currently the home is assigned a Lead Worker which assist with providing direction and oversight for the staff in the home. The Lead Worker has been assigned to perform a weekly meal observation to assure that substitutions are offered in the event that an individual refuses anything from the menu.
5. Person Responsible: Lead Worker, Program Supervisor and Program Manager
Completion Date: 6/15/14

MM197

Please refer to the responses given under W312.

MM337

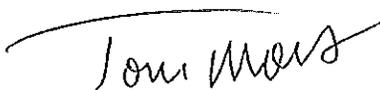
Please refer to the responses given under E440.

MM660

Please refer to the responses given under W478.

MM725

Please refer to the responses given under W159.



Tom Moss
Program Manager
Licensed Social Worker



Cathy Morales
Program Supervisor
Administrator