



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

Megan Thomas, Administrator
Preferred Community Homes - Sunset
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Sunset, Provider #13G052

Dear Ms. Thomas:

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

Megan Thomas, 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: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2014
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET			STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 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: ADHD - Attention Deficit Hyperactivity Disorder DVD - Digital Video Disc HRC - Human Rights Committee MAR - Medication Administration Record PCLP - Person Centered Lifestyle Plan QIDP - Qualified Intellectual Disability Professional	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 7 of 7 individuals (Individuals #1 - #7) whose incident and accident documentation was reviewed. This resulted in a loss of original documentation for individuals' incident and accident review forms. The findings include:	W 111		

RECEIVED
APR 28 2014
FACILITY STANDARDS

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

TITLE
Administrator

(X6) DATE
4/25/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	<p>Continued From page 1</p> <p>1. The facility utilized an Incident/Accident Report form to document accidents, significant events, injuries, injuries of unknown origin, etc. The back of the Incident/Accident Report form included an Investigation Report to be completed as part of the facility's process of detecting potential abuse, neglect and mistreatment.</p> <p>An entrance conference was held on 4/7/14 at 9:30 a.m. At that time, the facility's Incident/Accident Report forms were requested.</p> <p>At 10:16 a.m., the Program Supervisor informed the survey team there would be a delay in providing the Incident/Accident Report forms. The Program Supervisor stated she completed the Investigation Report section of the forms on the computer. However, due to a problem with her computer all Investigation Reports completed since November 2013 had been lost. The Program Supervisor stated she had attempted to have the facility's Information Technology staff recover the data, but was unsuccessful. The Program Supervisor stated she was recreating the Investigation Reports based on training notes from corrective action taken, but did not have the original information related to how the reports/investigations were completed.</p> <p>Incident/Accident Reports for Individuals #1 - #7 were reviewed on 4/8/14. Investigation information for November 2013 - April 2014 for all 7 individuals was dated in April 2014.</p> <p>During an interview on 4/10/14 from 1:10 - 1:50 p.m., the Program Manager stated the Investigation Reports could be completed by computer, but the expectation was to have them printed within a 5 day period and attached to the</p>	W 111			

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W 111	Continued From page 2 Incident/Accident Report forms. The Program Manager stated the reports should not have been stored on a computer.	W 111			
W 137	The facility failed to ensure Investigation Reports for the Incident/Accident Reports were printed in a timely fashion and maintained as part of Individuals #1 - #7's permanent records. 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure individuals had access to personal possessions for 3 of 4 individuals (Individuals #1 - #3) reviewed. This resulted in individuals not having access to their personal possessions. The findings include: 1. An observation was conducted on 4/8/14 from 6:30 - 8:00 a.m. During that time individuals' MARs for April 2014 were reviewed. Individual #1 and Individual #2's MARs both included a notation to give them their eyeglasses on the a.m. shift and take them back on the p.m. shift. Record reviews were conducted for both Individual #1 and Individual #2. Neither record contained documentation related to a need to restrict access to eyeglasses.	W 137			

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W 137	<p>Continued From page 3</p> <p>During an interview on 4/10/14 from 1:10 - 1:50 p.m., the Program Supervisor stated eyeglasses for both Individual #1 and Individual #2 were locked up in the medication cabinet at night and given to them in the morning. The Program Supervisor stated the eyeglasses were locked because Individual #1 would misplace her eyeglasses. It was not clear why Individual #2's eyeglasses were locked. The Program Manager, who was also present during the interview, stated the eyeglasses should not be locked without cause.</p> <p>The facility failed to ensure Individual #1 and Individual #2 had unrestricted access to their eyeglasses.</p> <p>2. Individual #3's PCLP, dated 3/21/14, documented a 19 year old female whose diagnoses included mild intellectual disability, autism, and ADHD.</p> <p>During an environmental observation on 4/8/14 from 10:20 - 10:52 a.m., Individual #3's DVD player and head phones were noted to be locked in a closet in the dining area. The Program Supervisor, who was present during the observation, stated the DVD player and head phones belonged to Individual #3, but were kept locked because she would use them 24/7 and would become over stimulated.</p> <p>When asked in an interview on 4/10/14 from 1:10 - 1:50 p.m., the Program Supervisor stated the locking of Individual #3's DVD player and head phones should have been incorporated in a reinforcement program, but had not.</p> <p>The facility failed to ensure Individual #3's right to</p>	W 137			

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W 137	Continued From page 4	W 137			
W 289	<p>retain and use her DVD player and head phones was upheld.</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</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 techniques used to manage inappropriate behavior were sufficiently incorporated into a program plan for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in an individual's personal items being locked up without being incorporated in a plan. The findings include:</p> <p>1. Individual #3's PCLP, dated 3/21/14, documented a 19 year old female whose diagnoses included mild intellectual disability, autism, and ADHD.</p> <p>During an environmental observation on 4/8/14 from 10:20 - 10:52 a.m., Individual #3's DVD player and head phones were noted to be locked in a closet in the dining area. The Program Supervisor, who was present during the observation, stated the DVD player and head phones belonged to Individual #3, but were kept locked because she would use them 24/7 and would become over stimulated.</p>	W 289			

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W 289	Continued From page 5 Individual #3's record was reviewed and did not contain a reinforcement objective related to her DVD player and head phones. When asked in an interview on 4/10/14 from 1:10 - 1:50 p.m., the Program Supervisor stated it should have been incorporated in a reinforcement program, but had not. The facility failed to ensure techniques to manage Individual #3's maladaptive behaviors were sufficiently incorporated into her PCLP.	W 289		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure individuals were taught to use and make informed decisions regarding adaptive equipment for 2 of 4 individuals reviewed (Individuals #1 and #2) who required eyeglasses. This resulted in a lack of plans being developed and implemented related to individuals' eyeglass needs. The findings include: 1. An observation was conducted on 4/8/14 from 6:30 - 8:00 a.m. During that time individuals' MARs for April 2014 were reviewed. Individual #1	W 436		

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W 436	<p>Continued From page 6 and Individual #2's MARs both included a notation to give them their eyeglasses on the a.m. shift and take them back on the p.m. shift.</p> <p>Record reviews were conducted for both Individual #1 and Individual #2. Neither record contained plans related to their eyeglasses or how to care for them.</p> <p>During an interview on 4/10/14 from 1:10 - 1:50 p.m., the Program Supervisor stated eyeglasses for both Individual #1 and Individual #2 were locked up in the medication cabinet at night and given to them in the morning. The Program Supervisor stated neither Individual #1 or Individual #2 had plans in place to teach them proper care of their eyeglasses.</p> <p>The facility failed to ensure Individual #1 and Individual #2 had plans related to the appropriate care of their eyeglasses.</p>	W 436			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

PREFERRED COMMUNITY HOMES - SUNSET **7591 BIRCH LANE**
NAMPA, ID 83686

(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 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 W289.	MM197		
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209		
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429		

RECEIVED
APR 28 2014
FACILITY STANDARDS

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

Megan Thomas

TITLE

Administrator

(X6) DATE

4/25/14

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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MM537	<p>16.03.11.210.01(b) Documentary Evidence</p> <p>Documentary evidence of the resident's progress and of his response to his habilitation program; This Rule is not met as evidenced by: Refer to W111.</p>	MM537		

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APR 28 2014

FACILITY STANDARDS



April 28, 2014

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

RE: Sunset Oaks, Provider #13G052

Dear Mr. Case:

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

W111

1. All of the incident reports for the Sunset Oaks home are currently in the record and up to date and there are currently no incident reports being stored on the computer.
2. Aspire Human Services has provided training to all Program Supervisors in regards to storage of reports and given the expectation that all reports are printed and kept in the file for review and that it is expected that all incident reports are completed and printed within a 5 day period.
3. Aspire Human Services has placed a protective measure in which it is clarified that the Program Manager will review all incident reports at least quarterly to assure they are adequately completed and in the file for review.
4. The Program Manager will review all incident reports at least quarterly and document on the incident report the date that the report was reviewed. In the event that errors are identified such as the back of the report not being printed off, the Program Manager will take corrective action with the Program Supervisor.
5. Person Responsible: Program Manager & Program Supervisor
Completion Date: 6/15/14

W137

1. At this time the eyeglasses for individual #1 and individual #2 are not being locked up at night while they are sleeping. Individual #3 currently has full access to her DVD player which was previously utilized as a reinforcement item.

2. Aspire Human Services has scheduled a team meeting to discuss each individual living in the home. The goal of the meeting is to discuss potential rights violations that are not addressed as part of a program plan. This could include glasses for individual's #1 and #2 and reinforcement items such as the DVD player for individual #3. The team will formulate a plan based on current assessments.
3. Aspire Human Services has revised the QIDP checklist to include review of potentially restrictive practices being implemented without the restrictive items being incorporated into the Program Plan.
4. Aspire Human Services will be completing the QIDP peer review quarterly. One part of the peer review will include a review of potentially restrictive practices that are not incorporated into the Program Plan.
5. Person Responsible: Program Supervisor, QIDP & Program Manager
Completion Date: 6/15/14

W289

1. Individual #3 currently has full access to her DVD player and headphones which was previously utilized as a reinforcement item.
2. Aspire Human Services has scheduled a team meeting to discuss each individual living in the home. The goal of the meeting is to discuss potential rights violations that are not addressed as part of a program plan. This could include reinforcement items such as the DVD player and headphones for individual #3. The team will formulate a plan based on current assessments.
3. Aspire Human Services has revised the QIDP checklist to include review of potentially restrictive practices being implemented without the restrictive items being incorporated into the Program Plan.
4. Aspire Human Services will be completing the QIDP peer review quarterly. One part of the peer review will include a review of potentially restrictive practices that are not incorporated into the Program Plan.
5. Person Responsible: Program Supervisor, QIDP & Program Manager
Completion Date: 6/15/14

W436

1. At this time the eyeglasses for individual #1 and individual #2 are not being locked up at night while they are sleeping.
2. Aspire Human Services has scheduled a team meeting to discuss each individual living in the home. The goal of the meeting is to discuss potential rights violations that are not addressed as part of a program plan and develop training programs in the event that rights are being violated. This could include glasses for individual's #1 and #2. The team will formulate training plans based on current assessments.
3. Aspire Human Services has revised the QIDP checklist to include review of potentially restrictive practices being implemented without the restrictive items being incorporated into the Program

Plan, specifically that individuals are being trained on how to care for personal items such as glasses.

4. Aspire Human Services will be completing the QIDP peer review quarterly. One part of the peer review will include a review of potentially restrictive practices that are not incorporated into the Program Plan and verifying that training plans have been developed into the plan.

5. Person Responsible: Program Supervisor, QIDP & Program Manager
Completion Date: 6/15/14

MM197

Please see response given under W289.

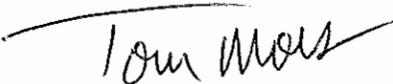
MM209

Please see response given under W137.

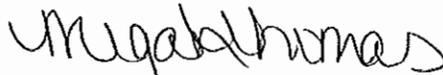
MM429

Please see response given under W436.

Please see response given under W111.



Tom Moss
Program Manager
Licensed Social Worker



Megan Thomas
Program Supervisor
Administrator