



IDAHO DEPARTMENT OF
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May 30, 2014

Mike Norris, Administrator
Preferred Community Homes - Courtyard
12553 W Explorer Dr Suite 190
Boise, ID 83713

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

Dear Mr. Norris:

On **May 28, 2014**, a complaint survey was conducted at Preferred Community Homes - Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006498

Allegation #1: The facility does not have sufficient numbers of trained staff to address individuals' care and behavioral needs.

Findings #1: An unannounced on-site complaint investigation was conducted from 5/27/14 - 5/28/14. During that time observations, review of accident/injury reports, investigations for abuse and neglect, illness reports, as-worked schedules, staff training documentation and individual records, and staff and individual interviews were conducted with the following results:

The facility housed 5 individuals who functioned in the mild to profound level of intellectual disability. The facility's accident/injury reports and investigations for abuse and neglect, from 4/23/14 - 5/27/14, were reviewed. The records documented incidents of maladaptive behaviors, such as elopement and client-to-client contact, that had been addressed, redirected, or diverted by staff present at the time of the incidents. None of the documentation indicated a lack of sufficient trained staff to meet individuals' needs.

One investigation documented an individual eloped from the facility during a shift change and was out of sight of facility staff for several minutes prior to being located. However, the investigation documented the facility had taken appropriate corrective action to address the issue and prevent further occurrences. Additionally, the implementation of the documented corrective action was witnessed during an observation on 5/27/14 from 2:05 - 3:10 p.m.

Observations were conducted at the facility on 5/27/14 from 2:05 - 3:10 p.m. and 4:05 - 5:00 p.m., and on 5/28/14 from 7:00 - 7:45 a.m. During those times, sufficient direct care staff were observed to be present to meet individuals' needs, including activities of daily living and addressing observed maladaptive behaviors.

For example, during the observation on 5/27/14 from 2:05 - 3:10 p.m., one individual was observed sitting on the couch. A second individual attempted to lean over and kiss the first individual. The direct care staff working with the second individual immediately stepped in between the individuals to prevent contact and redirected the second individual to an activity in another location.

The facility's as-worked schedules, from 5/1/14 - 5/27/14, were reviewed and documented the facility consistently had 3 direct care staff working the a.m. shift (6:00 a.m. - 2:00 p.m.) with 1 staff leaving after all of the individuals were at school. This left 2 direct care staff with 1 individual for the remainder of the shift.

The as-worked schedules documented 4 to 6 direct care staff worked each p.m. shift (2:00 - 10:00 p.m.) with 1 staff leaving after 2 of the individuals were in bed, from 5/6/14 to 5/27/14. Prior to 5/6/14, only 3 direct care staff were present for some p.m. shifts. During an interview on 5/28/14 at 7:55 a.m., the acting Program Supervisor stated an increase in staff was made on the p.m. shift to accommodate individuals' needs and increased activities.

The records of 3 individuals were selected for review. No issues related to a lack of sufficient trained staff to meet individuals needs were identified.

Additionally, the facility's behavior data and health status reports, from 5/1/14 - 5/27/14, for all individuals were reviewed. None of the documentation showed a lack of sufficient trained staff to address individuals' maladaptive behaviors or care needs.

Further, the facility's staff training documentation was reviewed and showed ongoing training, including training regarding notification of administration, and prevention and intervention for individuals' maladaptive behaviors, was being conducted.

During the course of the survey, 7 direct care staff were interviewed across all shifts, including fill-in staff. All staff stated they had been trained on individuals' programs prior to working with the individuals. All staff stated there were sufficient staff on duty during all shifts to address individuals' needs and maladaptive behaviors.

Additionally, 2 individuals residing at the facility were interviewed. Neither individual indicated a concern related to numbers of trained staff present to meet their needs.

Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff do not document and report individuals' maladaptive behaviors.

Findings #2: An unannounced on-site complaint investigation was conducted from 5/27/14 - 5/28/14. During that time observations, review of behavioral data, and staff interviews were conducted with the following results:

Observations were conducted at the facility on 5/27/14 from 2:05 - 3:10 p.m. and 4:05 - 5:00 p.m., and on 5/28/14 from 7:00 - 7:45 a.m. During those times, maladaptive behaviors that were observed were noted to be documented.

For example, during the observation on 5/27/14 from 2:05 - 3:10 p.m., one individual was observed sitting on the couch. A second individual attempted to lean over and kiss the first individual. The direct care staff with the second individual immediately stepped in between the individuals to prevent contact and redirect the second individual to an activity in another location. The incident was noted to be documented by the direct care staff.

During the same observation, another individual was observed to engage in spitting behavior. The staff working with the individual was observed to track and document the maladaptive behavior.

The facility's accident/injury reports and investigations for abuse and neglect, from 4/23/14 - 5/27/14, were reviewed. The records documented incidents of maladaptive behaviors, such as elopement and client-to-client contact, that had been reported. One report included delayed administrator notification. However, in-service records showed staff were re-trained on reporting requirements.

The facility's behavior data, from 5/1/14 - 5/27/14, for all individuals were reviewed. All of the data documented appropriate reporting had been completed.

Further, the facility's staff training documentation was reviewed and showed ongoing training related to individuals' maladaptive behaviors and reporting requirements was being conducted.

During the course of the survey, 7 direct care staff were interviewed across all shifts, including fill-in staff. All staff were able to indicate when incidents needed to be reported to management staff.

Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Management and nursing staff are not available.

Findings #3: An unannounced on-site complaint investigation was conducted from 5/27/14 - 5/28/14. During that time observations, review of accident/injury reports, health status reports and nursing notes, and staff interviews were conducted with the following results:

Upon entrance, on 4/27/14 at 1:35 p.m., the facility's Qualified Intellectual Disabilities Professional (QIDP) and a QIDP from a sister facility in another town were present at the facility. When asked during the entrance conference, the QIDP from the sister facility stated he was assisting with training of the facility's QIDP, and was providing on-site support as needed.

When asked during the entrance conference about staffing patterns, the facility's QIDP stated management staff were present daily. The QIDP stated he or the facility's Program Supervisor were generally present. Because the Program Supervisor was still in training, an acting Program Supervisor from another town was also present approximately 4 days a week to provide training and support.

When asked about nursing staff, the QIDP stated the facility's nurse was present 3 - 4 days per week and was available on-call 24/7. If an emergency situation arose, staff were to take individuals to the Emergency Department or call 911.

Approximately 30 minutes after entrance, the facility's Licensed Practical Nurse (LPN) was noted to arrive at the facility, as was the facility's acting City Director. The facility's Program Manager and State Director arrived later in the day.

Observations were conducted at the facility on 5/27/14 from 2:05 - 3:10 p.m. and 4:05 - 5:00 p.m., and on 5/28/14 from 7:00 - 7:45 a.m. During those times, management staff in the form of the QIDP, Program Supervisor, or acting Program Supervisor were observed to be present. Additionally, the LPN was in and out of the facility.

The facility's as-worked schedules were reviewed, from 5/1/14 - 5/27/14, and documented the Program Supervisor and acting Program Supervisor were present on the floor no less than 6 days per week.

The facility's accident/injury reports were reviewed from 4/23/14 - 5/27/14. None of the reports documented inability to reach management or nursing staff for notifications.

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Additionally, the facility's health status reports from 5/1/14 - 5/27/14 were reviewed. None of the reports documented an inability to reach nursing staff for notification. Additionally, 3 individuals were selected for review. All 3 individuals' nursing notes documented appropriate nursing involvement. For example, one individual's record documented he had vomited 2 times during the graveyard shift on 5/21/14. The notes documented direct care staff contacted the LPN, who in turn contacted the facility's Registered Nurse (RN) for consultation. Additionally, the LPN, RN, and management staff met the following morning and consulted with the individual's mother and physician, reviewed diet orders, and ordered a swallowing evaluation to ensure the individual's medical needs were being met.

During the course of the survey, 7 direct care staff were interviewed across all shifts, including fill-in staff. All staff stated management staff in the form of the QIDP, Program Supervisor, or acting Program Supervisor were generally at the facility on a daily basis. One direct care staff stated she was not sure the QIDP or Program Supervisor had days off as they were at the facility daily, even if only for a few hours on their scheduled days off. All direct care staff stated management staff were always available by phone.

Additionally, all direct care staff stated the LPN was at the facility anywhere from 3 - 4 days a week and was always available by telephone. All direct care staff stated if the nurse did not answer her phone, a voicemail could be left and she returned the call within minutes.

Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt