



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

July 2, 2014

Jonathon Daltow, Administrator  
Preferred Community Homes - Fieldstone  
12553 W Explorer Dr Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Mr. Daltow:

This is to advise you of the findings of the complaint survey of Preferred Community Homes - Fieldstone, which was conducted on June 26, 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Jonathon Daltow, Administrator  
July 2, 2014  
Page 2 of 2

6. Include dates when corrective action(s) 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 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 **July 15, 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:

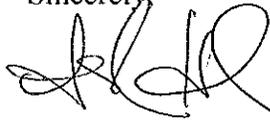
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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 July 15, 2014. If a request for informal dispute resolution is received after July 15, 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, option 4.

Sincerely,



ASHLEY HENSCHEN  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pmt  
Enclosures



8/8/14

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

RE: Fieldstone, Provider #13G030

Dear Ashley Henscheid:

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

RECEIVED

AUG 20 2014

FACILITY STANDARDS

**W112**

1. All of the incident reports for the Fieldstone home are currently in the record and being stored at the company office.
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 maintained at the company office.
3. Aspire Human Services has placed a protective measure in which it is clarified that Incident and Accident reports are stored in the Program Managers office at the company office. The office is secured with a security system in which the City Director is immediately notified in the event that the alarm is set off.
4. The Program Manager will verify that the incident and accident reports are kept safe by verifying their whereabouts each workday since the reports will be kept at the company office. This will typically occur each Monday – Friday.
5. Person Responsible: LPN & Program Supervisor  
Completion Date: 8/15/14

**W149**

1. Currently the QIDP and LPN are reviewing ABC data sheets and Health Status sheets to verify that incidents and health issues are being tracked correct forms according to policy. On 7/24/14 there is a scheduled training and the LPN's, QIDP's and Program Supervisors will be provided with additional training in relation to reviewing the logs and health status sheets weekly to verify that incidents are captured on the correct forms. In addition, all of the staff in the home are being re-trained to assure that they completely understand practices related to what is to be documented on an ABC data sheet, Health Status form and Incident and Accident form.

2. After the training on 7/24/14 has occurred all behavior logs and Health Status sheets will be reviewed weekly to verify that an I and A is not needed. If an I and A is needed the home Administrator will be notified immediately to address the concern.
3. At least weekly the LPN and QIDP will review as part of their responsibilities each Health Status sheets and ABC data sheets to verify that the appropriate forms have been completed and contact the Program Supervisor if an Incident and Accident form needs completed.
4. Weekly when nursing notes are made and ABC data sheets are reviewed the LPN's and QIDP's will sign and date the logs to document they have been reviewed. A note will also be made if the form required an Incident and Accident form to be completed. This note will be attached to the Incident & Accident report and monitored by the Program Supervisor.
5. Person Responsible: LPN, QIDP & Program Supervisor  
Completion Date: 8/29/14

Please see the response given under W154 as it relates to Staff Treatment of Clients.

#### **W154**

1. All of the incident reports at the Fieldstone home have been completed and are up to date. All of the incident reports for the Fieldstone home are currently in the record and being stored at the company office. Specifically, they are kept in the Program Managers office. With the reports being kept at the company office they can be reviewed by the Program Manager on a weekly basis to verify accuracy and timely completion.
2. Aspire Human Services has provided training to all Program Supervisors in regards to completing all investigations within 5 working days.
3. Aspire Human Services has placed a protective measure in which it is clarified that Incident and Accident reports are stored in the Program Managers office at the company office. The office is secured with a security system in which the City Director is immediately notified in the event that the alarm is set off. With the storage of the reports at the company office they can be reviewed weekly to verify accuracy and timely completion.
4. The Program Manager will verify that all incident reports are kept up to date and are complete on a weekly basis since the reports will be kept at the company office.
5. Person Responsible: Program Manager & Program Supervisor  
Completion Date: 8/15/14

#### **W252**

1. Currently the QIDP and LPN are reviewing ABC data sheets and Health Status sheets to verify that incidents and health issues are being tracked on correct forms according to policy. On 7/24/14 there is a scheduled training and the LPN's, QIDP's and Program Supervisors will be provided with additional training in relation to reviewing the logs and health status sheets weekly to verify that incidents are captured on the correct forms.

2. After the training has occurred all Health Status sheets will be reviewed weekly to verify that an ABC data sheet is not needed. If an ABC data sheet is required the home Program Supervisor will be notified immediately to address the concern.
3. On a weekly basis the LPN will be reviewing each Health Status Sheet. During the review the LPN will verify that the concern is captured on the correct form and that an ABC data sheet is not needed. If the LPN identifies that an ABC data sheet needs completed they will contact the QIDP and Program Supervisor to address the concern.
4. At least weekly the Health Status sheets will be monitored by the LPN. When reviewed the LPN will document this by signing the document. A note will also be made if the form required an ABC data sheet form to be completed. This note will be attached to the ABC data sheet and monitored by the Program Supervisor.
5. Person Responsible: LPN, QIDP & Program Supervisor  
Completion Date: 8/15/14

#### **W280**

1. Aspire Human Services is currently in the process of creating a specific policy and procedure for emergency restraints.
2. All individuals living with Aspire Human Services will be served under the revised emergency restraint policy and procedure.
3. Once the policy and procedure for Emergency Restraints has been written, all Program Supervisors will receive training and the policy will immediately take effect.
4. An incident report will be created for each emergency restraint. Once the report is created, each emergency restraint will be immediately reported to the Program Supervisor and an investigation will be initiated. All incident reports will be tracked and trended including reports of emergency restraints.
5. Person Responsible: Program Manager  
Completion Date: 8/15/14

Please see the response given under W299 as it relates to authorization of emergency restraints. .

#### **W299**

1. Aspire Human Services is currently in the process of creating a specific policy and procedure for emergency restraints.
2. All individuals living with Aspire Human Services will be served under the revised emergency restraint policy and procedure.

3. Once the policy and procedure for Emergency Restraints has been written, the Program Supervisor and direct care staff will receive training and the policy will immediately take effect.
4. An incident report will be created for each emergency restraint. Once the report is created, each emergency restraint will be immediately reported to the Administrator and an investigation will be initiated. All incident reports will be tracked and trended including reports of emergency restraints. In addition, all incident reports are kept in the Program Managers office and reviewed weekly to verify accuracy and completion.
5. Person Responsible: Program Manager  
Completion Date: 8/31/14

### W365

1. All staff in the home have been re-trained on accurately documenting the response from an individual when given a PRN medication. Individual #5 will be scheduled for the next available psych clinic to have his medications reviewed for accuracy. During the meeting the team will compare his documented displayed behavior and compare this to his current medications. The team will recommend and implement changes at this time.
2. Aspire Human Services has created a standard pre-psych clinic procedure to be utilized for all recommended medication adjustments including PRN medications. The team will utilize the form for all individuals that receive behavior modifying medications including PRN medications. The procedure includes procedural instructions for reviewing the past PRN usage and results of the PRN medication. If at this time the team feels that the data is inaccurate the Program Supervisor will provide additional training for the staff on how to accurately document PRN usage. This training will be kept at the home in the training records.
3. Aspire Human Services has created a standard pre-psych clinic procedure be utilized for all recommended medication adjustments. One part of the checklist includes reviewing the actual raw data including reviewing the back of the MAR sheets prior to implementing adjustments and verifying that it is accurate before medication adjustments are implemented. The procedure clarifies that the LPN will bring the MAR sheets to the team discussion for review when team decisions are made for all PRN medication adjustments.
4. Aspire Human Services will be completing the QIDP peer review quarterly. One part of the peer review will include a review that all documentation was considered before behavior modifying medications were implemented. A section has been added to the peer review form to capture if the MAR sheets were reviewed prior to implementing revisions to PRN medications.
5. Person Responsible: Program Manager  
Completion Date: 8/29/14

**MM170** – Please review the response given for W154.

**MM177** – Please review the response given for W149.

**MM179** – Please review the response given for W280.

**MM199** – Please review the response given for W112.

**MM380**

The repairs listed in the survey report are currently being repaired by the facilities maintenance person. Currently the facility maintenance person has been given a schedule in which to meet each Program Supervisor at least weekly at each facility. During the scheduled times the Maintenance Person and Program Supervisor will identify the needs of the home so appropriate repairs can be made. At least quarterly the facility maintenance person will complete a facility inspection and submit it to the City Director and Program Manager so repairs can be identified and scheduled.

Person Responsible: Maintenance, Program Manager and City Director  
Completion Date: 8/15/14

**MM428**

The facility is in the process of implementing water checks one time daily to verify that temperatures are between 105 – 120 degrees. The direct care staff in the home will be completing the water temperature checks. In the event that the water temperature is out of range the facility maintenance person will immediately be notified so the appropriate adjustments can be made. A log will be kept that documents temperatures daily and any repairs that are made to the water system to maintain hot water temperatures between 105 – 120 degrees.

Person Responsible: Maintenance, Program Manager and City Director  
Completion Date: 8/15/14

**MM558** – Please review response given for W299.

**MM561** – Please review response given for W252.

**MM570** – Please review response given for W365.



Tom Moss  
Program Manager  
Licensed Social Worker

Jonathon Daltow  
Program Supervisor  
Administrator

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/26/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642	
(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 complaint survey conducted from 6/23/14 to 6/26/14.  The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Jim Troutfetter, QIDP  Common abbreviations used in this report are: ABC - Antecedent, Behavior, Consequences AOD - Administrator On Duty ER - Emergency Room I&A - Incident/Accident Report LPN - Licensed Practical Nurse PRN - As needed QIDP - Qualified Intellectual Disability Professional	W 000		
W 112	483.410(c)(2) CLIENT RECORDS  The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.  This STANDARD is not met as evidenced by: Based on review of Incident/Accident Reports and staff interview, it was determined the facility failed to ensure records were maintained in a secure manner for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in portions of individuals' records being stored in the Program Supervisor's home. The findings include:  1. During the entrance conference at the facility's corporate office, on 6/23/14 at 8:35 a.m., the facility's Incident/Accident Reports were	W 112		

RECEIVED

JUL 15 2014

FACILITY STANDARDS

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

TITLE

(X6) DATE

*Tom Mous*

Program Manager 7/11/14

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.

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/26/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642		
(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 112	Continued From page 1 requested. The Program Manager stated the documents would be at the facility with the QIDP.  Upon entrance at the facility, on 6/23/14 at 9:32 a.m., the QIDP stated he did not have the Incident/Accident Reports. He stated the reports were at the Program Supervisor's house.  At 10:22 a.m. on 6/23/14, the Program Manager arrived at the facility with the Incident/Accident Reports. He stated he spoke with the Program Supervisor about not taking the reports home.  The Incident/Accident Reports from 1/27/14 - 6/23/14 were reviewed. The reports included documented incidents for each individual in the facility, Individuals #1 - #6.  During an interview on Tuesday, 6/24/14 from 10:00 - 10:13 a.m., the Program Supervisor stated he assisted with a company job fair before the weekend. The Program Supervisor stated he took the reports home with him after the fair, however, it was not normal practice.	W 112			
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.  This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention	W 149			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	<p>Continued From page 2</p> <p>and detection of abuse, neglect and mistreatment were sufficiently implemented and monitored. This failure directly impacted 6 of 6 individuals (Individuals #1- #6) for whom significant events occurred. This resulted in a lack of investigation and comprehensive documentation of incidents of potential abuse, neglect and mistreatment. The findings include:</p> <p>1. The facility's Incident and Accident Reporting policy, dated 7/15/12, documented direct care staff were to record incidents including, but not limited to, "Client injury due to an incident" and "Client abuse, neglect, mistreatment or exploitation" on an Incident/Accident Report. The policy defined "Client injury due to an incident" as "Any injury to a client due to the actions of themselves and/or another..." Additionally, the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, documented self-abuse "includes but is not limited to intentional injury to oneself resulting in tissue damage, head banging..." The policies were not implemented and monitored, as follows:</p> <p>a. Individual #5's Client Emergency Information sheet, dated 6/26/16 [sic], documented he was a 22 year old male whose diagnoses included moderate intellectual disability. Individual #5's ABC Behavior Logs from 1/27/14 - 6/23/14 were reviewed. Individual #5's behavior logs documented incidents for which no corresponding Incident/Accident Report could be found, as follows:</p> <p>- An ABC Behavior Log, dated 2/7/14 and timed 8:10 p.m., documented Individual #5 "hit himself in head 15+ times. Headbuded [sic] a staff in the noise [sic]."</p>	W 149			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	<p>Continued From page 3</p> <p>- An ABC Behavior Log, dated 2/15/14 and timed 9:50 p.m., documented Individual #5 "bit hands x 50 hit head x 20..."</p> <p>- An ABC Behavior Log, dated 4/8/14 at 5:00 p.m., documented "I cued &amp; tried redirecting [Individual #5] on last attempt he hit his head w/closed fist lightly."</p> <p>- An ABC Behavior Log, dated 4/14/14 at 7:00 p.m., documented Individual #5 "hit his forehead w/o [without] force..." and later during the incident "...hit head then hit me..."</p> <p>When asked about the documentation during an interview on 6/26/14 from 10:05 - 10:47 a.m., the Program Manager stated the incidents should have been documented on Incident/Accident Reports.</p> <p>b. Individual #6's Client Emergency Information sheet, dated 5/14/14, documented he was a 22 year old male whose diagnoses included moderate intellectual disability. Individual #6's ABC Behavior Logs from 1/27/14 - 6/23/14 were reviewed. Individual #6's behavior logs documented incidents for which no corresponding Incident/Accident Report could be found, as follows:</p> <p>- An ABC Behavior Log, dated 2/25/14 and untimed, documented Individual #6 "Scratched the right side of his face."</p> <p>- An ABC Behavior Log, dated 4/27/14 at 7:30 a.m., documented Individual #6 "hit himself in the face closed handed x 2 &amp; in the face with his glasses."</p>	W 149			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	<p>Continued From page 4</p> <p>- An ABC Behavior Log, dated 5/7/14 at 6:30 p.m., documented Individual #6 "tried to bite himself on his right forearm and it left a small mark. He lightly punched himself in the left eye which left no mark."</p> <p>When asked about the documentation during an interview on 6/26/14 from 10:05 - 10:47 a.m., the Program Manager stated the incidents should have been documented on Incident/Accident Reports.</p> <p>c. Individual #1's record documented he was a 26 year old male whose diagnoses included severe intellectual disability, autism, and mood disorder.</p> <p>His record contained a Health Status Report, dated 2/13/14, documenting he had bite marks and a dime-sized bruise on his left bicep.</p> <p>However, his record did not contain a corresponding Incident/Accident Report as required by the facility.</p> <p>When asked during an interview on 6/26/14 from 10:05 - 10:47 a.m., the QIDP stated the injuries noted in the Health Status Report should have been recorded on an Incident/Accident Report.</p> <p>d. Individual #4's record documented he was a 19 year old male whose diagnoses included mild intellectual disability, autism, and mood disorder.</p> <p>His record contained a Health Status Report, dated 4/25/14, documenting he had one minor cut on his right thumb and one minor cut on his left "pinkey."</p>	W 149			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	<p>Continued From page 5</p> <p>However, his record did not contain a corresponding Incident/Accident Report.</p> <p>When asked during an interview on 6/26/14 from 10:05 - 10:47 a.m., the QIDP stated the injuries noted in the Health Status Report should have been recorded on an Incident/Accident Report.</p> <p>The facility failed to ensure incidents and accidents were documented as indicated in policy.</p> <p>2. The facility's Incident and Accident Reporting policy, dated 7/15/12, documented "Nursing will review all Incident/Accident forms daily (Monday - Friday). On weekends, the Nurse on Duty (weekends) [sic] will be contacted. The LPN will note any instruction to staff in the designated area and sign/date the form...Follow up to the Incident/Accident will be noted in the nursing notes..." The policy was not implemented and monitored, as follows:</p> <p>Incident/Accident Reports from 1/27/14 - 6/23/14 were reviewed. The reports included incidents for which nursing instructions, follow-up and/or signature could not be found. Examples included, but were not limited to:</p> <ul style="list-style-type: none"> <li>- An Incident/Accident Report, dated 2/27/14 and timed 2:45 p.m., documented Individual #1 "drank 2 sips of bleach water." The instructions documented "2 [sic] call [Program Supervisor] - call her [Nurse on Duty] back w/what [Program Supervisor] says - take him to ER - Call [Nurse on Duty] back when back from Dr." No follow-up notes (e.g. the results of the phone calls, outcome of the ER visit, etc.) were included in the report. Additionally, the spaces for nursing</li> </ul>	W 149		

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	<p>Continued From page 6 signature and date were blank.</p> <p>- An Incident/Accident Report, dated 2/23/14 and timed 5:51 p.m., documented Individual #2 "hit head 3 x." No instructions, follow-up notes or nursing signature and date were included in the report.</p> <p>- An Incident/Accident Report for Individual #2, dated 3/8/14 and timed 7:05 p.m., documented "Both hands/wrists red with bite mark welts/left ankle rug burn sore/hit head x 4 with force. Open/closed hand hit face/head - made old sores bleed [right] elbow." The instructions documented "I&amp;A nero [neurological check] soap/water oitment [sic]." No follow-up notes (e.g. an updated status of the injuries) were included in the report. Additionally, the spaces for nursing signature and date were blank.</p> <p>- An Incident/Accident Report, dated 3/15/14 and timed 9:38 p.m., documented Individual #4 had "Two open blisters near toe on right foot on surface, one blister on left foot surface near ankle." The instructions documented "To apply Antibiotic Ointment. Told to file I&amp;A as well as she will get ahold of AOD." No follow-up notes (e.g. confirmation of AOD notification or an updated status of the injury) were included in the report. Additionally, the spaces for nursing signature and date were blank.</p> <p>- An Incident/Accident Report, dated 3/9/14 and timed 6:40 p.m., documented Individual #6 "Head bang [sic] on personal white board." No instructions, follow-up notes or nursing signature and date were included in the report.</p> <p>When asked during an interview on 6/23/14 from</p>	W 149		

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 149	Continued From page 7 11:05 - 11:16 a.m., the LPN stated the Incident/Accident Reports should be reviewed by nursing staff the next day with documentation in the designated spaces of the form to indicate to others that the report had been reviewed.  The facility failed to ensure injuries were addressed by nursing staff as indicated in policy.  The facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment, were sufficiently implemented and monitored.	W 149			
W 154	3. Refer to W154 as it relates to the facility's failure to ensure thorough investigations were conducted for Individual #3. 483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure a thorough investigation was conducted for all allegations of abuse, neglect, mistreatment and injuries of unknown origin. This failure impacted 1 of 6 individuals (Individual #3) involved in significant incidents. This resulted in a lack of sufficient information being available on which to base corrective action decisions. The findings include:  1. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, documented "The Company and/or	W 154			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 154	<p>Continued From page 8</p> <p>Administrator will ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are thoroughly investigated ..." The facility's Incident and Accident Reporting policy, dated 7/15/12, defined an unknown injury as "Any injury to a client for which you or the client is unaware of how it occurred."</p> <p>Individual #3's Client Emergency Information sheet, dated 6/26/14, documented she was a 24 year old female whose diagnoses included moderate intellectual disability. The facility's Incident/Accident Reports from 1/27/14 - 6/23/14 were reviewed and documented Individual #3 had two injuries of unknown origin which were not thoroughly investigated, as follows:</p> <p>a. An Incident/Accident Report, dated 5/26/14 and timed 8:20 p.m., documented Individual #3 "has bruises &amp; scratches &amp; red marks." The Incident/Accident Report included a human body outline used to indicate the location of any injuries and the entire body outline was circled. For the "Incident Type," there was a checkmark in the box next to "Unknown Injury." Additionally, the report documented "Notified AOD." However, an investigation related to the unknown injury could not be found.</p> <p>b. An Incident/Accident Report, dated 6/16/14 and timed 1:58 p.m., documented a direct care staff "Noticed a dime-sized red sore on her left inner breast." The Incident/Accident Report included a checkmark in the box next to "Unknown Injury" for the "Incident Type." The Incident/Accident Report indicated the Program Supervisor was notified. However, an investigation related to the unknown injury could</p>	W 154			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY</b> <b>MERIDIAN, ID 83642</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 9 not be found.	W 154		
W 252	<p>When asked, the City Director stated in an interview on 6/23/14 at 1:38 p.m., company investigations were always communicated to her and she was unaware of the injuries. The City Director stated the injuries had not been investigated.</p> <p>The facility failed to thoroughly investigate Individual #3's injuries of unknown origin.</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</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 data was collected and documented in measurable terms for 1 of 6 individuals (Individual #5) whose behavior data was reviewed. That failure had the potential to impede the ability of the team in evaluating the effectiveness of programmatic techniques. The findings include:</p> <p>1. The facility utilized an ABC Behavior Log to document comprehensive details of maladaptive behaviors including what preceded the behavior, if the environment was noisy, what actually occurred during the maladaptive behavior including staff interventions attempted and what happened after the individual's maladaptive behavior. Individual #5's behavior data was not</p>	W 252		

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/26/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642	
(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 252	Continued From page 10 comprehensive, as follows:  Individual #5's Client Emergency Information sheet, dated 6/26/16 [sic], documented he was a 22 year old male whose diagnoses included moderate intellectual disability. Individual #5's Health Status Reports from 1/27/14 - 6/23/14 were reviewed.  a. A Health Status Report, dated 2/9/14 and timed 8:12 p.m., documented Individual #5 received a PRN medication for "Dilated pupils [sic], hitting staff, lunging at staff, biting [sic] hand w/loud noises." However, a corresponding ABC Behavior Log could not be found.  b. A Health Status Report, dated 4/1/14 and timed 8:50 [a.m./p.m. unspecified], documented Individual #5 received a PRN medication for "aggression, hitting walls/tv, biting [sic]/pacing." However, a corresponding ABC Behavior Log could not be found.  When asked, the Program Manager stated during an interview on 6/26/14 from 10:05 - 10:47 a.m., an ABC Behavior Log should have been completed for the above incidents.  The facility failed to ensure Individual #5's behavior data was collected and documented in measurable terms.	W 252		
W 280	483.450(b)(1)(iv)(B) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  Procedures that govern the management of inappropriate client behavior must address the use of physical restraints.	W 280		

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 280	Continued From page 11  This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to ensure procedures to govern the management of inappropriate behavior comprehensively addressed the use of physical restraints. This directly impacted 1 of 6 individuals (Individuals #5) and had the potential to impact all individuals residing in the facility. The failure resulted in the potential for emergency restraints to be utilized without monitoring and oversight. The findings include:  1. The facility's Incident and Accident Reporting policy, dated 7/15/12, specified which incidents required Administrator notification as well as documentation on an Incident/Accident Report. The policy included incidents of physical restraints resulting in an injury, as well as, any client abuse, neglect, mistreatment or exploitation. The facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, included misuse of restraints, defined as "Chemical or physical control of the individual receiving services beyond physicians orders or not in accordance with accepted professional practice."  However, neither policy included procedures for when an emergency restraint in accordance with accepted professional practice was utilized before authorization could be obtained.  During an interview on 6/24/14 from 11:55 a.m. - 12:10 p.m., the Program Manager stated the company had emergency restraint procedures written in policy in the past. He stated the expectation was for direct care staff to document	W 280			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 280	Continued From page 12 emergency restraints on an Incident/Accident Report for Administrator review, as well as, immediately contact the Administrator for authorization. The Program Manager stated the Administrator needed the information to determine if emergency restraints were used appropriately or in an abusive nature. The Program Manager stated the company underwent a change of ownership and he thought the emergency restraint policy was missed in the policy changes.  The facility failed to ensure comprehensive procedures related to the use of physical restraints were included in policy.	W 280		
W 299	2. Refer to W299 as it relates to the facility's failure to ensure emergency physical restraint used for Individual #5 was authorized by the Administrator, as soon as possible. <b>483.450(d)(2)(ii) PHYSICAL RESTRAINTS</b>  Authorizations to use or extend restraints as an emergency measure must be obtained as soon as the client is restrained or stable.  This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure authorization to use emergency restraints was obtained as soon as possible for 1 of 6 individuals (Individual #5) whose behavior data was reviewed. That failure resulted in emergency restraints being utilized without monitoring and oversight. The findings include:  1. Individual #5's Client Emergency Information	W 299		

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 299	Continued From page 13 sheet, dated 6/26/16 [sic], documented he was a 22 year old male whose diagnoses included moderate intellectual disability.  Individual #5's behavior data from 1/27/14 - 6/23/14 was reviewed. Individual #5's behavior data included an ABC Behavior Log, dated 2/7/14, which documented "Staff put [Individual #5] in two emergency restraint [sic] each one lasting up to 3 mins [minutes]."  However, the log did not include documentation related to Administrator authorization.  During an interview on 6/24/14 from 11:55 a.m. - 12:10 p.m., the Program Manager stated the expectation was for direct care staff to document emergency restraints on an Incident/Accident Report for Administrator review, as well as, immediately contact the Administrator for notification. The Program Manager stated the Administrator needed the information to determine if emergency restraints were used appropriately or in an abusive nature.  The facility failed to ensure authorization for the use of emergency physical restraints was obtained as soon as possible after use with Individual #5.	W 299		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW  An individual medication administration record must be maintained for each client.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an	W 365		

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 365	<p>Continued From page 14</p> <p>accurate medication administration record was maintained for 1 of 6 individuals (Individual #5) whose medication administration records were reviewed. This resulted in an increase of an individual's behavior modifying drug without documented justification. The findings include:</p> <p>1. Individual #5's Client Emergency Information sheet, dated 6/26/16 [sic], documented he was a 22 year old male whose diagnoses included moderate intellectual disability.</p> <p>Individual #5's Health Status Reports from 2/1/14 - 6/23/14 were reviewed. A Health Status Report, dated 5/30/14, documented "[Individual #5's] PRN Olanzapine [an antipsychotic drug] has increased to 20 mg." The reports documented Individual #5 received the medication a total of nine times in the reviewed timeframe.</p> <p>Individual #5's Psychiatric Update, dated 5/29/14, was reviewed and included in the "Current Medications linked to this Diagnosis" section was Zyprexa Zydys (a brand name form of Olanzapine) 10 mg PRN. A handwritten note to the right of the order documented the medication was being increased to 20 mg PRN. The update also included a note which documented "PRN med not effective when given for anxiety/agitation."</p> <p>However, Individual #5's medication administration records from 2/20/14 - 6/23/14 were reviewed and documented each PRN administration was "effective." Additionally, Individual #5's last PRN administration was documented on 4/9/14, with no PRN needed for seven weeks prior to the medication increase.</p>	W 365			

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

PRINTED: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 365	Continued From page 15 When asked, the QIDP stated during an interview on 6/26/14 from 10:05 - 10:47 a.m., the PRN truly had been ineffective at the 10 mg dose and the medication administration records were inaccurate related to documented efficacy.  The facility failed to keep an accurate record of Individual #5's PRN medication administration.	W 365			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/26/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTC	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the complaint survey conducted from 6/23/14 to 6/26/14.  The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Jim Troutfetter, QIDP	M 000		
MM170	16.03.11.075.07(b)(ii) Method for Investigating Grievances  The facility must have a written procedure for registering and resolving grievances and recommendations by residents or any individual or group designated by the resident as his representative. The procedure must ensure protection of the resident from any form of reprisal or intimidation. The written procedure must include: A method for investigating and assessing the validity of a grievance or recommendation; and  This Rule is not met as evidenced by: Refer to W154.	MM170		
MM177	16.03.11.075.09 Protection from Abuse and Restraint  Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10).	MM177		

**RECEIVED**  
JUL 15 2014  
FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Tom Moss</i>	TITLE  <i>Program Manager</i>	(X6) DATE  <i>7/11/14</i>
--	-------------------------------------	---------------------------------

STATE FORM 6899 P9H911 # continuation sheet 1 of 6

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM177	Continued From page 1  This Rule is not met as evidenced by: Refer to W149.	MM177		
MM179	16.03.11.075.09(a)(i) Reasons for use of Restraints  The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: Orders must indicate the specific reasons for the use of restraints; and This Rule is not met as evidenced by: Refer to W280.	MM179		
MM199	16.03.11.075.11 Assurance of Confidentiality  Assurance of Confidentiality. Each resident admitted to the facility must be assured confidential treatment of his personal and medical records, and must be permitted to approve or refuse their release to any individual outside the facility except: This Rule is not met as evidenced by: Refer to W112.	MM199		
MM380	16.03.11.120.03(a) Building and Equipment  The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by:	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

MM380	<p>Continued From page 2</p> <p>Based on observation it was determined the facility failed to ensure the facility was kept in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 6/24/14 from 9:30 - 10:18 a.m. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- There was a piece of siding missing under the lower right side of Individual #2's bedroom window that was approximately 5 inches by 6 inches.</li> <li>- There was a section of siding approximately 1 foot by 1 foot that was rotting below Individual #2's bedroom window.</li> <li>- There was a section of siding approximately 1 foot by 1 foot that was rotting on the outside of the garage to the right of the side door.</li> <li>- There was a section of siding approximately 1 foot by 3 feet that was missing paint between the laundry room window and the bathroom window.</li> <li>- There was an exterior board below the front living room window that was hanging down on both sides.</li> <li>- There was approximately one-third of the caulking missing around the sink in the shared bathroom of Individuals #4 and #6.</li> <li>- There was an approximately four inch crack where repair had been attempted on the bathroom side of the door from Individual #4's bedroom to the bathroom.</li> </ul>	MM380		
-------	--	-------	--	--

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- The door to the bathroom in Individual #6's bedroom was warped on the bathroom side.</li> <li>- The door to the laundry room was cracked, approximately four inches, and had areas where repair had been attempted.</li> <li>- There was an approximately three inch diameter hole in the bedroom side of the bathroom door in Individual #2's bedroom.</li> <li>- The bathtub in the hall bathroom had linoleum peeling off at the foot of the tub and had bubbled areas with black spots on the material on the outside of the bathtub.</li> </ul> <p>The facility failed to ensure environmental repairs were completed and maintained.</p>	MM380		
MM428	<p>16.03.11.120.10(c) Temperature of hot water</p> <p>The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include:</p> <p>1. An environmental review was conducted at the facility on 6/24/14 from 9:30 - 10:18 a.m. During that time, the following water temperatures were noted:</p>	MM428		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/26/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - FIELDSTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM428	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- The water temperature in the shared bathroom of Individuals #4, #5 and #6 was noted to be 96.6 degrees Fahrenheit.</li> <li>- The water temperature in the shared bathroom of Individuals #1, #2 and #3 was noted to be 100.6 degrees Fahrenheit.</li> <li>- The water temperature in the hall bathroom utilized by Individuals #1 - #6 was noted to be 93.2 degrees Fahrenheit.</li> </ul> <p>2. A recheck of water temperatures was completed on 6/25/14 from 1:30 - 1:39 p.m. During that time, the following water temperatures were noted:</p> <ul style="list-style-type: none"> <li>- The water temperature in the shared bathroom of Individuals #4, #5 and #6 was noted to be 100 degrees Fahrenheit.</li> <li>- The water temperature in the shared bathroom of Individuals #1, #2 and #3 was noted to be 95.7 degrees Fahrenheit.</li> <li>- The water temperature in the laundry room utilized by Individuals #1 - #6 was noted to be 102.6 degrees Fahrenheit.</li> <li>- The water temperature in the hall bathroom utilized by Individuals #1 - #6 was noted to be 102.6 degrees Fahrenheit.</li> </ul> <p>When asked on 6/24/14 at 10:00 a.m., the Program Supervisor stated it was hit or miss on the hot water.</p> <p>The facility failed to ensure water temperatures were maintained between 105 and 120 degrees Fahrenheit.</p>	MM428		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/26/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - FIELDSTC	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
--	--

(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
MM558	16.03.11.210.04(b) Records of all periods of Restraint  Records of all periods of restraint, use of aversive stimuli and time out, with justification and authorization for each; and This Rule is not met as evidenced by: Refer to W299.	MM558		
MM561	16.03.11.210.04(e) Behavior Incidents  Records of significant behavior incidents; and This Rule is not met as evidenced by: Refer to W252.	MM561		
MM570	16.03.11.210.05(b) Medications and Treatments  A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W365.	MM570		



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

July 2, 2014

Jonathon Daltow, Administrator  
Preferred Community Homes - Fieldstone  
12553 W Explorer Dr Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Mr. Daltow:

On **June 26, 2014**, a complaint survey was conducted at Preferred Community Homes - Fieldstone. The complaint allegation, findings, and conclusion are as follows:

**Complaint #ID00006524**

**Allegation:** Individuals reside in an environment with unresolved mold issues, resulting in health complications.

**Findings:** An unannounced on-site complaint investigation was conducted from 6/23/14 - 6/26/14. During that time record reviews, interviews with facility staff and environmental reviews were completed with the following results:

An environmental review was conducted on 6/24/14 from 9:30 - 10:18 a.m. During the environmental review, the kitchen, bathrooms, bedrooms, living room and hallway were inspected. It was not possible to confirm the presence of mold. The facility was cited at M380 for observed environmental concerns.

On 6/23/14 from 11:18 - 11:21 a.m., an interview was conducted with the facility maintenance staff. He stated he had not needed to make any repairs to the facility related to water damage or mold.

Jonathon Daltow, Administrator  
July 2, 2014  
Page 2 of 2

On 6/23/14 and 6/24/14, interviews were conducted with nine direct care staff at the facility, whose employment duration ranged from 2 months to 10 years. Each of the nine staff stated they never had sanitation concerns related to the condition of the facility. Each stated they would tend to any environmental concerns and each were able to state the procedure for notifying maintenance if needed.

On 6/24/14 at 3:32 a.m., the Program Supervisor was interviewed. He stated the facility's back bathroom and bedrooms flooded after the toilet was clogged during a maladaptive behavior. The Program Supervisor stated the direct care staff present cleaned up the water at the time of the incident and he requested the carpets be professionally cleaned through maintenance.

The facility's repair invoices for 2014 were reviewed and documented the facility carpets were professionally cleaned on 5/21/14 and 6/2/14.

Four individuals were randomly selected to review. Nurses notes, medication administration records, physician's orders and health status forms for the four sample individuals documented there had been no health issues associated with mold or water damage.

Though flooding did occur, the issue was resolved and it could not be determined that water damage or mold remained. Therefore, the allegation was unsubstantiated due to a lack of sufficient evidence.

**Conclusion:** 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,



ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pmt