

COPY



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

**CERTIFIED MAIL: 70001670001133151781**

August 28, 2014

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

RE: Preferred Community Homes - Mallard, Provider #13G032

Dear Ms. Thomas:

Based on the Medicaid/Licensure survey completed at Preferred Community Homes - Mallard on August 14, 2014, we have determined that Preferred Community Homes - Mallard is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) **Conditions of Participation of Governing Body and Management (42 CFR 483.410)**, **Active Treatment Services (42 CFR 483.440)**, **Client Behavior and Facility Practices (42 CFR 483.450)**, **Health Care Services (42 CFR 483.460)**, and **Dietetic Services (42 CFR 483.480)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Preferred Community Homes - Mallard to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

Megan Thomas  
August 28, 2014  
Page 2 of 4

**It is important that your Credible Allegation/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
6. Include dates when corrective action(s) will be completed.

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

**Such corrections must be achieved and compliance verified by this office, before September 28, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 20, 2014.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 8, 2014.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Mallard ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective August 14, 2014, through December 12, 2014. The conditions of the Provisional License are as follows:

1. Post the provisional license.

Megan Thomas  
August 28, 2014  
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2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **September 22, 2014**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT  
Licensing and Certification Administration, DHW  
PO Box 83720  
Boise, ID 83720-0009  
Phone: (208)334-6626  
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

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 September 8, 2014. If a request for informal dispute resolution is received after September 8, 2014 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

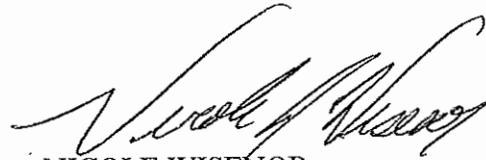
We urge you to begin correction immediately. If you have any questions regarding this letter or

Megan Thomas  
August 28, 2014  
Page 4 of 4

the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

  
JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/nw  
Enclosures



RECEIVED  
SEP 12 2014  
FACILITY STANDARDS

9/12/14

Nicole Wisenor, Co-Supervisor, Non-Long Term Care  
Jim Troutfetter, Health Facility Surveyor  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
PO Box 83720  
Boise, ID 83720

Dear Ms. Wisenor and Mr. Troutfetter:

Aspire Human Services – Mallard Landing alleges that corrections are in process to be compliant with Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions for Conditions of Participation of Governing Body and Management (42 CFR 483.410), Active Treatment Services (42 CFR 483.440), Client Behavior and Facility Practices (42 CFR 483.450), Health Care Services (42 CFR 483.460), and Dietetic Services (42 CFR 483.480).

Please see the attached Plan of Correction for specific details on the actions taken by the facility to achieve compliance.

If you have any further questions, please feel free to contact Tom Moss at 208-473-9032.

A handwritten signature in black ink, appearing to read 'Tony Franklin', with a long, sweeping underline.

Tony Franklin  
Regional Director



September 23, 2014

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

RE: Mallard Landing, Provider #13G032

Dear Ms. Wisenor:

Aspire Human Services — Preferred Community Homes is requesting a formal extension to the full 90 days for the plan of correction for Mallard Landing.

We anticipate that the credible date will be within the first part of the extended 45 days.

Thank you for your time and consideration and if you have any further questions, please feel free to contact me at 208-972-5259.

Sincerely,

A handwritten signature in cursive script that reads 'Shelly Brubaker'.

Shelly Brubaker  
Boise City Director



C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- Director

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T. -- Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

**CERTIFIED MAIL: 7000 1670 0011 3315 1729**

September 24, 2014

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

RE: Preferred Community Homes - Mallard, provider #13G032

Dear Ms. Thomas:

Due to Preferred Community Homes - Mallard's failure to provide an acceptable Allegation of Compliance to the survey completed August 14, 2014, the facility remains out of compliance with the Medicaid Intermediate Care Facility for Persons with Intellectual Disabilities Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Active Treatment Services (42 CFR 483.440)**, **Client Behavior and Facility Practices (42 CFR 483.450)**, **Health Care Services (42 CFR 483.460)**, and **Dietetic Services (42 CFR 483.480)**.

The deficiencies were described on the Statement of Deficiencies/Plan of Correction (CMS-2567) dated August 14, 2014.

In our letter to you dated August 28, 2014, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid program."

Because of your failure to correct, we have made that recommendation. The Medicaid Agency will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

NW/pmt

cc: Lisa Hettinger, Administrator  
Debbly Ransom, Bureau Chief  
Gary Keopanya, CMS Region X



C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- Director

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

LISA HETTINGER - Administrator  
DIVISION OF MEDICAID  
Post Office Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-5747  
FAX: (208) 364-1811

**CERTIFIED MAIL: 7000 1670 0011 3315 1736**

September 24, 2014

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

RE: Preferred Community Homes - Mallard, provider #13G032

Dear Ms. Thomas:

The Bureau of Facility Standards has advised us your facility is out of compliance with the Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Active Treatment Services (42 CFR 483.440)**, **Client Behavior and Facility Practices (42 CFR 483.450)**, **Health Care services (42 CFR 483.460)** and **Dietetic Services (42 CFR 483.480)**. To participate as a provider of services in the Medicaid program, an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) must meet all of the requirements established by the Secretary of Health and Human Services. The deficiencies are described on the Statement of Deficiencies/Plan of Correction (CMS-2567) dated August 14, 2014.

**Based on this information, the Department has scheduled termination of your Provider Agreement with the Idaho Medicaid Program effective November 12, 2014.** The Medicaid Program will not make payments for client days when there is not a Medicaid Provider Agreement in effect.

You have the opportunity to make corrections of those deficiencies that led to the finding of non-compliance with the Conditions of Participation referenced above by submitting an acceptable written Credible Allegation of Compliance/Plan of Correction. To resolve the deficiencies, the facility must submit a letter of Credible Allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problems corrected.

It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

- What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- How you will identify other individuals having the potential to be affected by the same deficient practice;
- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur;
- 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
- The plan must include the title of the person responsible for implementing the acceptable plan of correction;
- Include dates when corrective action(s) will be completed; and
- The administrator's signature and the date signed on page 1 of each form.

**Such corrections must be achieved and compliance verified by this office before November 12, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than October 27, 2014.**

Please complete your Allegation of Compliance/Plan of Correction and submit to the Medicaid Agency and Survey Agency by **October 21, 2014**. Please keep in mind that once the Department receives the letter of Credible Allegation, an unannounced visit could be made at the facility at any time. If you fail to notify us, we will assume you have not made corrections.

Please be advised that you have the right to appeal this action as described in 42 CFR Subpart B, Sections 431.151 through 431.154. The appeal procedures are described in the Department's Contested Case Rules (IDAPA 16.05.03.300). The first step in the appeal process is an administrative review. **To be entitled to an administrative review, your request must be submitted in writing within twenty-eight (28) days after the date of this letter.** A request for administrative review must be signed by the facility's administrator, identify the challenged decision(s), and state specifically the grounds for your contention that the decision was in error.

If you wish to request an administrative review, please submit your written request to:

**Debby Ransom, Bureau Chief  
Department of Health & Welfare  
Licensing & Certification Section  
P.O. Box 83720  
Boise, ID 83720-0009**

Megan Thomas, Administrator  
September 24, 2014  
Page 3 of 3

Additionally, 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 **October 21, 2014**. If a request for informal dispute resolution is received after **October 21, 2014** the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions, please feel free to contact Nicole Wisenor, Non-Long Term Care Co-Supervisor, Bureau of Facility Standards.

Sincerely,



Lisa Hettinger  
Administrator

LH/pmt

ec: Debby Ransom, Chief, Bureau of Facility Standards  
Gary Keopanya, Centers for Medicare and Medicaid Services, Region X Office



10/21/14  
Revised: 10/30/14

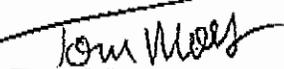
Nicole Wisenor, Co-Supervisor, Non-Long Term Care  
Michael Case, Health Facility Surveyor  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
PO Box 83720  
Boise, ID 83720

Dear Ms. Wisenor and Mr. Troutfetter:

Aspire Human Services – Mallard Landing alleges that corrections are in process to be compliant with Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions for Conditions of Participation of Governing Body and Management (42 CFR 483.410), Active Treatment Services (42 CFR 483.440), Client Behavior and Facility Practices (42 CFR 483.450), Health Care Services (42 CFR 483.460), and Dietetic Services (42 CFR 483.480).

Please see the attached Plan of Correction for specific details on the actions taken by the facility to achieve compliance.

If you have any further questions, please feel free to contact Tom Moss at 208-473-9032.

  
Tom Moss  
Program Manager

W100

Please refer to the responses given under W195.

W102

Please refer to the responses given under W103.

W103

1. The policy and procedure for the facility's governing body is being revised to include how the governing body is to meet the needs of the individual residing in the facility. Specifically the policy will identify an individual or individuals to constitute governing body of the facility. Roles and responsibilities will be clearly defined in the operations and direction of the facility. In addition Aspire Human Services is implementing a structural reorganization to provide more oversight and support to homes. With the revisions there is a Program Supervisor assigned specifically to the Mallard Landing home and a Clinical Director position added to the Aspire Human Services ICF/ID program in Boise Idaho. Please see attached Organizational Chart.
2. The policy and procedure revision will affect all individuals being served by Aspire Human Services in the ICF/ID setting.
3. After the policy and procedure has been revised all parties involved will be provided with training on the policy and procedure so all responsible parties understand their role in meeting the needs of the individuals.
4. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W104.

W104

1. The Mallard Landing facility will ensure the governing body exercises general policy, budget, and operating direction over the facility. In addition, the governing body will ensure sufficient monitoring and oversight that identifies and resolves systematic problems.
2. Aspire Human Services has developed a system for performing QIDP peer reviews between facilities. This includes a revised peer review form which will help the facility identify problem areas.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.

4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W124, 214, 234, W290, W312, W322, W111, W114, W120, W195, W266, W318 and W459.

W111

1. The Mallard Landing facility is developing a record keeping system that documents the individual's health care, active treatment, social information, and protection of individual's rights.
2. The client records for individual's 1, 3, 2 and 5 have been revised to include accurate records. Aspire Human Services is in the process of reviewing all individual's files to verify that the files contain accurate records.
3. Aspire Human Services is in the process of revising the order of the assessment process. Specifically, the CFA is being completed before all other professional assessments to the professionals can utilize the assessment while performing their assessments. After the professionals complete their assessments the QIDP will compare the professional assessments to the CFA to verify accuracy. . Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will be verifying that appropriate signatures on on all assessments.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W114.

W114

1. All entries in the files for individuals 1, 2 & 3 have been signed by the appropriate professional.
2. All files at the Mallard Landing home are being reviewed to verify that all professional documents have the appropriate signature.
3. All QIDP's will receive training in relation to obtaining appropriate signatures before assessments are placed in the individual files. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will be verifying that appropriate signatures on on all assessments.

4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W120

1. Individual #2 has received a comprehensive dental examination.
2. The Director of Nursing is reviewing all files in the home to verify that comprehensive dental examinations have been completed for all individuals being served at the Mallard Landing home.
3. The Director of Nursing is developing a quarterly peer review. One part of the quarterly review will verify that comprehensive dental evaluations are on file for each individual being served. The review form will include review to assure that individuals are receiving comprehensive dental examinations.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

## W124

1. The guardians for individuals #1 and #3 have been informed of the potential drug complications as specified in their pharmacy notes.
2. The Director of Nursing is review each of the charts at the facility and is informing each guardian of any potential drug complications that are identified in the pharmacy notes.
3. Each RN and LPN will receive training on the expectation that each time a pharmacy note is received that identifies potential complications that the guardian receives a copy of the pharmacy note.
4. The Director of Nursing is developing a quarterly peer review. One part of the quarterly review will verify that guardians have been notified of potential complications identified in pharmacy reviews. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented. This includes assuring nursing peer reviews are kept on file and current.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP  
Completion Date: 10/27/14

## W159

1. Individual #1's sleep hygiene program has been revised to include specific individualized instructions. In Addition, Individual #1's community utilization is currently being documented appropriately. Individual #7's travel mug has been addressed by his treatment team and IPP adjustments and revision have been made. In addition, the facility created and implemented a preliminary IPP during the survey visit to include ADL

- training programs and an active treatment schedule and the facility has updated the data collection system for individual #5 to include documentation methods for how refusal data is collected. In addition, individual #3's data collection systems have been revised to assure they are capturing how many times activities are refused.
2. All identified system failures have been corrected for each individual residing at the Mallard Landing home.
  3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
  4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
  5. Person Responsible: Director of Nursing, LPN, Clinical Director, Program Manager, Program Supervisor & QIDP
  6. Completion Date: 10/27/14

Please refer to the responses given under W111, W114, W120, W124, W190, W194, W195, W266, W318 & W459.

#### W190

1. The Mallard Landing facility will ensure staff working with individuals focus on skills and competencies directed toward individuals' developmental needs. Mallard Landing will also ensure opportunities for individuals to practice skills and maximize their developmental potential.
2. The facility has provided additional training and oversight for all of the staff employed at the home and given support and instruction on how to provide opportunity training so they have the ability to provide cross-cutting skills necessary to meet the individual's developmental needs.
3. The facility has revised the orientation process for training new staff at the home. The training includes a two hour training session on active treatment and the regulatory requirement to provide opportunity training at all times during an individual's day.
4. Aspire human services is providing additional training for the Program Supervisors and QIPD's in relation to regulatory requirements for cross cutting skills and opportunity training. Moving forward documented Active Treatment observations will occur on a monthly basis to verify individuals are receiving the necessary opportunities to meet their developmental needs. Observations will be documented on training sheets and/or Active Treatment forms.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14.

#### W194

Please refer to the responses given under W249.

W195

Please refer to the responses given under W196.

W196

1. The Mallard Landing facility will ensure staff working with individuals focus on skills and competencies directed toward individuals' developmental needs. Mallard Landing will also ensure opportunities for individuals to practice skills and maximize their developmental potential.
2. The facility has provided additional training and oversight for all of the staff employed at the home and given support and instruction on how to provide opportunity training so they have the ability to provide cross-cutting skills necessary to meet the individual's developmental needs.
3. The facility has revised the orientation process for training new staff at the home. The training includes a two hour training session on active treatment and the regulatory requirement to provide opportunity training at all times during an individual's day.
4. Aspire human services is providing additional training for the Program Supervisors and QIPD's in relation to regulatory requirements for cross cutting skills and opportunity training. Moving forward documented Active Treatment observations will occur on a monthly basis to verify individuals are receiving the necessary opportunities to meet their developmental needs. Observations will be documented on training sheets and/or Active Treatment forms.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W214, W216, W217, W218, W220, W221, W223, W225, W227, W234, W237, W242, W249, W250 & W262.

W200

1. The Mallard Landing facility will ensure each preliminary evaluation contains background information as well as current valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the individual's needs and if the individual is likely to benefit from placement in the facility. The IDT will use this information to determine if the facility is able to meet the needs of each individual. During the survey week the facility created and implemented a preliminary IPP for individual #5 so she could be provided with Active Treatment during her 30 day admission process. All Program Supervisors and QIDP's are being training on the Admissions Policy. The Preliminary IPP process has been reviewed and the document has been revised to contain adequate information.
2. Moving forward the facility will implement the revised admission preliminary IPP to include an active treatment schedule, ADL instructions, behavior management instructions and dietary instructions for all individuals being admitted into the facility.

3. Systematically the preliminary IPP process will be implemented for all individuals being admitted into Aspire Human Services. The QIDP's will be providing training for the staff before and individual moves.
4. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W214

1. The Mallard Landing facility will ensure the comprehensive each comprehensive functional assessment identifies the individual's specific developmental and behavioral management needs. The behavior assessments for individuals 1,3 and 4 have been revised to include accurate and comprehensive information.
2. The behavior assessments for all individuals living at the home have been reviewed and revised to include accurate and comprehensive information.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W216

1. The Mallard Landing facility will ensure the comprehensive functional assessment includes physical and developmental health. The CFA's for individual #1 - #4 have been revised to include comprehensive health information.
2. The facility is implementing a SAM assessment to be included within the CFA and a Pain assessment for each individual.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W217

1. The Mallard Landing facility will ensure the comprehensive functional assessment must include nutritional status. The facility has implemented an eating pace program and

consistent instructions for staff in relation to his IPP for individual #1. In addition Individual #1's anemia is being addressed in his nutritional assessment. The facility is re-assessing individual #2's needs in his dietary assessment in relation to a diagnosis of osteoporosis and the Vitamin D 25-OH insufficiency.

2. The facility is reviewing and revising all dietary assessments to verify each individual has been adequately assessed.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP  
Completion Date: 10/27/14

## W218

1. The Mallard Landing facility will ensure the comprehensive functional assessment includes sensorimotor development. Individual #1 is scheduled to have an additional Occupational Therapy assessment completed to clarify assessment documentation related to decreased maladaptive behavior and increased time in the community.
2. All Occupational Therapy evaluations are being reviewed and updated at the facility to verify accuracy.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W220

1. The Mallard Landing facility will ensure the comprehensive functional assessment will include speech and language development. Individual #1's IPP has been revised to include consistent instructions for his communication strategies. The facility has implanted a teaching strategy for individual #3 to help him learn how to communicate if he is in pain. Aspire Human Services has added information in all Behavior Assessment to adequately assess pain for each individual and how that affects their behavior.
2. All individuals files are being reviewed to verify that pain teaching strategies in place when appropriate and that communication strategies are consistent based on assessment.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will be verifying pain strategies are in place when appropriate.

4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W221

1. The Mallard Landing facility will ensure the comprehensive functional assessment must include auditory functioning. Individual #3 has had a hearing evaluation to assess ability to hear. The assessmet results have been incooperated into his program plan.
2. All individual files are being reviewed to verify that the CFA in which the QIDP marks if the individual can hear matches the professional assessment. Revisions are being made when necessary.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that professional assessments match CFA's.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W223

1. The Mallard Landing team will ensure the comprehensive functional assessment includes social development. Individual #1's CFA has been revised and now includes comprehensive information related to his leisure skills.
2. All individual files are being reviewed to verify that appropriate assessments have been completed related to leisure skills.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specifio days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that leisure skills have been assessed.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP  
Completion Date: 10/27/14

## W225

1. The Mallard Landing facility will ensure the comprehensive functional assessment includes, as applicable, vocational skills. The vocational assessments for individuals 1 and 3 have been revised to include relevant and comprehensive information.
2. All individual files are being reviewed to verify that appropriate vocational assessments have been completed.

3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will vocational assessments are completed appropriately.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

**W227**

1. The Mallard Landing facility will ensure the individual program plan states specific objectives necessary to meet the individual's needs. The facility has implemented leisure skill training objectives for individuals 1 and 3.
2. All individual files are being reviewed to verify that appropriate and comprehensive leisure skill training is being implemented when appropriate.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that appropriate leisure skills are trained when appropriate.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W242.

**W234**

1. The Mallard Landing facility will ensure each written training program designed to implement the objectives in the individual program plan must specify the methods used. All of individual's 1 & 3's program instructions have been revised to include comprehensive and consistent instructions.
2. All individuals' files are being reviewed to verify that comprehensive and consistent instructions are being implemented.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that comprehensive and consistent instructions are being implemented.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W289.

## W237

1. The Mallard Landing facility will ensure each written training program designed to implement the objectives in the individual program plan specifies the type of data and the frequency of data collection necessary to be able to assess progress toward the desired objective. All programs for individuals 1 – 4 have been revised to include specific instructions for type of data to be collected (prompt level, plus or minus, tally mark etc.)
2. All individuals' files are being reviewed and revision are being implemented to assure that adequate instructions are implemented in relation to data collection systems.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that adequate instructions are implemented in relation to data collection systems.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W242

1. The Mallard Landing team will ensure the individual program plans include, for those individuals that lack them, training in personal skills essential for privacy and independence until it has been demonstrated the individual is developmentally incapable of acquiring them. Individuals' 1 & 3 currently have programs in place to teach them how to communicate if they are in pain. Individual #1 currently has a program in place to teach him privacy skills and bathing skills.
2. All individual program plans in the facility are being reviewed to verify that the treatment teams have adequately identified and addressed training needs.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that treatment teams have adequately identified and addressed training needs.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W249

1. The Mallard Landing facility will ensure the interdisciplinary team has formulated an Individual Program Plan. Each individual will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. During the survey week the facility created and implemented a preliminary IPP for individual #5 so she could be provided with Active Treatment during her 30 day admission process. In addition, Aspire Human Services has provided additional training

for the staff in regards to consistent program implementation. Staff have received additional training on the implementation of individual #1 through #4's dietary guidelines to assure their dietary needs are being met.

2. Moving forward the facility will implement the revised admission preliminary IPP to include an active treatment schedule, ADL instructions, behavior management instructions and dietary instructions for all individuals being admitted into the facility. In addition the facility has scheduled monthly active treatment observations to be conducted by the QIDP's to assure consistent program implementation.
3. Systematically the preliminary IPP process will be implemented for all individuals being admitted into Aspire Human Services. In addition, monthly active treatment observations to be completed by the Program Supervisor.
4. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP  
Completion Date: 10/27/14

#### W250

1. The Mallard Landing team will develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Active treatment schedules for individuals 1,2,3 & 5 have been revised to schedule current active treatment needs.
2. All individual files are being reviewed and revised to verify that accurate active treatment schedules are implemented.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that appropriate active treatment schedules are in place.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

#### W262

1. The Mallard Landing facility will ensure the HRC reviews, approves, and monitors individual programs designed to manage inappropriate behavior and other program that, in the opinion of the committee, involve risk to client protections. The video Monitoring consents are currently in the files for individuals #1 through 3.
2. All individual files are being reviewed and revised to verify that consents are on file and current.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of

the review will include that individuals' needs are being met. The QIDP's will verify that consents are obtained in a timely manner.

4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

#### W266

Please refer to the responses given under W268, W285, W289, W290, W312 & W313.

#### W268

1. The Mallard Landing facility will ensure policies and procedures must promote the growth, development and independence of the individuals. Aspire Human Services is in the process of writing a policy that specifically addresses growth and development of individuals.
2. After the policy is generated, all Aspire Human Service employees associated with the Mallard Landing home will receive training on the new policy and given the expectation that the policy is consistently implemented.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that all individuals being served are provided with growth and development opportunities.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

#### W285

Please refer to the responses given under W290 & W313.

#### W289

1. The Mallard Landing facility will ensure the use of systematic interventions to manage inappropriate individual behavior in incorporation into the individual's program plan. Individual #1's interventions to assist him with his maladaptive behavior is being revised to include systematic interventions to assist him to manage his behavior.
2. All individual program plans at the facility are being reviewed and revised as needed to assure they include systematic interventions to assist with any targeted maladaptive behavior.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that there are interventions to assist individuals with maladaptive behavior include systematic interventions to manage his behavior

4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W290

1. The Mallard Landing facility will ensure no standing or as needed programs to control inappropriate behaviors are implemented. The bite release instructions have been removed from individual #3's program plan.
2. All individual program plans are being reviewed to verify that standing or as needed programs are removed if appropriate.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that there are not routine standing orders in place.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP  
Completion Date: 10/27/14

## W312

1. The Mallard Landing facility will ensure any drugs used for control of inappropriate behavior is used only as an integral part of the individuals program plan that is directed specifically towards the reduction of an eventual elimination of the behaviors for which the drugs are employed. Individual #1 has been to see his Licensed Nurse Practitioner and his medications have been reduced. In addition, his medication reduction plan has been updated to include current information.
2. All individual files are being reviewed to verify that medication reduction plans are written appropriately and implemented per regulation. In Addition, Aspire Human Services has developed a procedure for pre-psych meetings to guide the treatment team through the process of reviewing and revising medication reduction plans. Please see attached forms.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met The QIDP's will verify that medication reduction plans are implemented appropriately.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

## W313

1. The Mallard Landing facility will ensure drugs used for control of inappropriate behavior are not used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. Individual #1 has been to see his Licensed Nurse Practitioner and his medications have been reduced. In addition, his medication reduction plan has been updated to include current information.
2. All individual files are being reviewed to verify that medication reduction plans are written appropriately and implemented per regulation. In Addition, Aspire Human Services has developed a procedure for pre-psych meetings to guide the treatment team through the process of reviewing and revising medication reduction plans. Please see attached forms.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met The QIDP's will verify that medication reduction plans are implemented appropriately.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

W318

Please refer to the response given under W345.

W322

Please refer to the responses given under W326, W338, W353 & W363.

W326

1. The Mallard Landing facility will provide or obtain annual physical examinations for each individual that at a minimum includes special studies when needed. Individual #2's DXA test has been scheduled and he will be receiving this evaluation as specified by his health care professional.
2. All individual files are being reviewed to verify that all doctor's orders have been followed as written. All appointments will be scheduled if needed to meet current doctors orders.
3. Aspire Human Services has developed a system for performing nursing peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include physical examinations are provided when needed.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

## W331

1. The Mallard Landing facility will provide individuals with nursing services in accordance with their needs. Individual #3 has been scheduled to have an additional auditory evaluation to determine his hearing acuity. Individual #1 is no longer utilizing Tylenol for pain. Individual #3's file currently contains information related to when staff are to notify the LPN after doing his BP checks. Individual #2's vitamin D levels have been assessed to assure they are within appropriate levels.
2. The Director of Nursing is currently reviewing all nursing files for individuals being served at the home to verify that nursing services are being provided with individuals' needs.
3. Aspire Human Services has developed a system for performing nursing peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include verifying that individuals are receiving nursing services in accordance with their needs.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W322.

## W338

1. Mallard will ensure nursing services include, for those individuals certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address individual health problems). Individual 2 is currently receiving medications as ordered by his doctor. The Director of Nursing is in the process of reviewing all individuals' files to ensure that medications are implemented in a timely manner after orders are received. The Nursing department will ensure follow up with the Pharmacist regarding recommendations based on the pharmacy review.
2. The Director of Nursing is in the process of reviewing all individuals' files to assure that medications are implemented in a timely manner after orders are received.
3. Aspire Human Services has developed a system for performing nursing peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include verifying that individuals are receiving appropriate nursing services.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

## W345

1. The Mallard Landing facility will utilize registered nurses as appropriate and required by State law to perform the health services. A revised job description is being generated to assist in guiding the Director of Nursing. The revised job description contains more specific information and direction as it relates to ICF/ID regulations.
2. Once the job description is revised, the Director of Nursing will sign the job description and have the opportunity to ask questions as they relate to ICF/ID regulations.
3. Aspire Human Services has developed a system for performing nursing peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include verifying that the registered nurse is utilized appropriately by verifying individuals are receiving appropriate medical care.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W331.

## W353

1. The Mallard Landing facility will ensure comprehensive dental diagnostic services include periodic examination and diagnosis performed including radiographs when indicated and detection of manifestations of systemic disease. Individual #2 has been scheduled to have a dental x-ray.
2. The Director of Nursing is currently in the process of reviewing all individuals' files to assure that dental x-rays are in the chart for review.
3. Aspire Human Services has developed a system for performing nursing peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include verifying that dental examinations are performed when needed.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

## W363

1. The Mallard Landing facility will ensure the pharmacist reports any irregularities in individual's drug regimens to the prescribing physician and interdisciplinary team. Individual #3's Physician and the IDT have been informed of the pharmacy note dated 6/20/14. Individual #1 is no longer utilizing Tylenol every 4 hours for pain related to his teeth.

2. The Director of Nursing is currently auditing the individuals' files for each individual being served at the home to assure that physicians and IDT members are informed of risk identified by the pharmacist.
3. Aspire Human Services has developed a system for performing nursing peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include verifying that the pharmacist reports any irregularities to the physician.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Director of Nursing, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

## W434

1. The Floor at Mallard Landing has been replaced and currently promotes sanitary conditions.
2. All individuals will be affected by the floor. All of the floors in the home have been inspected and are being replaced as needed.
3. The facility has a monthly maintenance checklist to be completed by each Program Supervisor. One part of the checklist verifies that the flooring is safe for the individuals'.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Clinical Director, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

## W459

Please refer to the responses given under W460, W481 & W486.

## W460

Please refer to the responses given under W463.

## W463

1. The Mallard Landing facility will ensure the individual's interdisciplinary team, including a qualified dietitian and physician prescribe all modified and special diets. Individual #5's diet texture has been clarified and there is currently a doctors order in her file indicating the consistency of food she is to be consuming. This is reflected in her current program plan.
2. All individuals' files have been reviewed to verify that there is a current doctor's order for food consistency.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that a qualified dietitian and physician prescribe all modified and special diets.

4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

Please refer to the responses given under W 474.

W474

1. The Mallard Landing facility will ensure the individual's interdisciplinary team, including a qualified dietitian and physician prescribe all modified and special diets. Individual #5's diet texture has been clarified and there is currently a doctors order in her file indicating the consistency of food she is to be consuming. This is reflected in her current program plan.
2. All individuals' files have been reviewed to verify that there is a current doctor's order for food consistency.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that a qualified dietitian and physician prescribe all modified and special diets.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

W481

1. The Mallard Landing facility will ensure menus for food actually served are kept on file for 30 days. Individual #5's food consumption is currently being tracked.
2. All food consumed by the individuals in the facility is currently being tracked after each meal or snack.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that food actually served is kept on file for 30 days.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 10/27/14

W486

Please refer to the responses given under W488.

W488

1. The Mallard Landing facility will assure that each individual eats in a manner consistent with his or her developmental level.
2. The facility has provided additional training and oversight for all of the staff employed at the home and given support and instruction on how to provide opportunity training so they have the ability to provide cross-cutting skills necessary to meet the individual's developmental needs.
3. The facility has revised the orientation process for training new staff at the home. The training includes a two hour training session on active treatment and the regulatory requirement to provide opportunity training at all times during an individual's day. This includes training related to eliciting the participation of each individual during meals.
4. Aspire human services is providing additional training for the Program Supervisors in relation to regulatory requirements for cross cutting skills and opportunity training including during mealtimes. Moving forward documented Active Treatment observations will occur on a monthly basis to verify individuals are receiving the necessary opportunities to meet their developmental needs.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager, Program Supervisor & QIDP
6. Completion Date: 10/27/14

MM112

Please see responses under W223.

MM164

Please see responses under W124.

MM177

Please see responses under W285.

MM191

Please see responses under W290 and 313.

MM194

Please see responses under W262.

MM197

Please see responses under W312.

MM 203

Please see responses under W268.

MM212

Please see responses under W195, W196, W242, W249 and W266.

MM238

Please see responses under W250.

MM298

Please see responses under W434

MM 512

Please see responses under W100.

MM520

Please see responses under W102 and W104.

MM539

Please see responses under W114.

MM620

Please see responses under W190.

MM622

Please see responses under W194.

MM650

Please see responses under W217.

MM654

Please see responses under W463.

MM672

Please see responses under W481.

MM678

Please see responses under W460.

MM679

Please see responses under W474.

MM724

Please see responses under W225 and W234.

MM725

Please see responses under W159, W486 and W488.

MM729

Please see responses under 227.

MM730

Please see responses under W214.

MM735

Please see responses under W318 and W322.

MM755

Please see responses under W216.

MM760

Please see responses under W331.

MM821

Please see responses under W220.

MM836

Please see responses under W218.

MM859

Please see responses under W120.

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

PRINTED: 09/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
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NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - MALLARD	STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey conducted from 8/4/14 to 8/14/14.</p> <p>The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are: ABC - Antecedent Behavior Consequence ACE - Angiotensin Converting Enzyme ADL - Activities of Daily Living ASA - Acetylsalicylic Acid (Aspirin) BP - Blood Pressure Ca - Calcium CFA - Comprehensive Functional Assessment DCS - Direct Care Staff DXA - Dual-energy X-ray absorptiometry GERD - Gastroesophageal Reflux Disease GI - Gastrointestinal HRC - Human Rights Committee ICF/ID - Intermediate Care Facility for Individuals with Intellectual Disabilities ICF - Intermediate Care Facility ICF/MR - Intermediate Care Facility for Persons With Mental Retardation IDAPA - Idaho Administrative Procedures Act IDT - Interdisciplinary Team IPP - Individual Program Plan ISP - Individual Support Plan IU - International Units LPN - Licensed Practical Nurse MAR - Medication Administration Record NKDA - No Known Drug Allergies NSAID - Non-Steroidal Anti-Inflammatory Drug OT/PT - Occupational Therapy/Physical Therapy PCP - Primary Care Provider</p>	W 000	<p style="text-align: center;"><b>RECEIVED</b> SEP 12 2014 <b>FACILITY STANDARDS</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom M... TITLE: Program Manager (X6) DATE: 08/21/14

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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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - MALLARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER MERIDIAN, ID 83642</b>		
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W 000	Continued From page 1 PCLP - Person Centered Lifestyle Plan PoC - Plan of Correction PRN - As Needed QA - Quality Assurance QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse SAM - Self Administration of Medication SIB - Self Injurious Behavior SSRI - Selective Serotonin Reuptake Inhibitor Tab - Tablet	W 000			
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS  "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined each recipient for whom payment was requested was not receiving active treatment as specified in 483.440. The findings include:	W 100			

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W 100	Continued From page 2 1. Refer to W195 Condition of Participation: Active Treatment Services not met and related standard level deficiencies.	W 100			
W 102	483.410 GOVERNING BODY AND MANAGEMENT  The facility must ensure that specific governing body and management requirements are met.  This CONDITION is not met as evidenced by: Based on observation, policy review, record review, staff interview and a review of the facility's compliance history and previous plans of correction, it was determined the facility failed to define the governing body and its roles and responsibilities in the operation and direction of the facility. This resulted in the governing body's ability to identify and resolve systematic problems of a serious and recurrent nature being significantly impeded. The findings include:  1. Refer to W103 as it relates to the facility's failure to identify the person(s) who comprised the facility's governing body.	W 102			
W 103	483.410(a) GOVERNING BODY  The facility must identify an individual or individuals to constitute the governing body of the facility.  This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to identify the person(s) who comprised the facility's governing	W 103			

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W 103	<p>Continued From page 3</p> <p>body for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of clearly defined roles and responsibilities in the operation and direction of the facility. The findings include:</p> <p>1. Upon request, the facility submitted a list of the staff who comprised the facility's governing body. The list included the typed names and telephone numbers of facility staff and had the words "Governing Body" handwritten at the top of the list. The list included 8 staff members as follows:</p> <ul style="list-style-type: none"> <li>- Idaho State Director</li> <li>- Regional Director</li> <li>- City Director</li> <li>- Program Manager</li> <li>- Program Supervisor</li> <li>- Director of Nursing</li> <li>- QIDP</li> <li>- LPN</li> </ul> <p>However, the LPN job description, updated 5/14/14, was reviewed. The job description stated the LPN did "not have supervisory responsibilities," and information related to the LPN's role as part of the governing body could not be found.</p> <p>The Regional Director was not available for interview from 8/11/14 - 8/15/14. On 8/20/14 at 9:24 a.m., a follow up interview was conducted with the Regional Director. He stated he understood the chain of command as the Program Manager reporting to the City Director, the City Director reporting to the Regional Director and the Regional Director reporting to the Idaho State Director. However, he was unsure which staff were part of the facility's</p>	W 103			

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W 103	<p>Continued From page 4</p> <p>governing body. When asked, he stated he was not aware of any policies and procedures related to the roles and responsibilities of the governing body.</p> <p>On 8/20/14 at 9:50 a.m., the Idaho State Director was interviewed. The Idaho State Director was not able to state who comprised the facility's governing body. When asked about policies and procedures related to the roles and responsibilities of the governing body, he stated he had contacted his supervisor, the Chief Operating Officer. He stated the Chief Operating Officer stated such policies did exist, but he would need to speak with her further.</p> <p>On 8/21/14 at 10:02 a.m., the Idaho State Director submitted a "Governing Body" policy, revised 1/9/13, via email. The policy stated there was a facility governing body comprised of the Program Manager, Program Supervisor, Director of Nursing, QIDP, LPN and any other facility staff designated by the City Director.</p> <p>The policy also stated there was a corporate governing body comprised of the Chief Executive Officer, the Chief Operating Officer, the Senior Vice President, the Chief Financial Officer, the Idaho State Director, the Regional Director and the City Director.</p> <p>The "Governing Body" policy stated the corporate governing body was responsible for "...financial management, facility budgeting, and fiscal oversight; assistance with development, review, and approval of policies, practices, and systems; philosophical and operating direction of the facility; corporate compliance assurance to all applicable state and federal regulation [sic] and</p>	W 103			

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W 103	Continued From page 5 authorities."  The policy did not describe how the corporate governing body was providing direction, oversight and monitoring to ensure policies were developed and/or sufficiently developed, staff were made aware of and trained on facility policies, or that policies were implemented and/or implemented appropriately.  The Idaho State Director's email, received on 8/21/14 at 10:02 a.m., stated he had spoken with the Chief Operating Officer and both agreed the policy "needs some revision/updating."  The facility failed to ensure policies and procedures clearly specified how the corporate governing body was providing the structure and processes necessary to ensure individuals' needs were met. Further, the governing body failed to adequately monitor policies, procedures and practices necessary to ensure they were sufficiently developed and appropriately implemented. The cumulative effect of these deficient practices resulted in systems which were not effective in ensuring individuals were being provided with active treatment and that their health and safety needs were met.	W 103			
W 104	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.	W 104			

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W 104	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility's governing body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. These failures directly impacted 7 of 7 individuals (Individuals #1 - #7) residing at the facility and resulted in individual needs not being met. The findings include:</p> <p>1. The governing body failed to provide sufficient monitoring and oversight to ensure facility plans of correction were implemented as follows:</p> <p>a. During the facility's 10/3/13 recertification survey, W214 was cited for a failure to ensure individuals' behavior assessments contained comprehensive information. The facility was also cited at W312 for a failure to ensure behavior modifying drugs were not being used without plans that identified the drug usage and how it may change in relation to individuals' progress or regression.</p> <p>The facility submitted a plan of correction, dated 10/21/13. The plans of correction for W214 and W312 both stated the facility was "implementing a quarterly peer review" The PoC documented the Program Manager was responsible for the correction.</p> <p>When asked, during an interview on 8/13/14 at 2:00 p.m., the Program Manager stated the company had experienced some staff changes and the quarterly peer reviews were not completed.</p>	W 104			

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W 104	Continued From page 7  The City Director was not available for interview from 8/11/14 - 8/15/14. When asked, during a follow up interview on 8/19/14 at 3:46 p.m., the City Director stated she was responsible for managing the Program Manager. She stated she and the Program Manager had monthly 1:1 meetings. She stated approximately 60 days prior to the survey (on 8/4/14), she and the Program Manager had discussed PoC monitoring. She stated it had been identified that the peer reviews were not being completed. However, a schedule for the peer reviews had not been created or implemented at the time of the 8/4/14 survey.  b. During the facility's 10/3/13 recertification survey, W322 was cited for a failure to provide general medical and preventative care. The facility submitted a plan of correction, dated 10/21/13, which stated the facility was in the process of "hiring a Director of Nursing. This will be an RN. The RN will audit all facility charts on a quarterly basis to ensure the nursing department is following through on all physician orders and recommendations." The PoC documented the City Director was responsible for the correction.  On 8/11/14, documentation of monitoring was requested from the RN. The RN provided "QA Idaho ICF/ID Client File Review" forms, an "Environmental Assessment" form, and several forms titled "ICF/MR Record Review Form." The RN stated, on 8/11/14 at 3:05 p.m., that he, LPN A and LPN B completed the "ICF/MR Record Review Form" and he followed up with staff regarding concerns identified on the "Environmental Assessment." The RN stated the	W 104			

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W 104	<p>Continued From page 8</p> <p>facility's Quality Assurance person had completed the "QA Idaho ICF/ID Client File Review" forms.</p> <p>The "ICF/MR Record Review Forms" were not dated as to when the review was completed, the forms did not include consistent information and a form was not submitted for Individual #4.</p> <p>When asked, during an interview on 8/13/14 at 2:00 p.m., the RN stated the review forms were an internal document he used for monitoring. The RN stated a review form for Individual #4 was probably completed by the company's QA person, so a record review form was not completed by nursing staff. When asked about additional documentation of quarterly reviews, as specified in the facility's 10/21/13 plan of correction, the RN stated he was not aware of other reviews. He stated the plan of correction had been submitted prior to his hire date (on 2/24/14).</p> <p>When asked for information related to how the record review forms were to be completed, the facility submitted "RN QA Checklist Instructions," dated 10/8/10. The instructions stated the RN was to review the PRN Record on the current MAR in the home, review the physician's orders, dietary and speech therapy recommendations regarding dietary texture, and review the most current physician recap orders in each individual's chart. The instructions did not include all areas of the record review form.</p> <p>The City Director was not available for interview from 8/11/14 - 8/15/14. When asked, during a follow up interview on 8/19/14 at 3:46 p.m., the City Director stated she was responsible for managing the RN. She stated she and the RN</p>	W 104		

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W 104	<p>Continued From page 9</p> <p>had monthly 1:1 meetings. She stated she had spoken with the RN regarding quarterly reviews and visiting the facilities. She stated written instruction regarding how to complete the chart audits had not been developed.</p> <p>The governing body facility failed to provide sufficient operating direction and monitoring over the facility necessary to ensure adequate quarterly reviews were conducted as specified in the facility's 10/21/13 plan of correction.</p> <p>2. The facility's governing body failed to provide sufficient monitoring and oversight necessary to achieve and sustain regulatory compliance, as follows:</p> <p>a. Refer to W124 as it relates to the facility's failure to ensure written informed consents were obtained based on individuals' needs. The facility was previously cited at W124 during an annual recertification survey dated 10/3/13 and an annual recertification survey dated 8/24/12.</p> <p>b. Refer to W214 as it relates to the facility's failure to ensure individuals' behavioral assessments contained accurate and comprehensive information. The facility was previously cited at W214 during an annual recertification survey dated 10/3/13 and an annual recertification survey dated 8/24/12.</p> <p>c. Refer to W234 as it relates to the facility's failure to ensure the individuals' training programs included sufficient direction to staff regarding how to implement the intervention strategies. The facility was previously cited at W234 during an annual recertification survey dated 10/3/13.</p>	W 104			

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W 104	<p>Continued From page 10</p> <p>d. Refer to W290 as it relates to the facility's failure to ensure the standing or as needed programs to control inappropriate behavior were not used. The facility was previously cited at W290 during an annual recertification survey dated 8/24/12.</p> <p>e. Refer to W312 as it relates to the facility's failure to ensure individuals' medications to control maladaptive behavior were appropriately incorporated into a plan. The facility was previously cited at W312 during an annual recertification survey dated 10/3/13 and an annual recertification survey dated 8/24/12.</p> <p>f. Refer to W322 as it relates to the facility's failure to ensure individuals were provided with general and preventative health care. The facility was previously cited at W322 during an annual recertification survey dated 10/3/13 and an annual recertification survey dated 7/13/11.</p> <p>The City Director was not available for interview from 8/11/14 - 8/15/14. When asked during a follow up interview on 8/19/14 at 3:46 p.m., what mechanisms (policy, procedures, systems, etc.) were in place to ensure the facility achieved and sustained regulatory compliance, the City Director stated there were none beyond the PoC monitoring that had been implemented with the Program Manager.</p> <p>The governing body failed to develop, implement and monitor systems to ensure the facility was able to achieve and sustain regulatory compliance.</p> <p>3. The facility's governing body failed to provide sufficient monitoring and oversight to ensure</p>	W 104		

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W 104	Continued From page 11 policies were adequately developed, implemented and monitored to ensure appropriate records were maintained and outside services met the individuals' needs.  a. Refer to W111 as it relates to the governing body's failure to ensure a record keeping system that contained accurate, comprehensive information was maintained.  b. Refer to W114 as it relates to the governing body's failure to ensure all entries in the individuals' records were signed and dated.  c. Refer to W120 as it relates to the governing body's failure to ensure outside services met the individuals' needs.  4. The facility's governing body failed to provide sufficient monitoring and oversight to ensure policies were adequately developed, implemented and monitored to meet individuals' active treatment, behavioral, health and dietary needs.  a. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the governing body's failure to ensure active treatment services were provided to each individual.  b. Refer to W266 Condition of Participation: Client Behavior and Facility Practices and associated standard level deficiencies as they relate to the governing body's failure to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored.	W 104		

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W 104	Continued From page 12 c. Refer to W318 Condition of Participation: Health Care Services and associated standard level deficiencies as they relate to the governing body's failure to ensure adequate health care monitoring and follow up occurred for the individuals residing in the facility.  d. Refer to W459 Condition of Participation: Dietetic Services and associated standard level deficiencies as they relate to the governing body's failure to ensure appropriate dietary monitoring and services were provided to each individual residing in the facility.  The cumulative effect of these deficient practices significantly impeded the facility's ability to provide individuals' with habilitative and health services necessary to achieve and maintain optimal functional status and that each individual was provided with the opportunity to function with as much self-determination and independence as possible.	W 104		
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 complete information for 4 of 5 individuals (Individuals #1 - #3 and #5) whose records were reviewed. This resulted in a lack of accurate, comprehensive information being available on which to base	W 111		

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W 111	<p>Continued From page 13 program decisions. The findings include:</p> <p>1. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with autistic disorder, mood disorder and severe intellectual disability.</p> <p>Individual #1's record was reviewed. His record did not include consistent, accurate information. Examples included, but were not limited to, the following:</p> <p>a. The "Likes" section on page 1 of his 9/3/13 CFA stated he liked "personal space and being alone." However, the "Personal Orientation and Relationships" section on page 28 of his CFA stated he did not prefer to be alone.</p> <p>When asked about the discrepancy, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #1 did prefer to be alone.</p> <p>b. The "Personal Orientation and Relationships" section on page 28 of his CFA stated he was not generally happy. However, Individual #1's IPP stated in the "Personal Orientation and Relationships" section on page 8 that he was "generally happy."</p> <p>When asked about the discrepancy between the CFA and the IPP, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 was generally happy. The QIDP, who was also present during the interview, stated Individual #1's CFA would need to be updated.</p> <p>c. Individual #1's 6/30/13 Speech and Language Annual Review stated he was "beginning to sort</p>	W 111			

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W 111	<p>Continued From page 14</p> <p>laundry, vacuum, etc." However the "Dislikes" section on page 1 of his CFA stated he did not like loud noises.</p> <p>When asked about the discrepancy during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 did not vacuum. The QIDP, who was also present during the interview, stated Individual #1's speech evaluation was not accurate.</p> <p>d. Individual #1's CFA stated when given a specific verbal cue, he would follow instructions given by means of picture cue. However, his 6/30/13 Speech and Language Annual Review did not include information regarding Individual #1's use of pictures. The Speech and Language Annual Review stated Individual #1 was working on using tangible objects that represented an event or activity. Further, Individual #1's 3/13/14 Behavioral Assessment stated in the "Weaknesses" section that he communicated "via sounds/gesture or pictures."</p> <p>When asked about the assessments, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #1 did not use pictures to communicate.</p> <p>The facility failed to ensure information related to Individual #1's communication was consistent.</p> <p>e. Individual #1's 8/15/13 Nutritional Assessment stated he was cued to take small bites and eat slowly, alternating food and drinks to decrease risk of aspiration. His 8/25/13 Occupational Therapy Report stated he "Continues to require supervision for self-feeding for pacing with pureed diet," and his 9/3/13 CFA stated in the "Eating &amp;</p>	W 111			

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W 111	<p>Continued From page 15</p> <p>Dining" section on page 9 that he required specific verbal cues to not rush eating, but relax and enjoy meals.</p> <p>However, Individual #1's IPP did not include an objective related to his eating pace.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated the assessments were not accurate. DCS H stated since Individual #1's teeth were extracted (on 9/8/13) he has seemed to calm and really enjoy his meals now.</p> <p>The facility failed to ensure Individual #1's assessments included accurate information regarding his dining skills.</p> <p>f. Individual #1's 6/26/14 Psychiatric Update documented the following objective criteria related to his maladaptive behaviors and medications:</p> <ul style="list-style-type: none"> <li>- Decrease incidents of self abuse to 1 or less per month for 3 consecutive months.</li> <li>- Decrease incidents of repetitive behaviors to 850 or less per month for 3 consecutive months.</li> </ul> <p>However, his 3/27/14 medication reduction plan, revised 5/7/14, include the following criteria:</p> <ul style="list-style-type: none"> <li>- Decrease incidents of self-abuse to 0 per month for 12 consecutive months.</li> <li>- Decrease incidents of self-stimulating behavior to 650 or less per month for 3 consecutive months.</li> </ul> <p>When asked about the discrepancy during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m.</p>	W 111		

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W 111	<p>Continued From page 16 and 1:08 - 2:40 p.m., the QIDP stated the Psychiatric Update criteria needed to be updated.</p> <p>The facility failed to ensure Individual #1's record contained comprehensive, accurate information.</p> <p>2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #3's record was reviewed. His record did not include consistent, accurate information. Examples included, but were not limited to, the following:</p> <p>a. Individual #3's record contained a nurse's note, dated 12/6/13, that documented "Shingles injection given per orders." However, his immunization record documented he received the shingles vaccination on 9/27/13.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., LPN B stated 12/6/13 was the correct date.</p> <p>The facility failed to ensure Individual #3's immunization record contained accurate information related to his shingles vaccination.</p> <p>b. Individual #3's record contained MARs dated 3/2014 and 5/2014. Both MARs had a section titled Personal Care Orders which documented he was to have his fingernails trimmed every 2 weeks on Friday and have his toe nails trimmed once a month on a Friday.</p> <p>However, neither MAR had documentation of the procedures being completed.</p>	W 111		

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W 111	<p>Continued From page 17</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated the procedures were not being documented.</p> <p>c. Individual #3's record contained an Individual Support Plan dated 6/8/14. The objective stated Individual #3 would obtain his receipt after making a purchase with a specific verbal prompt.</p> <p>However, the status section documented Individual #3 "cannot hear very well so verbal prompting will be skipped."</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated it was an oversight.</p> <p>The facility failed to ensure Individual #3's record contained comprehensive, accurate information.</p> <p>3. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability, right sided hemiparesis, chronic left hand tremor and stroke.</p> <p>Individual #2's record was reviewed.</p> <p>His record did not include consistent information. Examples included, but were not limited to, the following:</p> <p>a. Individual #2's History and Physical, dated 8/13/13, documented a diagnosis of osteoporosis. His PCLP did not include the diagnosis of osteoporosis.</p> <p>During interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIPD stated</p>	W 111			

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W 111	<p>Continued From page 18</p> <p>the diagnosis of osteoporosis was not included in his program plan.</p> <p>b. Individual #2's May 2014 Record of Outings sheet documented he participated in 9 community outings. However, 3 of the 9 outings were for Meals on Wheels and 1 of the 9 outings was for a doctor's appointment. Only 5 of the entries were reflective of Individual #2 participating in activities of his interest and choice.</p> <p>When asked about Individual #2's community outings, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the May 2014 data collection was inaccurate. She stated Individual #2 was provided the opportunity and did go on outings more often than his May 2014 Record of Outings sheet documented.</p> <p>The facility failed to ensure Individual #2's May 2014 community outing record was accurate.</p> <p>c. Individual #2's PCLP included a SAM objective which documented he was working on self-initiating pulling his med box from the medication cabinet. However, his ISP, revised 6/8/14, stated he was working on disinfecting the table in the medication room prior to taking his medications with a specific verbal prompt.</p> <p>However, Individual #2's 12/3/13 CFA did not include a SAM assessment.</p> <p>When asked about Individual #2's SAM program during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #2 did participate in the SAM program and his program would be assessed and</p>	W 111			

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W 111	Continued From page 19 updated.  The facility failed to ensure Individual #2 had a SAM assessment.  4. Individual #5's record included a Tentative Treatment Plan, dated 7/29/14, which documented a 63 year old female whose diagnoses included profound intellectual disability.  The speech section of her Tentative Treatment Plan, dated 7/29/14, documented Individual #5 should receive a mechanical soft diet. However, the Dietary section of the plan documented she was to receive a regular texture diet.  Additionally, a physician's order for a modified texture diet, could not be found.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she was not sure what texture Individual #5's diet should be.  The facility failed to ensure Individual #5's diet texture was appropriately assessed and ordered by the physician.	W 111			
W 114	483.410(c)(4) CLIENT RECORDS  Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114			

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W 114	<p>Continued From page 20</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure that all entries in the individuals' records were signed and dated for 3 of 5 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in a lack of information related to who completed the entries. The findings include:</p> <p>1. Individuals #1 - #3's records included "Vocational Addendums," dated 1/17/14. The forms included information related to the individuals' past employment, present employment, future employment, work related behaviors and work related strengths and needs. However, none of the addendums were signed or indicated who had documented the information.</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she had completed the addendums.</p> <p>2. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability, right sided hemiparesis, chronic left hand tremor and stroke.</p> <p>a. His record contained a CFA, dated 12/3/13. Section IX of the CFA, "Nursing: Medications," contained a section for participation in a SAM program. There was a handwritten line through the entire section. However, an initial, signature, or date indicating when the SAM program information was lined through was not present on the assessment.</p> <p>b. Individual #2's record contained an Annual Nutritional Assessment which was undated and unsigned.</p>	W 114		

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W 114	Continued From page 21  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she lined through the SAM section on Individual #2's CFA. During the same interviews, LPN A reviewed Individual #2's Annual Nutrition Assessment and stated his Assessment was not signed and dated.	W 114			
W 120	The facility failed to ensure all entries were signed and dated.  483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of 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 outside services met the needs of 1 of 5 individuals (Individual #2) whose records were reviewed. This resulted in the potential for an individual's dental needs to be unidentified. The findings include:  1. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability and stroke.  Individual #2's record documented dental visits on 11/7/13 and 5/8/14. However, an x-ray report was not in his record. His record did not contain a dental note indicating when the most recent x-rays were obtained.  When asked about the most recent x-rays, during	W 120			

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W 120	Continued From page 22 an interview on 8/13/14 from 2:00 - 2:40 p.m., the RN stated a telephone call was made to Individual #2's dentist and, according to the dentist, Individual #2 had not had dental x-rays. The RN said all attempts to obtain x-rays had been unsuccessful. When asked what decision was made by Individual #2's guardian and the IDT to determine the best possible course of action since the dentist could not obtain dental x-rays, the RN stated no action had been taken to address the dentist's unsuccessful attempts to obtain dental x-rays for Individual #2.	W 120		
W 124	The facility failed to provide sufficient communication and coordination to ensure a comprehensive dental examination had been obtained for Individual #2.  483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base decisions for 2 of 5 individuals (Individuals #1 and #3) whose records were reviewed. This resulted in a lack of information being provided to the individuals' guardians regarding potential drug complications.	W 124		

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W 124	<p>Continued From page 23</p> <p>The findings include:</p> <p>1. Individual #1 and #3's records included the following:</p> <p>a. Individual #1's IPP, dated 9/4/13, documented a 53 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #1's 3/27/14 Physician's Orders documented he received Risperdal (an antipsychotic drug) 5 mg, Zyprexa (an antipsychotic drug) 12.5 mg, Clonidine (an antihypertensive drug) 0.05 mg three times a day and Zoloft (an antidepressant drug) 50 mg daily for behavior modification purposes.</p> <p>The Physician's Orders also documented he received ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.</p> <p>Individual #1's Consultant Pharmacist's Medication Regimen Review, dated 6/20/14, stated "Aspirin and Ibuprofen can independently increase risk if [sic] a GI bleed. There is some evidence to suggest that the SSRI's (seraline) can also increase this risk. As [Individual #1] is on both classes of medications, it is recommended that GI bleed be considered during his routine visits with PCP and if he has any signs or symptoms during regular nursing review."</p>	W 124		

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W 124	<p>Continued From page 24</p> <p>However, documentation that Individual #1's guardian had been notified of the increased risks due to the drug combinations could not be found in his record.</p> <p>b. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #3's Physician's Orders, dated 7/2014, documented he received lisinopril (an antihypertensive drug) 20 mg daily. The document also included an order for ibuprofen (an NSAID) 400 mg twice daily as needed.</p> <p>Individual #3's Consultant Pharmacist's Medication Regimen Review, dated 6/13/14, stated "...the risk of nephrotoxicity (destructive to kidney cells) to either ACE Inhibitors or NSAID's, including hyperkalemia (elevated potassium level), may be increased by this drug combination.... Periodic measurement of renal function and potassium concentrations may be necessary."</p> <p>However, documentation that Individual #3's guardian had been notified of the increased risk due to the drug combination could not be found in his record.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the LPN and QIDP stated guardians had not been notified of the increased risks.</p> <p>The facility failed to ensure Individual #1 and Individual #3's guardians were informed of increased health risks due to their drug combinations as identified by the pharmacist.</p>	W 124			

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W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</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 the QIDP provided sufficient monitoring and oversight for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of individuals' active treatment programs. The findings include:</p> <p>1. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with autistic disorder, mood disorder, and severe intellectual disability. His record did not include documentation of consistent QIDP coordination and monitoring. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's 9/3/13 CFA stated in the "Bed Making," "House Keeping," and "Clothing Care" sections on pages 6 and 7 that he required light physical assistance to full physical assistance to complete all bed making and house keeping tasks. The clothing care section stated he could put his dirty clothes a hamper with a gestural prompt, and put away clean clothes and discard stained or torn clothes with a specific verbal prompt. Individual #1 required light physical to full physical assistance for all other clothing care tasks.</p> <p>Individual #1's IPP stated in the bed making and</p>	W 159		

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W 159	<p>Continued From page 26</p> <p>housekeeping sections that Individual #1 would have "No programming at this time." However, Individual #1's Occupational Therapy Report, dated 8/25/13, included a recommendation for Individual #1 to "Continue to develop increased participation in higher level activities of daily living including (meal preparation, making his bed, doing laundry, dishes, etc.) for functional life skills and a daily meaningful interaction with his environment." A corresponding Occupational Therapy Service objective and plan, dated 10/18/12, stated staff were to "Encourage [Individual #1's] participation in assisting with meal preparation, making his bed, doing his laundry, assisting with dishes, etc."</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., why a service objective had been developed rather than a training objective, the QIDP stated it was probably what the IDT determined at that time, but there were no notes or documentation regarding the rationale.</p> <p>b. Individual #1's record included an occupational therapy service program, dated 10/18/12, and an engage in sensory activities training program, revised 5/7/14. Both programs stated staff were to engage Individual #1 in sensory activities by offering him a choice of "rhythm activities," warm baths, warm clothing/bedding, or deep pressure massage. Neither program included instructions to staff regarding how long Individual #1 was to engage in the activities. Additionally, neither program required data collection to provide information regarding what Individual #1 was choosing to engage in or the amount of time he participated in the activities.</p>	W 159			

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W 159	<p>Continued From page 27</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the service objective would probably need to be discontinued. When asked what activities Individual #1 was choosing to participate in and how long he participated, the QIDP stated it was not documented.</p> <p>c. Individual #1's Sleep Hygiene service program, revised 3/13/14, stated Individual #1 had a difficult time sleeping. The program included general guidelines which had not been individualized to meet Individual #1's specific needs such as "Avoid stimulants such as caffeine, nicotine, and alcohol too close to bedtime" and "Avoid things that may trigger worry or anxiety before bed, like upsetting news or gory television shows."</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the service objective was not individualized to meet Individual #1's needs. DCS H, who was also present during the interview, stated Individual #1 would put on warm clothes from the dryer as part of his sleep hygiene routine.</p> <p>d. Individual #1's record included a Community Access Service Program, dated 10/18/12, which documented "[Individual #1] will access the community at least eight times monthly for twelve consecutive months." The program instructed staff "Before the activity begins, tell [Individual #1] about the activity and allow [Individual #1] to decide if he would like to go. Offer [Individual #1] choices of outings..."</p> <p>Individual #1's CFA, dated 9/3/13, documented in</p>	W 159		

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W 159	<p>Continued From page 28</p> <p>the Community Leisure section that Individual #1 "enjoys going to the park and going out for milkshakes if given a choice." The assessment also documented Individual #1 "enjoys swimming with his peers at [facility name]" and "enjoys going on walks."</p> <p>However, review of Individual #1's Record of Outings, dated 5/2014 - 7/2014, documented Individual #1 did not participate in monthly, preferred activities, as follows:</p> <p>5/2014: Eight community outings for a total of 6 hours 15 minutes were documented. Individual #1 went out for ice cream on 5/3/14, to the park on 5/10/14 and for a walk in a park on 5/17/14. There was no documentation of incorporation of Individual #1's preferred activities for the other five outings.</p> <p>6/2014: Four community outings for a total of 5 hours were documented. Individual #1 went for a walk on 6/12/14. There was no documentation of incorporation of Individual #1's preferred activities for the other three outings.</p> <p>7/2014: Four community outings for a total of 3 hours were documented. Individual #1 went out for ice cream on 7/2/14. There was no documentation of incorporation of Individual #1's preferred activities for the other three outings.</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #1 should be engaged in preferred activities and she believed Individual #1 was accessing the community but staff were not always recording it.</p>	W 159			

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W 159	<p>Continued From page 29</p> <p>The facility failed to ensure Individual #1's community utilization documentation adequately reflected he was engaging in preferred activities of his choice.</p> <p>The facility failed to ensure the QIDP provided sufficient oversight and monitoring of Individual #1's program plan.</p> <p>2. Individual #7's Client Emergency Information sheet documented a 63 year old male whose diagnoses included severe intellectual disability.</p> <p>During an observation on 8/5/14 from 6:55 - 9:05 a.m., Individual #7 was noted to be served pureed breakfast casserole in a travel mug. DCS H, who was present, stated using the travel mug was easier for Individual #7 than a dish.</p> <p>However, Individual #7's Dietary Guidelines, dated 4/3/14, did not include the use of the travel mug.</p> <p>During a follow up visit to the facility on 8/8/14 from 2:40 - 3:20 p.m., the QIDP stated the travel mug was easier for him and that it should have been included in his feeding guidelines.</p> <p>The facility failed to ensure Individual #7's travel mug was included in his guidelines.</p> <p>3. Individual #5's 7/29/14 Tentative Treatment Plan documented she was a 63 year old female whose diagnoses included profound intellectual disability. She had been residing in a sister facility within the company, and was admitted to the facility on 7/29/14.</p> <p>a. The facility's Admissions policy, dated 2/14/12,</p>	W 159		

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W 159	<p>Continued From page 30</p> <p>stated the IDT was to have a pre-admission review. The policy stated once the pre-admission information was received, the facility was to conduct an "IDT Review Meeting." The policy stated the IDT was to review the appropriateness of placement. If it was determined placement in the facility was appropriate, the IDT was to "begin discussion regarding the Initial Plan of Care." The policy stated "An initial plan of care must be in place prior to admission and should address those key areas needed to ensure the health and safety of the individual." The following areas were to be addressed within the initial plan of care:</p> <ul style="list-style-type: none"> <li>- Orders for evaluations;</li> <li>- Initial habilitation programs;</li> <li>- Initial health care programs;</li> <li>- Initial behavioral management programs;</li> <li>- Initial psychotropic medication plans; and</li> <li>- Social-recreational activities.</li> </ul> <p>The policy stated "After the initial plan of care is developed, the IDT will meet to review implementation of the plan before the individual arrives. This includes, but is not limited to identifying staff training needs, scheduling and implementation of such training...that must be immediately implemented to provide for the health and safety of the individual and staff."</p> <p>The facility's policy was not implemented as follows:</p> <p>Individual #5's Tentative Treatment Plan included various sections, such as daily living skills, psycho/social, speech, OT/PT, etc. Each section stated the goal was to assess Individual #5's capabilities in each of the listed areas. However,</p>	W 159			

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W 159	<p>Continued From page 31</p> <p>no other information related to staff interventions, training, etc., in accordance with the facility's policy, was present in Individual #5's Tentative Treatment Plan.</p> <p>During an interview on 8/5/14 from 8:55 - 9:02 a.m., the QIDP stated information related to Individual #5 from her time at the sister facility was not incorporated into Individual #5's plan as it was company policy to start over with programming and treat each admission like a brand new admission.</p> <p>b. The facility's "Active Treatment" policy, effective 12/14/11, stated when an individual moved into the home "...a team of professionals (Physician, Behavior Specialist, Social Worker, QMRP, Dietician, Guardian, etc.) spends the first 30 days assessing the strengths and needs of the resident..."</p> <p>The policy did not include information related to how the assessments were to be conducted.</p> <p>When asked on 8/4/14 at 5:55 p.m., the lead worker stated they had only received Individual #5's Tentative Treatment Plan. She stated they also had a blank CFA. When asked what information was supposed to be completed on the CFA and who was supposed to complete it, the lead worker stated she was not sure, she thought everyone was to complete the CFA. When asked how information regarding Individual #5's adjustment, strengths, needs, etc., was being communicated to the QIDP and other staff members, the lead worker stated they talked to each other. When asked if the information was being documented anywhere, the lead worker stated no.</p>	W 159		

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W 159	<p>Continued From page 32</p> <p>During interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated data had not been taken on Individual #5's ADL activities and that she only had verbal input from the staff.</p> <p>The facility failed to ensure Individual #5's 30 day assessment information was collected in a comprehensive manner.</p> <p>4. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>His record contained a volunteer service objective, dated 8/20/12, that stated he would be assisted to volunteer 2 days a week for 12 consecutive months.</p> <p>The corresponding data sheet for 6/2014 had a "+" marked for every day of the month.</p> <p>During a visit to the facility on 8/8/14 from 2:40 - 3:20 p.m., the Administrator, who was present, stated the "+" indicated he participated in Meals on Wheels or that staff had asked him and he refused. When asked how one would tell how many times he refused to go and how many times he went, she stated she did not know. The QIDP, who was also present, stated the data collection needed to be revised to distinguish the difference.</p> <p>The facility failed to ensure Individual #3's data collection was sufficiently developed.</p> <p>5. Refer to W111 as it relates to the QIDP's failure to ensure a record keeping system that contained accurate, comprehensive information was</p>	W 159			

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W 159	Continued From page 33 maintained.  6. Refer to W114 as it relates to the QIDP's failure to ensure all entries in the individuals' records were signed and dated.  7. Refer to W120 as it relates to the QIDP's failure to ensure outside services met the individuals' needs.  8. Refer to W124 as it relates to the QIDP's failure to ensure sufficient information was provided to parents/guardians.  9. Refer to W190 as it relates to the QIDP's failure to ensure staff were able to demonstrate cross-cutting skills and competencies related to the individuals' developmental needs.  10. Refer to W194 as it relates to the QIDP's failure to ensure staff were able to demonstrate the skills and competencies necessary to implement individuals' IPPs.  11. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the QIDP's failure to ensure active treatment services were provided to each individual.  12. Refer to W266 Condition of Participation: Client Behavior and Facility Practices and associated standard level deficiencies as they relate to the QIDP's failure to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored.  13. Refer to W318 Condition of Participation:	W 159			

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W 159	Continued From page 34 Health Care Services and associated standard level deficiencies as they relate to the QIDP's failure to ensure adequate health care monitoring and follow up occurred for the individuals residing at the facility.	W 159			
W 190	14. Refer to W459 Condition of Participation: Dietetic Services and associated standard level deficiencies as they relate to the QIDP's failure to ensure appropriate dietary monitoring and services were provided to each individual residing in the facility. 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental needs.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure staff were able to demonstrate cross-cutting skills and competencies related to the developmental needs of 7 of 7 individuals (Individual #1 - #7) observed. This resulted in a lack of opportunities for individuals to practice skills and maximize their developmental potential. The findings include:  1. Observations were conducted of Individuals #1 - #7 on 8/4/14 from 3:15 - 4:20 p.m. and from 5:10 - 6:20 p.m. During the observations, DCS F was noted to prepare the evening meal. Individuals #1 - #7 were not observed to be prompted or encouraged to assist in any facets of the meal preparation.	W 190			

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - MALLARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER MERIDIAN, ID 83642</b>		
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W 190	<p>Continued From page 35</p> <p>When asked about the observations, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to be using every opportunity to prompt individuals to participate in functional, meaningful activities.</p> <p>2. Individual #1's IPP, dated 9/4/13, documented a 53 year old male diagnosed with severe intellectual disability and autistic disorder.</p> <p>Individual #1 was observed at the facility on 8/4/14 and 8/5/14 for a cumulative 5 hours and 10 minutes. During the observations, staff were not observed to consistently encourage or prompt Individual #1 to participate in skill building activities as opportunities presented themselves. Examples included, but were not limited to, the following:</p> <p>a. On 8/4/14 from 2:15 - 2:30 p.m. and 2:45 - 3:00 p.m., Individual #1 sat in a chair in the corner of the living room. Other than placing dog biscuits in a Ziploc plastic bag between 2:30 and 2:38 p.m., he was not engaged in any meaningful skills development and staff were not observed to offer him choices or elicit his participation in activities.</p> <p>b. On 8/4/14 from 5:10 - 5:30 p.m., Individual #1 was sitting in a chair in a corner of the living room, rocking back and forth. Staff were not observed to offer him choices or elicit his participation in activities.</p> <p>c. On 8/4/14 at 5:30 p.m., Individual #1 washed his hands, went into the kitchen, and obtained a plate of pureed food. Individual #1 was not given the opportunity to obtain his dishes from the</p>	W 190			

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W 190	<p>Continued From page 36</p> <p>cupboards or serve himself his own food.</p> <p>d. On 8/4/14 at 5:40 p.m., DCS F placed a scoop of ice cream on Individual #1's plate. Individual #1 was not provided the opportunity to serve himself.</p> <p>When asked about the observations, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to be using every opportunity to prompt individuals to participate in functional, meaningful activities.</p> <p>3. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #3's record included an Occupational Therapy report, dated 9/5/11. The Fine Motor Skills section of the report stated he was to be offered activities to increase fine motor skills such as bead work, coloring, painting, etc. Additionally, the Maximum Opportunities for Movement section stated he was to be offered opportunities to walk outside through out his day.</p> <p>However, Individual #3 was not observed to go out for a walk and was not offered the opportunity to choose other recommended activities, as follows:</p> <p>Individual #3 was observed at the facility on 8/4/14 and 8/5/14 for a cumulative 4 hours and 5 minutes. During the observations, staff were not observed to consistently encourage or prompt Individual #3 to participate in skill building activities as opportunities presented themselves. Examples included, but were not limited to, the</p>	W 190			

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W 190	<p>Continued From page 37 following:</p> <p>a. On 8/4/14 from 2:15 - 2:45 p.m., Individual #3 was sitting on the couch in the living room. He was not engaged in any meaningful skills development and staff were not observed to offer him choices or elicit his participation in activities.</p> <p>b. On 8/4/14 from 3:30 - 4:20 p.m., Individual #3 was sitting on the couch with a magazine. At 3:40 p.m., direct care staff briefly shook a box of items at him with no interest shown by Individual #3. Individual #3 remained sitting on the couch, periodically fidgeting with the magazine. Staff were not observed to offer him any additional choices of activities or elicit his participation in activities.</p> <p>c. On 8/4/14 from 5:10 - 5:30 p.m., Individual #3 was sitting on the couch. Staff were not observed to offer him a choice of activities or elicit his participation in activities.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., QIDP stated staff were to be using every opportunity to prompt individuals to participate in functional, meaningful activities.</p> <p>4. Individual #5's record included a Tentative Treatment Plan, dated 7/29/14, which documented a 63 year old female whose diagnoses included profound intellectual disability.</p> <p>Individual #5 was observed at the facility on 8/4/14 and 8/5/14 for a cumulative 4 hours and 5 minutes. During the observations, staff were not observed to consistently encourage or prompt</p>	W 190		

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W 190	<p>Continued From page 38</p> <p>Individual #5 to participate in skill building activities as opportunities presented themselves. Examples included, but were not limited to, the following:</p> <p>a. On 8/4/14 from 2:15 - 3:00 p.m., Individual #5 was sitting at the dining room table with a toy. At 2:37 p.m. she was observed to place small plastic bears in a container. She remained at the table until the end of the observation at 3:00 p.m.</p> <p>Individual #5 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 45 minute observation period.</p> <p>b. On 8/4/14 from 3:15 - 4:15 p.m., Individual #5 was laying on the couch. During that time staff asked if she wanted to walk 2 times. Individual #5 did not respond and continued laying on the couch.</p> <p>Staff were not observed to offer her a choice in activities or follow the prompt hierarchy to encourage her to participate in activities.</p> <p>c. On 8/4/14 from 5:10 - 5:30 p.m., Individual #5 was sitting at the dining room table unengaged while staff prepared the evening meal. Staff were not observed to offer her a choice in activities or follow the prompt hierarchy to encourage her to participate in meal preparation.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to be using every opportunity to prompt individuals to participate in functional, meaningful activities.</p>	W 190			

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W 190	Continued From page 39 The facility failed to ensure staff demonstrated cross-cutting skills and competencies related to the individual's developmental needs.	W 190		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM  Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure staff were able to demonstrate the skills and competencies necessary to implement individuals' IPPs for 5 of 5 individuals (Individuals #1 - #5) whose records were reviewed. This resulted in individuals not receiving training and services consistent with their needs. The findings include:  1. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their IPPs.	W 194		
W 195	483.440 ACTIVE TREATMENT SERVICES  The facility must ensure that specific active treatment services requirements are met.  This CONDITION is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of necessary	W 195		

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W 195	Continued From page 40 services and supports being provided to individuals in order to adequately address their needs. The findings include:  1. Refer to W196 as it relates to the facility's failure to ensure each individual was provided with continuous and consistent active treatment services in accordance with their individualized needs.	W 195			
W 196	483.440(a)(1) ACTIVE TREATMENT  Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure individuals were provided with continuous and consistent active treatment services in accordance with their individualized needs for 5 of 7 individuals (Individuals #1 - #5) residing at the facility. That failure resulted in individuals not receiving services and supports necessary to meet their needs. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with severe intellectual disability and autistic disorder.	W 196			

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W 196	Continued From page 41  a. Individual #1 was observed at the facility on 8/4/14 from 2:15 - 3:00 p.m. During the 45 minute observation period, the following was noted:  2:15 - 2:27 p.m.: Individual #1 was sitting in a chair in the corner of the living room, rocking back and forth.  2:28 - 2:30 p.m.: A direct care staff verbally cued Individual #1 to the dining room table to bag dog biscuits, at which point he went to the table. Individual #1 sat at the table and placed dog biscuits into a plastic bags.  2:31 - 2:37 p.m.: Individual #1 went into the kitchen and independently poured a glass of juice. A direct care staff verbally cued him to put the juice away, which he did.  2:38 - 2:49 p.m.: Individual #1 went to his bedroom and layed on his bed.  2:50 - 2:54 p.m.: Individual #1 returned to the living room and sat in the same chair in the corner of the living room. DCS C approached him, placed a hand on his back, and patted on his back two times.  2:55 p.m.: DCS C patted on his back one time. Individual #1 was still sitting in the chair when the observation ended at 3:00 p.m.  Other than placing dog biscuits into a plastic Ziploc bag and independently obtaining juice, Individual #1 was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives during the 45 minute observation period.	W 196		

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W 196	Continued From page 42  b. Individual #1 was observed at the facility on 8/4/14 from 3:15 - 4:20 p.m. During the 1 hour and 5 minute observation period, the following was noted:  3:15 - 3:24 p.m.: Individual #1 was sitting in a chair in the corner of the living room.  3:25 p.m.: DCS G approached Individual #1, placed a hand on his back, and patted one time.  3:26 - 3:29 p.m.: Individual #1 continued sitting in the chair in the corner of the living room.  3:30 p.m.: Individual #1 went to his bedroom and was observed folding pads.  3:31 p.m.: Individual layed on his bed. DCS E entered the room and closed the bedroom door.  3:32 - 3:45 p.m.: Individual #1's door was in his bedroom with the door closed.  3:46 p.m.: DCS E came out of Individual #1's room. Individual #1 was observed to still be laying on his bed.  3:49 p.m.: Individual #1 returned to the living room and sat in the same chair in the corner. DCS E placed a hand on his back and patted two times.  3:50 - 3:45 p.m.: Individual #1 and DCS E went into the kitchen. Individual #1 obtained a red plastic drinking glass from the cupboard and a soda from the refrigerator. Individual #1 took the items to the table where he sat and drank the soda.	W 196		

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W 196	<p>Continued From page 43</p> <p>3:55 p.m.: Individual #1 returned to his room and layed on his bed.</p> <p>3:56 - 4:18 p.m.: Individual #1 remained in his room laying on his bed.</p> <p>4:19 p.m.: DCS G went into Individual #1's room. Individual #1 came out of his bedroom and used a cloth to wipe the top of the dining room table. He was wiping the top of the dining room table when the observation ended at 4:20 p.m.</p> <p>Other than folding a pad, obtaining a drink, and wiping the top of the dining room table, Individual #1 was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives during the 1 hour and 5 minute observation period.</p> <p>c. Individual #1 was observed at the facility on 8/4/14 from 5:10 - 6:20 p.m. During the 1 hour and 10 minute observation period, the following was noted:</p> <p>5:10 - 5:30 p.m.: Individual #1 was sitting in the chair in the corner of the living room, rocking back and forth.</p> <p>5:30 p.m.: Direct care staff verbally cued Individual #1 to wash his hands. which he did.</p> <p>5:31 - 5:39 p.m.: Individual #1 went into the kitchen and obtained a section plate that had already been prepared by direct care staff, which he took to the table. Individual #1 fed himself independently. DCS E verbally cued him to use a napkin one time.</p>	W 196			

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W 196	<p>Continued From page 44</p> <p>5:40 - 5:43 p.m.: DCS F placed a scoop of ice cream on Individual #1's plate, which he ate.</p> <p>5:44 p.m.: Individual #1 finished eating, took his dirty dishes and eating utensils to the kitchen. He then sat in a chair in the corner of the living room.</p> <p>5:45 p.m.: DCS E and DCS F both verbally cued Individual #1 to put the salad dressing away. He got up from the chair, removed the bottles of salad dressing from the dining room table, placed the bottles in the kitchen refrigerator, and walked to his bedroom.</p> <p>5:46 - 6:20 p.m.: Individual #1 went to his bedroom and layed on the bed, where he remained until the observation ended at 6:20 p.m.</p> <p>With the exception of washing his hands, obtaining his plate, eating dinner and putting salad dressing away, Individual #1 was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives during 1 hour and 10 minute observation period.</p> <p>When asked about the observations, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to be implementing training programs and using every opportunity as a learning opportunity.</p> <p>The facility failed to ensure Individual #1 was consistently encouraged or prompted to participate in functional, meaningful activities.</p> <p>2. Individual # 3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p>	W 196			

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W 196	<p>Continued From page 45</p> <p>a. Individual #3 was observed at the facility on 8/4/14 from 2:15 - 3:00 p.m. During the 45 minute period, the following was observed:</p> <p>2:15 - 2:53 p.m.: Individual #3 was sitting on the couch in the living room.</p> <p>2:54 p.m.: A direct care staff told Individual #3 the coffee was ready. Individual #3 got up from the couch and went to the kitchen and obtained coffee, which he took to the table to drink.</p> <p>2:55 - 3:00 p.m.: Individual #3 sat at the table drinking his coffee. He was still sitting at the table when the observation ended at 3:00 p.m.</p> <p>Other than going to the kitchen to get coffee, Individual #3 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 45 minute observation period.</p> <p>b. Individual #3 was observed at the facility on 8/4/14 from 3:15 - 4:20 p.m. During the 1 hour and 5 minute observation period, the following was noted:</p> <p>3:15 p.m.: Individual #3 was observed in his bedroom with DCS G putting an exercise mat away.</p> <p>3:16 - 3:17 p.m.: Individual #3 was observed sitting in the living on the couch.</p> <p>3:18 - 3:24 p.m.: Individual #3 went to the table where he drank coffee and ate crackers.</p> <p>3:25 p.m.: Individual #3 took his coffee cup and</p>	W 196			

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - MALLARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER 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 196	<p>Continued From page 46</p> <p>bowl to the sink, then went to the living room and sat on the couch.</p> <p>3:26 - 3:43 p.m.: Individual #3 was observed sitting on the couch, periodically fidgeting with a magazine.</p> <p>3:44 p.m.: A direct care staff briefly shook a box of items at Individual #3. He showed no interest in the box.</p> <p>3:45 - 4:20 p.m.: Individual #3 was sitting on the couch periodically fidgeting with a magazine.</p> <p>Other than drinking coffee and eating cracker, and direct care staff shaking a box at him, Individual #3 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 1 hour and 5 minute observation period.</p> <p>c. Individual #3 was observed at the facility on 8/4/14 from 5:10 - 6:20 p.m. During the 1 hour and 10 minute observation period, the following was noted:</p> <p>5:10 - 5:26 p.m.: Individual #3 was sitting on the couch.</p> <p>5:27 p.m.: Individual #3 was cued to wash his hands in the bathroom, which he did.</p> <p>5:28 - 5:29 p.m.: Individual #3 placed 3 bowls of food, serving utensils, salad dressing, and his place setting on the table.</p> <p>5:30 - 5:34 p.m.: Individual #3 sat at the table and food was served.</p>	W 196		

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W 196	<p>Continued From page 47</p> <p>5:35 p.m.: Individual #3 was observed cutting a pork chdp with a knife.</p> <p>5:36 - 5:39 p.m.: Individual #3 was observed eating his meal independently.</p> <p>5:40 p.m.: Individual #3 cleared his dirty dishes to the sink, rinsed the dishes and placed them in the dishwasher. Individual #3 then returned to the living room and sat on the couch.</p> <p>5:41 - 6:06 p.m.: Individual #3 sat on the couch.</p> <p>6:07 - 6:08 p.m.: Individual #3 cleared the table with a verbal cue.</p> <p>6:09 p.m.: Individual #3 returned to the couch.</p> <p>6:10 - 6:11 p.m.: Individual #3 entered the medication area to take meds, then returned to the couch.</p> <p>6:12 - 6:20 p.m.: Individual #3 was observed sitting on the couch. The observation ended at 6:20 p.m.</p> <p>With the exception of setting and clearing the table, eating dinner, and taking medications, Individual #3 was not observed to be consistently encouraged or prompted to participate in functional, meaningful actives during the 1 hour and 10 minute observation period.</p> <p>d. Individual #3 was observed at the facility on 8/5/14 from 6:55 to 9:05 a.m. During the 2 hour and 10 minute observation period, the following was noted:</p> <p>6:55 - 7:25 a.m., Individual #3 was in his room</p>	W 196			

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W 196	<p>Continued From page 48 with the door closed.</p> <p>At 7:26 a.m.: Individual #3 came out of his bedroom and took a towel to the laundry room and went to the medication administration area.</p> <p>7:30 a.m.: Individual #3 exited the medication room and obtained coffee from the kitchen, which he took to the dining room table.</p> <p>7:31 - 7:44 a.m., Individual #3 sat at the table drinking coffee.</p> <p>7:46 - 7:49 a.m.: Individual #3 went to the kitchen and obtained his breakfast plate which direct care staff had prepared for him. Individual #3 took the plate to the table and independently ate breakfast.</p> <p>7:50 a.m.: Individual #3 finished breakfast and took his dishes to the kitchen and placed them in the dishwasher. Individual #3 went out the back door and sat on the patio.</p> <p>7:52 a.m.: Individual #3 entered the living room and sat on the couch.</p> <p>7:52 - 8:09 a.m.: Individual #3 sat on the living room couch.</p> <p>8:10 a.m.: Individual #3 returned to sit on the back patio. A direct care staff took him a glass of water.</p> <p>8:11 - 8:30 a.m.: Individual #3 continued to sit on the back patio.</p> <p>8:31 a.m.: A direct care staff went to the patio to check on Individual #3.</p>	W 196		

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W 196	Continued From page 49  8:32 - 8:44 a.m.: Individual #3 continued to sit on the back patio.  8:45 - 8:46 a.m.: Individual #3 entered the mediation administration area.  8:47 a.m.: Individual #3 exited the medication administration area and sat on the couch in the living room.  8:48 - 9:00 a.m.: Individual #3 remained sitting on the couch. The observation ended at 9:00 a.m.  With the exception of drinking coffee, eating breakfast, clearing his plate, and taking medications, Individual #3 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during 2 hour and 10 minute observation period.  When asked about the observations, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to be implementing training programs and using every opportunity as a learning opportunity.  The facility failed to ensure Individual #3 was consistently encouraged or prompted to participate in functional, meaningful activities.  3. Individual #5's record included a Tentative Treatment Plan, dated 7/29/14, which documented a 63 year old female whose diagnoses included profound intellectual disability.  a. Individual #5 was observed at the facility on 8/4/14 from 2:15 - 3:00 p.m. During the 45	W 196		

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W 196	<p>Continued From page 50</p> <p>minute period, the following was observed:</p> <p>2:15 - 2:36 p.m.: Individual #5 was sitting at the dining room table shaking a toy.</p> <p>2:37 p.m.: A direct care staff placed different colored small plastic bears on the table in front of Individual #5. The direct care staff tapped Individual #5's hand to prompt her to place the bears into a plastic container.</p> <p>2:38 - 3:00 p.m.: Individual #5 sat with the plastic bears in front of her, intermittently placing bears in the container.</p> <p>Individual #5 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 45 minute observation period.</p> <p>b. Individual #5 was observed at the facility on 8/4/14 from 3:15 - 4:20 p.m. During the 1 hour and 5 minute observation period, the following was noted:</p> <p>3:15 - 3:17 p.m.: Individual #5 was in her bedroom.</p> <p>3:18 p.m.: Individual #5 exits her room and goes to the living room where she laid on the couch.</p> <p>3:19 - 3:51 p.m.: Individual #5 layed on the couch.</p> <p>3:52 p.m.: A direct care staff asked Individual #5 is she wanted to go for a walk. Individual #5 did not respond.</p> <p>3:53 - 4:04 p.m.: Individual #5 layed on the couch.</p>	W 196			

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W 196	<p>Continued From page 52</p> <p>6:17 - 6:20 p.m.: Individual #5 sat on the couch where she remained until the observation ended at 6:20 p.m.</p> <p>With the exception of eating dinner and walking up and down the hallway, Individual #5 was not observed to be consistently encouraged or prompted to participate in functional, meaningful activities during the 1 hour and 10 minute observation period.</p> <p>When asked about the observations, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to be using every opportunity as a learning opportunity.</p> <p>The facility failed to ensure Individual #5 was consistently encouraged or prompted to participate in functional, meaningful activities.</p> <p>4. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments contained comprehensive information.</p> <p>5. Refer to W216 as it relates to the facility's failure to ensure health assessments were completed and contained comprehensive information.</p> <p>6. Refer to W217 as it relates to the facility's failure to ensure dietary assessments contained comprehensive information.</p> <p>7. Refer to W218 as it relates to the facility's failure to ensure sensorimotor assessments contained comprehensive information.</p> <p>8. Refer to W220 as it relates to the facility's</p>	W 196			

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W 196	<p>Continued From page 53</p> <p>failure to ensure speech assessments contained comprehensive information.</p> <p>9. Refer to W221 as it relates to the facility's failure to ensure an individual's auditory functioning was accurately assessed.</p> <p>10. Refer to W223 as it relates to the facility's failure to ensure social assessments contained comprehensive information.</p> <p>11. Refer to W225 as it relates to the facility's failure to ensure vocational assessments contained comprehensive information.</p> <p>12. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs included objectives to meet their needs.</p> <p>13. Refer to W234 as it relates to the facility's failure to ensure the individuals' training programs included sufficient direction to staff regarding how to implement the intervention strategies.</p> <p>14. Refer to W237 as it relates to the facility's failure to ensure training programs specified the type of data necessary to be able to assess progress toward objectives.</p> <p>15. Refer to W242 as it relates to the facility's failure to ensure individuals received training in personal skills essential for privacy and independence.</p> <p>16. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their IPPs.</p> <p>17. Refer to W250 as it relates to the facility's</p>	W 196			

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W 196	Continued From page 54 failure to ensure active treatment schedules were consistent with the individuals' objectives.	W 196			
W 200	18. Refer to W262 as it relates to the facility's failure to ensure restrictive interventions were implemented only with the approval of the human rights committee. 483.440(b)(3) ADMISSIONS, TRANSFERS, DISCHARGE  A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure admission evaluation information was current and comprehensive for 1 of 1 individual (Individual #5) admitted to the facility in the past year. This failure resulted in an individual being admitted without indications the facility could meet their needs. The findings include:  1. The facility's Admissions policy, dated 2/14/12, stated in the "Pre-Admission Information section that "...it is imperative that appropriate and adequate information be supplied to the IDT to be used in the pre-admission review. The following information is required of the placing agency or party before our IDT will meet to review the individual's placement in the facility..." The policy stated required pre-admission information	W 200			

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W 200	<p>Continued From page 55</p> <p>included the individual's personal history (social evaluations, functional development, financial status, etc.), medical history (physical examinations, dietary and nutritional summaries, etc.), psychological evaluations, and a release planning summary.</p> <p>Individual #5 had been residing in a sister facility within the company, and was admitted to the facility on 7/29/14.</p> <p>When asked about Individual #5's pre-admission information, during an interview on 8/5/14 from 8:55 - 9:02 a.m., the QIDP stated the information related to Individual #5 from her time at the sister facility was not incorporated into Individual #5's plan as it was company policy to start over with programming.</p> <p>During additional interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated information was gathered and an IDT meeting had been held. However, documentation of the meeting discussion could not be found.</p> <p>The facility failed to ensure Individual #5's record included preliminary evaluation information which supported the facility could meet Individual #5's needs and that she would benefit from placement.</p>	W 200		
W 214	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by:</p>	W 214		

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W 214	<p>Continued From page 56</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure developmental and behavioral assessments contained accurate and comprehensive information for 3 of 4 individuals (Individuals #1, #3 and #4) whose assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with autistic disorder, mood disorder, and severe intellectual disability. Individual #1's 9/3/13 CFA and 3/13/14 Behavioral Assessment were reviewed. The assessments did not include consistent comprehensive information, as follows:</p> <p>a. Individual #1's Behavior Assessment stated he engaged in self-abuse and self-stimulating behavior which were "essentially the same behavior" with self-abuse leaving an injury and self stimulation not resulting in injury. Both behaviors included hitting his head, biting his fingers, poking his chest, and hitting his shin with his heel. The assessment stated he engaged in the behaviors as a way to meet his sensory needs. The assessment also stated "it has been noted to increase during allergy season. This may be due to the increase [sic] sinus pressure. [Individual #1] does take routine allergy medication in addition to routine pain medications."</p> <p>The assessment stated Individual #1 also engaged in Socially Offensive Behavior which included taking off his clothes, spitting, and urinating in inappropriate places to express his wants. The assessment stated "Additionally, he</p>	W 214			

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W 214	<p>Continued From page 57</p> <p>is unable to communicate his needs regarding his health status such as pain from his allergies."</p> <p>Individual #1's 3/27/14 Physician's Orders documented he received routine allergy medication and routine pain medication which included ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.</p> <p>Further, he received routine behavior modifying medications which included Risperdal (an antipsychotic drug) 5 mg, Zyprexa (an antipsychotic drug) 12.5 mg, Clonidine (an antihypertensive drug) 0.05 mg three times a day and Zoloft (an antidepressant drug) 50 mg daily.</p> <p>When asked about Individual #1's pain, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 was doing really well since having his teeth extracted (on 9/8/13).</p> <p>Further, his QIDP behavior summaries documented he had not engaged in self-abuse from 10/2013 - 7/2014.</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if Individual #1's pain level and pain medication had been re-evaluated after his teeth were extracted, LPN A and LPN B both stated they were not aware of such an evaluation. When asked about</p>	W 214			

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W 214	<p>Continued From page 58</p> <p>the origin of Individual #1's current pain, LPN A, LPN B and the QIDP were not able to say where Individual #1's pain was originating from or if he was experiencing chronic pain which warranted the use of the 3 routine pain medications. When asked if a pain assessment had been completed or if Individual #1's non-verbal indicators of pain, prior to engaging in self-abuse, had been assessed, LPN A, LPN B and the QIDP all stated they had not. When asked if the use of Individual #1's behavior modifying drugs had been re-evaluated based on the potential decrease in oral pain and the documented absence of self-abuse, the QIDP stated it had not. When asked if Individual #1 had programming in place to teach him to communicate when he was in pain, the QIDP stated he did not.</p> <p>The facility failed to ensure Individual #1's Behavior Assessment included comprehensive information based on a re-evaluation of his current pain concerns and its impact on his maladaptive behaviors. This resulted in on-going use of routine pain and behavior modifying drugs without documented justification and the absence of less restrictive programming to identify Individual #1's non-verbal indicators of pain and to teach Individual #1 appropriate ways to communicate pain.</p> <p>b. Individual #1's Behavioral Assessment stated in the "Weaknesses" section that he communicated "via sounds/gesture or pictures." However, his 6/30/13 Speech and Language Annual Review did not include information regarding Individual #1's use of pictures. The Speech and Language Annual Review stated Individual #1 was working on using tangible objects that represented an event or activity.</p>	W 214			

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W 214	Continued From page 59  When asked about the assessments, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #1 did not use pictures to communicate.  The facility failed to ensure Individual #1's Behavior Assessment contained accurate information.  c. The "Dislikes" section on page 1 of his CFA and the "Dislikes" section of his Behavior Assessment stated he did not like "continuous cuing." The CFA and Behavior Assessment did not include specific assessment information related to prompting Individual #1 (e.g. amount of time to wait between prompts, frequency of prompts, etc.). Additionally, the "Following Instructions" section on page 18 of the CFA stated Individual #1 would independently comply with requests within 0 - 60 seconds.  When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if an assessment had been completed to determine what would constitute continuous cuing for Individual #1, the QIDP stated an assessment had not been completed.  d. Individual #1's CFA stated in multiple places that "All his tasks have to be quick and he requires lots of breaks for anything that's not" and "He may get upset if it's not quick." However, his Behavior Assessment did not include information related to the duration of Individual #1's tasks or his need for frequent breaks.  When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the	W 214		

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W 214	<p>Continued From page 60</p> <p>QIDP stated the information should be included in Individual #1's Behavior Assessment.</p> <p>The facility failed to ensure Individual #1's CFA and Behavior Assessment included comprehensive information.</p> <p>e. Individual #1's Communication program, revised 5/7/14, stated he "...demonstrates frustration by rocking, biting his hand, and deeper breathing." However, the signs of frustration were not included in Individual #1's Behavior Assessment.</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the information should be included in Individual #1's Behavior Assessment.</p> <p>The facility failed to ensure Individual #1's CFA and Behavior Assessments included accurate, comprehensive information.</p> <p>2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #3's Behavioral Assessment, dated 8/19/13, stated he engaged in SIB which included biting, head hitting, picking at his skin, and scratching himself. The Behavior Assessment did not include comprehensive information, as follows:</p> <p>a. Individual #3's record contained two ABC Behavior Logs, dated 5/12/14 and 5/17/14. Both documented pain as being a possible cause of SIB.</p>	W 214		

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W 214	<p>Continued From page 61</p> <p>Additionally, his record contained an Incident/Accident report, dated 11/14/13, documenting he had engaged in SIB. The "Conclusions" section of the report documented "...[Individual #3] hits himself when he is in pain...."</p> <p>However, Individual #3's Behavioral Assessment did not include information regarding how his pain impacted his SIB.</p> <p>b. Individual #3's Behavior Intervention Plan for SIB, dated 11/26/13, documented he did not like noise. However, his Behavioral Assessment did not include information regarding how noise impacted his SIB.</p> <p>c. The Dislikes section of his Behavioral Assessment, dated 8/19/13, documented he did not like "...being rushed/being cued..." However, no information relating to what being rushed/cued was (e.g. times between prompts etc.) was included in the assessment.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #3 was to be cued one time and then again in 5 minutes. She further stated it should have been included in the assessment and the assessment needed to be updated.</p> <p>The facility failed to ensure Individual #3's behavior assessment contained comprehensive information.</p> <p>3. Individual #4's PCLP, dated 5/28/14, documented a 37 year old male whose diagnoses included Moderate intellectual disability.</p>	W 214		

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W 214	Continued From page 62  Individual #4's Behavioral Assessment, dated 5/27/14, stated he engaged in swearing, verbally threatening staff or peers, yelling and mumbling under his breath.  The Dislikes section of the assessment documented he did not like "...being rushed/cued ...." However, no information relating to what being rushed/cued was (e.g. times between prompts etc.) was included in the assessment.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #4 was to be cued one time and then again in 5 minutes. She further stated it was an oversight that the information had not been included.  The facility failed to ensure Individual #4's behavior assessment included comprehensive information.	W 214			
W 216	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include physical development and health.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals' CFAs include consistent comprehensive health information for 4 of 4 individuals (Individuals #1 - #4) whose CFAs were reviewed. This resulted in a lack of information being available on which to base program intervention and health decisions. The findings include:	W 216			

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W 216	<p>Continued From page 63</p> <p>1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. Individual #1's record did not included comprehensive information regarding his health, as follows:</p> <p>a. Individual #1's 9/3/13 Annual Nursing Summary stated, on 5/13/08, Individual #1 began receiving Clonidine (an antihypertensive drug) in addition to routine doses of Tylenol (an analgesic drug) and Ibuprofen (an NSAID) for possible pain. The nursing summary stated the Clonidine and pain medications "have been very helpful. His SIB has significantly decreased."</p> <p>The summary also stated Individual #1 had been seen by a dentist and had heavy teeth clenching and grinding with clinical wear with close proximity to the pulp on numerous teeth. The concern was discussed with the IDT and the decision was made to extract Individual #1's teeth. The summary stated his upper teeth were extracted on 1/8/13 and his lower teeth were extracted on 9/8/13.</p> <p>Individual #1's 3/27/14 Physician's Orders documented he received ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg, 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if</p>	W 216			

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W 216	<p>Continued From page 64</p> <p>Individual #1's pain medication had been re-evaluated after his tooth extractions, LPN A and LPN B both stated they were not aware of a re-evaluation. When asked if Individual #1's routine standing orders had been re-evaluated in light of his routine pain medications, LPN A stated the physician had signed the routine standing orders, but a specific discussion regarding the as needed pain medication had not occurred. When asked about the origin of Individual #1's current pain LPN A, LPN B and the QIDP were not able to say where Individual #1's pain was originating from or if he was experiencing chronic pain which warranted the use of the 3 routine pain medications.</p> <p>b. Individual #1's 9/3/13 CFA stated, in the "Communication Skills" section on page 8, that he was non-verbal and he could not communicate that he was in pain or sick. The CFA included a note which stated he communicated he was in pain or sick "Only through agitation."</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., about assessment related to Individual #1's non-verbal indicators of pain prior to him becoming agitated (e.g. facial grimaces, increased vocalizations, restlessness, etc.) the QIDP and LPN A both stated there was none.</p> <p>The facility failed to ensure Individual #1's record included comprehensive assessment information related to pain and pain management.</p> <p>c. Individual #1's 9/3/14 Annual Nursing Summary stated he participated in a program to administer his own medication. However, assessment information related to Individual #1's strengths</p>	W 216			

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W 216	<p>Continued From page 65 and needs in self-administration of medication could not be found.</p> <p>When asked, during interviews on 8/11/14 at 9:00 a.m., about assessment related to Individual #1's self-administration of medication, the QIDP stated the CFA had recently been revised and a self-administration of medication assessment was not completed for Individual #1.</p> <p>The facility failed to ensure Individual #1's record included comprehensive assessment information.</p> <p>2. Individual #2's CFA, dated 12/3/13, documented a 60 year old male whose diagnoses included severe intellectual disability, right sided hemiparesis, GERD, seizure disorder, hypothyroidism, chronic left hand tremor, and stroke.</p> <p>His record contained a CFA, dated 12/3/13. Section IX of the CFA, "Nursing: Medications," contained a section for participation in a SAM program. However, there was a handwritten line through the entire section.</p> <p>When asked about Individual #2's SAM assessment, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the CFA had recently been revised and a SAM assessment was not used for Individual #2. However, he did participate in a SAM program and it would need to be assessed.</p> <p>The facility failed to ensure Individual #2's ability to self administer his medications had been assessed.</p> <p>3. Individual #3's IPP, dated 9/20/13, documented</p>	W 216		

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W 216	<p>Continued From page 66</p> <p>a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>His record contained an objective for a SAM program stating "[individual #3] will pop 2 of his medications out daily with a specific verbal prompt in 10 of 12 trials per month for three consecutive months."</p> <p>However, his CFA, dated 8/19/13, did not include an assessment of his ability to self administer his medications.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated his ability to self administer his medications had not been assessed.</p> <p>The facility failed to ensure Individual #3's ability to self administer his medications had been assessed.</p> <p>4. Individual #4's PCLP, dated 5/28/14, documented a 37 year old male whose diagnoses included moderate intellectual disability.</p> <p>However, his CFA, dated 4/21/14, did not include an assessment of his ability to self administer his medications.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated his ability to self administer medications had not been assessed.</p> <p>The facility failed to ensure Individual #4's ability to self administer his medications had been assessed.</p>	W 216			

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W 217 W 217	Continued From page 67 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include nutritional status.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure dietary assessments contained comprehensive information for 2 of 4 individuals (Individuals #1 and #2) whose dietary assessments were reviewed. This resulted in a lack of comprehensive information being available necessary to ensure individuals' dietary needs were being addressed. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. His 8/15/13 Nutritional Assessment did not include accurate, comprehensive information, as follows:  a. Individual #1's Nutritional Assessment stated he was cued to take small bites and eat slowly, alternating food and drinks to decrease risk of aspiration. His 8/25/13 Occupational Therapy Report stated he "Continues to require supervision for self-feeding for pacing with pureed diet," and his 9/3/13 CFA stated in the "Eating & Dining" section on page 9 that he required specific verbal cues to not rush eating, but relax and enjoy meals.  However, Individual #1's IPP did not include an objective related to his eating pace.  When asked during interviews on 8/11/14 from	W 217 W 217			

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W 217	<p>Continued From page 68</p> <p>9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated the assessments were not accurate. DCS H stated since Individual #1's teeth were extracted (on 9/8/13) he has seemed to calm and really enjoy his meals.</p> <p>The facility failed to ensure Individual #1's assessments included accurate information regarding his dining skills.</p> <p>b. Individual #1's CFA stated, in the "Adaptive Equipment" section on page 31, that he required a lip plate and a seat cushion. However, his Nutritional Assessment did not include adaptive eating equipment and his Dietary Guidelines, revised 3/26/14, stated he used a lip plate and a rocker knife.</p> <p>Additionally, during an observation at the facility on 8/4/14 from 5:10 - 6:20 p.m., Individual #1 was observed to use a high-sided, divided plate and a seat cushion during the evening meal.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H and the QIDP both stated he used the seat cushion and either a lip plate or a high-sided divided plate. He no longer required the use of a rocker knife as he received a pureed diet since having his teeth extracted (on 9/8/13).</p> <p>The facility failed to ensure Individual #1's record included consistent accurate information related to his adaptive equipment.</p> <p>c. Individual #1's 9/3/13 Annual Nursing Summary stated he was diagnosed with anemia and received ferrous sulfate (an iron supplement) 325 mg twice daily. However, his Nutritional</p>	W 217			

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W 217	<p>Continued From page 69</p> <p>Assessment did not include information regarding the diagnosis.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., LPN A and the QIDP both stated they did not know why Individual #1's anemia was not addressed on his Nutritional Assessment.</p> <p>The facility failed to ensure Individual #1's Nutritional Assessment included comprehensive information for his relevant diagnoses.</p> <p>The facility failed to ensure Individual #1's Nutritional Assessment contained accurate, comprehensive information.</p> <p>2. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability, right sided hemiparesis, GERD, seizure disorder, hypothyroidism, chronic left hand tremor, and stroke.</p> <p>Individual #2's 8/13/13 Physician History and Physical Examination Report documented he was diagnosed with osteoporosis and a 10/4/12 DXA test documented his "...Fracture risk is high..."</p> <p>Further, Individual #2's 8/30/12 Vitamin D 25-OH laboratory value was 24.3 ng/mL. The reported documented values in the 20-29 range indicated a relative insufficiency of Vitamin D 25-OH.</p> <p>The Vitamin D 25-OH test determines the level of Vitamin D in the body.</p> <p>Individual #2's Annual Nutritional Assessment, undated and unsigned, included a section entitled</p>	W 217			

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W 217	Continued From page 70 laboratory data. The laboratory data section documented laboratory data, dated 8/30/12 and 8/16/13. The section did not include the Vitamin D 25-OH insufficiency and the section titled "Nutritional Assessment" did not include the diagnosis of osteoporosis or the Vitamin D 25-OH insufficiency.  During interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., LPN A reviewed the nutritional assessment and confirmed it did not include the diagnosis of osteoporosis or the laboratory value of Vitamin D 25-OH insufficiency.	W 217			
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The facility failed to ensure Individual #2's nutritional assessment was comprehensive.  The comprehensive functional assessment must include sensorimotor development.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sensorimotor assessments contained accurate comprehensive information for 1 of 4 individuals (Individual #1) whose assessments were reviewed. This resulted in the potential for an individual to not receive appropriate training and services. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. Individual #1's 8/25/14 Occupational Therapy Report did not include accurate information, as follows:	W 218			

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W 218	<p>Continued From page 71</p> <p>a. Individual #1's Occupational Therapy Report stated he "Continues to require supervision for self-feeding for pacing with pureed diet."</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated the assessment was not accurate. DCS H stated since Individual #1's teeth were extracted (on 9/8/13) he has seemed to calm and really enjoy his meals now.</p> <p>b. His Occupational Therapy Report stated Individual #1 continued to demonstrate decreased behaviors, he was tolerating more time in the community and maladaptive behaviors "following meal time have remained lower than historically. These changes may be due to regulating what he watched on television, avoiding chocolate and spicy foods, and limiting fluids before bed time..." The assessment further stated he demonstrated increased gagging with his fingers, especially in the morning when agitated.</p> <p>However, data to support the increased time in the community, the decreased maladaptive behaviors after meals and the increased gagging in the morning was not available at the facility. Further, none of the intervention strategies listed in the Occupational Therapy Report could be found in Individual #1's 3/13/14 Behavioral Assessment.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the Occupational Therapy Report was not accurate.</p> <p>The facility failed to ensure Individual #1's</p>	W 218			

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W 218	Continued From page 72 Occupational Therapy Report included accurate information.	W 218		
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include speech and language development.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure consistent, comprehensive information related to each individual's communication strengths and needs was kept for 2 of 4 individuals (Individuals #1 and #3) whose CFAs were reviewed. This resulted in a lack of information being available on which to base program intervention decisions. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with autistic disorder, mood disorder, and severe intellectual disability. Individual #1's 9/3/13 CFA stated, in the "Communication Skills" section on page 8, that he was non-verbal.  a. Individual #1's 3/27/14 Physician's Orders documented he received ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.  Individual #1's CFA stated, in the "Communication	W 220		

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W 220	<p>Continued From page 73</p> <p>Skills" section on page 8, that he could not communicate that he was sick or in pain. The CFA included a note which stated he communicated he was sick or in pain "Only through agitation." Further, his 6/30/13 Speech and Language Annual Review did not include information regarding Individual #1's strengths and needs related to communicating when he was sick or in pain.</p> <p>When asked about assessment related to Individual #1's non-verbal indicators of pain prior to him becoming agitated (e.g. facial grimaces, increased vocalizations, restlessness, etc.) during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP and LPN A both stated there was none.</p> <p>The facility failed to ensure Individual #1's non-verbal indicators to communicated sickness or pain were comprehensively addressed.</p> <p>b. Individual #1's CFA stated when given a specific verbal cue, he would follow instructions given by means of picture cue and his 3/13/14 Behavioral Assessment stated in the "Weaknesses" section that he communicated "via sounds/gesture or pictures."</p> <p>However, his 6/30/13 Speech and Language Annual Review did not include information regarding Individual #1's use of pictures. The Speech and Language Annual Review stated Individual #1 was working on using tangible objects that represented an event or activity.</p> <p>When asked about the assessments, during an interview on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual</p>	W 220			

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W 220	Continued From page 74 #1 did not use pictures to communicate.  The facility failed to ensure information related to Individual #1's communication was consistent.  2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.  His record contained a Physician's Order, dated 7/2014, documenting he received acetaminophen (an NSAID) 650 mg twice a day for arthritis pain.  His record also contained two ABC Behavior Logs, dated 5/12/14 and 5/17/14. Both documented pain as a possible cause of SIB.  Additionally, his record contained an Incident/Accident report, dated 11/14/13, documenting he had engaged in SIB. The "Conclusions" section documented "... [Individual #3] hits himself when he is in pain...."  However, his CFA, dated 8/9/13, documented he did not communicate pain.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated his ability to communicate pain should be assessed.  The facility failed to ensure information related to Individual #3's ability to communicate pain was comprehensively addressed.	W 220			
W 221	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include auditory functioning.	W 221			

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W 221	Continued From page 75  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to determine an Individual's ability to hear for 1 of 4 individuals (Individual #3) whose auditory assessments were review. This resulted in the potential for an individual to not receive programming based on his auditory functioning. Findings include:  1. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.  Records of his auditory assessments were reviewed and documented the following:  - His record contained a physician report, dated 9/7/12, documenting he had retracted tympanic membranes bilaterally and that his communication was limited by impaired hearing.  - A Speech and Language Annual Review, dated 6/30/13, stated he had experienced ear infections but "These infections have not caused a hearing impairment." The report further stated "[Individual #3] continues to demonstrate comprehension of simple language use."  - The Communication section of his CFA, dated 8/19/13, documented he had poor hearing and that he was deaf. The "Hears spoken language" column was marked "Yes and No."  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she was unsure of Individual #3's auditory acuity.	W 221			

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W 221	Continued From page 76	W 221			
W 223	<p>The facility failed to ensure a comprehensive and accurate assessment of Individual #3's hearing was obtained.</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include social development.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, it was determined the facility failed to ensure individuals' CFAs include consistent comprehensive information related to their social preferences and leisure activities for 1 of 4 individuals (Individual #1) whose CFAs were reviewed. This resulted in a lack of information and activities/items being available in the facility. The findings include:</p> <p>1. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with autistic disorder, mood disorder and severe intellectual disability.</p> <p>a. Individual #1's 9/3/13 CFA was reviewed. Page 26 of the CFA included a section for "Home Leisure" which included items such as selecting something to do at home when given a choice, looking at books and magazines, trying new leisure activities, etc. The CFA stated Individual #1 required full physical assistance to participate in all of the listed home leisure activities.</p> <p>Additionally, pages 27 and 28 of the CFA included a section for "Interests" which included activities such as playing dominoes, sewing, puzzles, cards, etc. The CFA stated Individual #1 required</p>	W 223			

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W 223	<p>Continued From page 77</p> <p>full physical assistance to participate in all of the listed activities and no leisure preferences were included on the CFA.</p> <p>Further, page 29 of the CFA stated "NO" next to the assessment item "Needs leisure skills training" and Individual #1's IPP stated, in the "Recreation and Leisure" section on page 8, that he was "able to independently choose activities to participate in at home" and the activities were usually sensory oriented.</p> <p>When asked about the discrepancy between the CFA and the IPP, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 would take a nap or engage in sensory activities such as taking a bath, holding a pillow or engaging in sensory rhythm activities during his leisure time.</p> <p>Individual #1 was observed at the facility on 8/4/14 and 8/5/14 for a cumulative 5 hours and 10 minutes. During the observations, Individual #1 was not observed to be offered or engage in normalized leisure activities. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- On 8/4/14 from 2:15 - 2:30 p.m., Individual #1 was sitting in a chair in a corner of the living room.</li> <li>- On 8/4/14 from 3:15 - 3:30 p.m.: Individual #1 was sitting in a chair in the corner of the living room rocking back and forth. At 3:25 p.m., DCS G approached him, placed a hand on his back, and pat his back one time.</li> <li>- On 8/4/14 from 5:10 - 5:30 p.m., Individual #1 was sitting in a chair in a corner of the living</li> </ul>	W 223		

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W 223	<p>Continued From page 78 room, rocking back and forth.</p> <p>On 8/4/14 from 6:00 - 6:20 p.m., Individual #1 was laying on his bed in his bedroom, where he remained when the observation ended at 6:20 p.m.</p> <p>Individual #1 was not observed to be offered or engage in normalized leisure activities.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #1's leisure skills would need to be re-assessed.</p> <p>The facility failed to ensure Individual #1's CFA included comprehensive information regarding his home leisure skills.</p> <p>b. Individual #1's CFA did not include consistent, comprehensive information regarding his social preferences and attitudes, as follows:</p> <ul style="list-style-type: none"> <li>- The "Likes" section on page 1 of his CFA stated he liked "personal space and being alone." However, the "Personal Orientation and Relationships" section on page 28 of his CFA stated he did not prefer to be alone.</li> </ul> <p>When asked about the discrepancy, during an interview on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #1 did prefer to be alone.</p> <ul style="list-style-type: none"> <li>- The "Personal Orientation and Relationships" section on page 28 of his CFA stated he was not generally happy. However, Individual #1's IPP stated, in the "Personal Orientation and Relationships" section on page 8, that he was</li> </ul>	W 223			

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W 223	Continued From page 79 "generally happy."  When asked about the discrepancy between the CFA and the IPP, during an interview on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 was generally happy. The QIDP who was also present during the interview stated Individual #1's CFA would need to be updated.	W 223		
W 225	The facility failed to ensure Individual #1's CFA included consistent comprehensive information. 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include, as applicable, vocational skills.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was completed for 2 of 4 individuals (Individuals #1 and #3), whose vocational assessments were reviewed. This resulted in a lack of information on which to base program decisions. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. His IPP included a vocational objective to "...bag 1 bag of dog biscuits with a specific verbal cue..."  On 8/4/14 from 2:30 - 2:45 p.m., Individual #1 was observed sitting at the dining room table placing dog biscuits into Ziploc plastic bags for his vocational activity.	W 225		

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W 225	Continued From page 80  However, Individual #1's record included a "Vocational Addendum," dated 1/17/14, which stated "Voc. Dog Biscuits [sic]" in "Past Employment" section.  Additionally, the "Present Employment" section of the Addendum stated "Non [sic]." However, the "Present Employment" section of Individual #1's 9/3/13 CFA stated, on page 21, "None - but works on vocational programming of wiping off the table." Further, his 8/25/13 Occupational Therapy report stated he participated in meals on wheels at times for vocational activity.  The "Vocational Addendum" also stated, in the "Work Related Strengths and Needs" section, "unsure if there are any strengths." However, his CFA included multiple strengths and needs in the "Pre-Vocational Skills" section on pages 18 and 19. Examples included, but were not limited to, the following:  - Selects one object from a group of different items on request with a gesture. - Picks up small objects with one hand independently. - Transfers small objects from one hand to the other independently. - Folds paper in 3 equal sections and seals it in an envelope with full physical assistance. - When shown or instructed, participant can learn a new job or task involving one-step with a gesture.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 was working on bagging dog biscuits and did participate in meals on	W 225			

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - MALLARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER MERIDIAN, ID 83642</b>	
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W 225	<p>Continued From page 81 wheels.</p> <p>The facility failed to ensure Individual #1's vocational assessment included accurate, comprehensive information.</p> <p>2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability. His 8/19/13 CFA stated in the "Vocational Skills" section that he was retired. However, his record included a Vocational Addendum, dated 1/17/14, which stated he was volunteering in Meals on Wheels.</p> <p>Additionally, the Vocational Addendum stated, in the "Work Related Behaviors" section, that Individual #3 "would need constant cuing." However, the "Vocational Skills" section of Individual #3's CFA, documented the following:</p> <ul style="list-style-type: none"> <li>- "When given an instruction, complies within 0 to 30 seconds" The prompt required box listed him as independent.</li> <li>- "When given an instruction, complies within 30 to 60 seconds" The prompt required box listed him as independent.</li> <li>- "When given an instruction, complies within more than 60 seconds" The prompt required box listed him as independent.</li> </ul> <p>When asked on 8/25/14 at 8:22 a.m. the QIDP stated Individual #3 would complete activities when he chose to.</p> <p>However, Individual #3's record did not include information as to why a Vocational Addendum had been completed if Individual #3 was retired.</p> <p>The facility failed to ensure Individual #3's record included clear, consistent information regarding</p>	W 225		

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W 225	Continued From page 82	W 225			
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure each individual's IPP included objectives to meet their identified needs for 2 of 4 individuals (Individuals #1 and #3) whose IPPs were reviewed. This resulted in a lack of program plans designed to promote individuals' independence and maximize their developmental potential. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. Individual #1's assessments documented needs in multiple areas. However, corresponding objectives and training programs designed to meet those needs could not be found, as follows:  a. Individual #1's 9/3/13 CFA was reviewed. Page 26 of the CFA included a section for "Home Leisure" which included items such as selecting something to do at home when given a choice, looking at books and magazines, trying new leisure activities, etc. The CFA stated Individual #1 required full physical assistance to participate in all of the listed home leisure activities.	W 227			

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W 227	<p>Continued From page 83</p> <p>Additionally, pages 27 and 28 of the CFA included a section for "Interests" which included activities such as playing dominoes, sewing, puzzles, cards, etc. The CFA stated Individual #1 required full physical assistance to participate in all of the listed activities and no leisure preferences were included on the CFA.</p> <p>Further, page 29 of the CFA stated "NO" next to the assessment item "Needs leisure skills training" and Individual #1's IPP stated, in the "Recreation and Leisure" section on page 8, that he was "able to independently choose activities to participate in at home" and the activities were usually sensory oriented.</p> <p>When asked about the discrepancy between the CFA and the IPP, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 would take a nap or engage in sensory activities such as taking a bath, holding a pillow or engaging in sensory rhythm activities during his leisure time.</p> <p>Individual #1 was observed at the facility on 8/4/14 and 8/5/14 for a cumulative 5 hours and 10 minutes. During the observations, Individual #1 was not observed to be offered or engage in normalized leisure activities. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- On 8/4/14 from 2:15 - 2:30 p.m., Individual #1 was sitting in a chair in a corner of the living room.</li> <li>- On 8/4/14 from 3:15 - 3:30 p.m., Individual #1 was sitting in a chair in the corner of the living room rocking back and forth. At 3:25 p.m., DCS G approached him, placed a hand on his back,</li> </ul>	W 227		

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W 227	<p>Continued From page 84 and gave him a pat.</p> <p>- On 8/4/14 from 5:10 - 5:30 p.m., Individual #1 was sitting in a chair in a corner of the living room, rocking back and forth.</p> <p>On 8/4/14 from 6:00 - 6:20 p.m., Individual #1 was laying on his bed in his bedroom, where he remained when the observation ended at 6:20 p.m.</p> <p>Individual #1 was not observed to be offered or engage in normalized leisure activities.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., why a training objective had not been developed to teach Individual #1 home leisure skills, the QIDP stated it was probably what the IDT determined at that time, but there were no notes or documentation regarding the rationale.</p> <p>The facility failed to ensure a training objective was developed to teach Individual #1 home leisure skills.</p> <p>2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>The Recreational, Leisure and Retirement section of Individual #3's CFA, dated 8/19/13, documented he needed leisure skill training.</p> <p>However, his record did not contain objectives related to leisure skills.</p> <p>When asked on 8/25/14 at 8:22 a.m. the QIDP stated Individual #3 did not have an objective for</p>	W 227		

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W 227	Continued From page 85 leisure skills training and that he was given "fidget" stuff.  The facility failed to ensure Individual #3 had objectives related to leisure skills training.	W 227			
W 234	3. Refer to W242 as it relates to the facility's failure to ensure individuals received training in all skills essential for independent living. 483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure clear, consistent direction to staff was provided in each written training program for 2 of 4 individuals (Individuals #1 and #3) whose training plans were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program strategies. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. Individual #1's programs did not include sufficient instructions to staff regarding how to implement the intervention strategies, as follows:  a. The "Dislikes" section on page 1 of Individual #1's 9/3/13 CFA stated he did not like "continuous cuing." The CFA did not include specific assessment information related to prompting Individual #1 (e.g. amount of time to wait between prompts, number of prompts considered	W 234			

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W 234	<p>Continued From page 86</p> <p>continuous, etc.). Additionally, the "Following Instructions" section on page 18 of the CFA stated Individual #1 would independently comply with requests within 0 - 60 seconds.</p> <p>However, Individual #1's training programs did not include consistent instructions to staff related to prompting Individual #1 to participate. Examples included, but were not limited to the following:</p> <ul style="list-style-type: none"> <li>- Individual #1's toothbrushing program, dated 7/7/14, documented "If [Individual #1] refuses, recue in 5 minutes..."</li> <li>- Individual #1's self feeding program, dated 5/7/14, documented "If [Individual #1] refuses, re-cue in 2 minutes..."</li> <li>- Individual #1's medical desensitization program, dated 7/7/14, documented "If [Individual #1] refuses, recue him in 1 minute..."</li> <li>- Individual #1's money management program, dated 5/7/14, documented "If [Individual #1] refuses, simply record the refusal..."</li> </ul> <p>The programs were not consistent regarding when to re-cue Individual #1.</p> <p>When asked about the programs, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated prompting would need to be re-assessed.</p> <p>The facility failed to ensure Individual #1's program instructions were consistent.</p> <p>b. Individual #1's toothbrushing program, revised</p>	W 234			

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W 234	<p>Continued From page 87</p> <p>7/7/14, stated staff were to "Be sure to follow up with [Individual #1's] tooth brushing/flossing service" after he removed the lid from his toothpaste.</p> <p>However, Individual #1's 9/3/13 Annual Nursing Summary stated his upper teeth were extracted on 1/8/13 and his lower teeth were extracted on 9/8/13.</p> <p>When asked about the programs, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated program needed to be revised.</p> <p>c. Individual #1's CFA, stated in the "Adaptive Equipment" section on page 31, that he required a lip plate and a seat cushion. When asked about the seat cushion, during an interview on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., DCS H stated Individual #1 had been using the seat cushion for a long time as it was thought maybe the hard chairs were causing him pain.</p> <p>However, the seat cushion was not incorporated into Individual #1's Medical Desensitization program, revised 7/7/14, which directed staff to have Individual #1 sit in a kitchen chair.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the cushion should be used when implementing the Medical Desensitization program.</p> <p>d. Individual #1's record included an occupational therapy service program, dated 10/18/12, and a separate training program, revised 5/7/14, to engage in sensory activities. Both programs</p>	W 234			

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W 234	<p>Continued From page 88</p> <p>stated staff were to engage Individual #1 in sensory activities by offering him a choice of "rhythm activities," warm baths, warm clothing/bedding, or deep pressure massage. Neither program included instructions to staff regarding how long Individual #1 was to engage in the activities.</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the service objective would probably need to be discontinued. When asked about what activities Individual #1 was choosing to participate in and how long he participated, the QIDP stated it was not documented.</p> <p>The facility failed to ensure program instructions included sufficient information to staff on how to implement Individual #1's program strategies.</p> <p>2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>The Dislikes section of his Behavioral Assessment, dated 8/19/13, documented he did not like "...being rushed/being cued..." However, no information relating to what being rushed/cued was (e.g. times between prompts etc.) was included in the assessment.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #3 was to be cued one time and then again in 5 minutes.</p> <p>However, Individual #3's training programs did not include consistent instructions to staff related to prompting Individual #3 to participate.</p>	W 234			

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W 234	<p>Continued From page 89</p> <p>Examples included, but were not limited to the following:</p> <ul style="list-style-type: none"> <li>- Individual #3's Housekeeping program, dated 5/27/14, documented "If [Individual #3] refuses, re-cue in one minute."</li> </ul> <p>Additionally, the objective stated he would clear the food off his dishes before putting them in the dishwasher with a specific verbal prompt, which did not match the Gesture/Modeling cue assessed in his CFA, dated 8/19/13.</p> <ul style="list-style-type: none"> <li>- Individual #3's Money Management program, dated 6/8/14, documented "If [Individual #3] refuses, re-cue in 15 seconds."</li> </ul> <p>Additionally, the objective stated he would obtain his receipt after making the purchase with a specific verbal prompt.</p> <p>However, the status section stated "[Individual #3] cannot hear very well so verbal prompting will be skipped."</p> <p>When asked about the programs, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the program needed to be revised.</p> <p>The facility failed to ensure program instructions included sufficient information to staff on how to implement Individual #3's program strategies.</p> <p>3. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into each individual's program plan.</p>	W 234			

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W 237 W 237	Continued From page 90 483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure training programs specified the type of data necessary to be able to assess progress toward objectives for 4 of 4 individuals (Individuals #1 - #4) whose training programs were reviewed. This failure had the potential to prevent the facility from making objective decisions regarding individuals' success or lack of success. The findings include:  1. Individuals #1 - #4's training programs were reviewed and did not identify the type of data to be collected, as follows:  a. Individual #1's IPP, dated 9/4/13, documented a 53 year old male whose diagnoses included severe intellectual disability.  Individual #1's Individual Support Plan training programs were reviewed and did not identify the type of data to be collected.  Examples included, but were not limited to, Individual #1's Toothbrushing program, dated 7/7/14, his Self Feeding program, dated 5/7/14, his Medical Desensitization program, dated 7/7/14 and his Communication program, dated 5/7/14. Each of the programs stated refusals	W 237 W 237		

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W 237	<p>Continued From page 91</p> <p>were to be recorded in "care tracker" and stated "Data collection: Daily for 12 trials."</p> <p>No additional information related to the type of data to be collected (e.g. prompt level, plus or minus, tally mark, etc.) was included in the programs.</p> <p>b. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability and stroke.</p> <p>Individual #2's Individual Support Plan training programs were reviewed and did not identify the type of data to be collected.</p> <p>Examples included, but were not limited to, Individual #2's Pre-Rinse Dishes program, dated 5/7/14, his self feeding program, dated 12/13/13, and his Using Cookie Cutters program, dated 5/7/14. Each of the programs stated refusals were to be recorded in Care Tracker and stated "Data collection: Daily for 12 trials." (For the Using Cookie Cutters and Pre-Rinse Dishes programs) and daily on both AM and PM shifts for his self feeding program.</p> <p>No additional information related to the type of data to be collected (e.g. prompt level, plus or minus, tally mark, etc.) was included in the programs.</p> <p>c. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #3's Individual Support Plan training programs were reviewed and did not identify the type of data to be collected.</p>	W 237		

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W 237	Continued From page 92  Examples included, but were not limited to, Individual #3's Hand Washing program, dated 7/28/14, his Housekeeping program, dated 5/27/14, and his Tooth Brushing program, dated 7/7/14. Each of the programs stated refusals were to be recorded in "care tracker" and stated "Data collection: 12 times a month."  No additional information related to the type of data to be collected (e.g. prompt level, plus or minus, tally mark, etc.) was included in the programs.  d. Individual #4's PCLP, dated 5/28/14, documented a 37 year old male whose diagnoses included moderate intellectual disability.  Individual #4's Individual Support Plan training programs were reviewed and did not identify the type of data to be collected.  Examples included, but were not limited to, Individual #4's Money Management program, his Safety Awareness program, and his Housekeeping program, all dated 5/22/14. Each of the programs stated refusals were to be recorded in Care Tracker and stated "Data collection: 4 times a month." (For the Housekeeping and Safety Awareness programs) and 12 times a month for the Money Management program.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the type of data should be specified.  The facility failed to ensure training programs specified the type of data to be collected	W 237			

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W 237	Continued From page 93 necessary to be able to assess progress toward objectives.	W 237		
W 242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure each individual received training in skills essential for independent living for 2 of 4 individuals (Individual #1 and #3) whose training objectives were reviewed. This resulted in a lack of training programs designed to meet individuals' basic needs. The findings include:</p> <p>1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. Individual #1's assessments documented needs in areas essential of independence. However, corresponding objectives and training programs designed to meet those needs could not be found, as follows:</p> <p>a. Individual #1's 3/27/14 Physician's Orders documented he received ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine</p>	W 242		

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W 242	<p>Continued From page 94</p> <p>standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.</p> <p>However, Individual #1's 9/3/13 CFA stated, in the "Communication Skills" section on page 8, that he was non-verbal and he could not communicate that he was sick or in pain. The CFA included a note which stated he communicated he was sick or in pain "Only through agitation."</p> <p>When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., about programming to teach Individual #1 to communicate when he was in pain or sick prior to demonstrating maladaptive behaviors, the QIDP stated there was none.</p> <p>b. Individual #1's CFA stated, in the "Showering/Bathing" section on page 2, that "He has to be washed by staff he will not even help with assist." However, Individual #1's IPP did not include an objective related to Individual #1 washing himself.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., why a training objective was not developed, the QIDP stated it was probably what the IDT determined at that time, but there were no notes or documentation regarding the rationale.</p> <p>c. Individual #1's CFA stated, in the "Privacy" section on page 30, that Individual #1 refused to take measures to protect his own privacy such as closing doors and blinds when dressing and undressing. His IPP included an objective which</p>	W 242			

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W 242	<p>Continued From page 95</p> <p>stated he was working on self-initiating closing the bathroom door before using the restroom. However, his QIDP notes for May 2014 stated "After team discussion it was felt that [Individual #1's] privacy is provided if he doesn't shut the bathroom door. [Individual #1] does not like it closed but is comfortable with his bedroom door being closed. Therefore, this program will be discontinued."</p> <p>When asked about programming to increase Individual #1's ability to protect his own privacy, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the IDT had determined Individual #1 had learned as much as he could and she would provide team meeting notes on the discussion.</p> <p>Team meeting notes, dated 5/20/14, were reviewed. The notes stated "Toileting program: [Individual #1]..., has been working on the program for several years. Therefore, it will be discontinued."</p> <p>However, comprehensive data necessary to establish Individual #1 was developmentally incapable of learning privacy skills could not be found.</p> <p>The facility failed to ensure Individual #1 received training in skills essential for independent living.</p> <p>2. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>The Communication section of Individual #3's CFA, dated 8/19/13, documented he did not communicate pain.</p>	W 242			

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W 242	Continued From page 96  His record contained two ABC Behavior Logs dated 5/12/14 and 5/17/14. Both documented pain as being a possible cause of SIB.  Additionally, his record contained an Incident/Accident report, dated 11/14/13, which stated Individual #3 had engaged in SIB. The "Conclusions" section documented "...[Individual #3] hits himself when he is in pain...."  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #3 needed an objective for communicating pain.  The facility failed to ensure Individual #3's communication needs were addressed.	W 242			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.  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 received training and services consistent with their program plans for 5 of 5 individuals (Individuals #1 - #5) whose records were reviewed. This resulted in individuals'	W 249			

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W 249	<p>Continued From page 97</p> <p>training programs not being consistently implemented. The findings include:</p> <p>1. Individual #1's IPP, dated 9/4/13, documented a 53 year old male diagnosed with severe intellectual disability, sleep disturbance, autistic disorder, and mood disorder.</p> <p>Observations were conducted on 8/4/14 and 8/5/14 for a cumulative 5 hours and 10 minutes. During the observations, individual #1's programs were not noted to be consistently implemented. Examples included, but were not limited to, the following:</p> <p>Individual #1's Dietary Guidelines, revised 3/26/14, were not implemented, as follows:</p> <p>a. The guidelines stated before Individual #1 started serving himself, staff were to follow the prompt hierarchy to assist him to measure his servings to be pureed. Staff were to use the prompt hierarchy to assist him to prepare some part of his meal (such as - pouring food into the blender, getting a pan or bowl, getting food items out of the refrigerator, freezer, or pantry, etc.). The guidelines stated staff were to provide descriptive verbal praise for assisting to prepare some of his meal, or getting his items for his meal.</p> <p>On 8/4/14 at 5:25 p.m., DCS F was observed in the kitchen preparing the dinner meal. Individual #1 was sitting in a chair in the corner of the living room. The direct care staff were not observed to prompt him to participate in the meal preparation, measure his servings to be pureed, or assist with some part of his meal preparation such as pouring food into the blender.</p>	W 249		

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W 249	<p>Continued From page 98</p> <p>b. Individual #1's guidelines stated staff were to prompt Individual #1 to get his glass, silverware, lip plate and/or bowl, and napkin and take these items to the table. The guidelines further stated Individual #1 was to receive descriptive verbal praise for following meal guidelines, serving himself, and passing food items to others.</p> <p>On 8/4/14 at at 5:31 p.m., Individual #1 walked from the living room to the kitchen. He then walked to the dining room with a plate of pureed food in his hands. The plate was high sided and divided. He sat at the dining room table and ate his meal independently. DCS E cued him to obtain a napkin.</p> <p>Individual #1 was not offered a rocker knife and his plate was high sided and divided, not lipped and his participation in serving himself or passing items was not elicited.</p> <p>c. Individual #1's guidelines stated staff were to assist him in taking small bites and eating slowly, alternating food and drinks, to decrease the chance of aspiration.</p> <p>On 8/4/14 from 5:31 - 5:44 p.m., Individual #1 ate the dinner meal. He was observed to tilt the plate up against his mouth, lean his head back, and suck the remaining contents of food from his plate into his mouth.</p> <p>The direct care staff were not observed to assist him in taking small bites, to eat slowly or alternate food and drink.</p> <p>When asked about the observation and program, during interviews on 8/11/14 from from 9:05 a.m.</p>	W 249		

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W 249	<p>Continued From page 99</p> <p>- 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the guidelines needed to be revised, but Individual #1 should be participating when he could.</p> <p>The facility failed to ensure Individual #1 received training and services consistent with his dietary guidelines.</p> <p>2. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability and stroke. During the observations, Individual #2's programs were not noted to be consistently implemented. Examples included, but were not limited to, the following:</p> <p>Individual #2's Dietary Guidelines, revised 12/12/13, were not implemented, as follows:</p> <p>a. Individual #2's guidelines documented staff were to "Use the prompt hierarchy to assist [Individual #2] to prepare some part of his meal (such as - pouring a food a food item into a pan, getting a pan or bowl, getting food items out of the refrigerator, freezer, or pantry etc.)."</p> <p>However, on 8/4/14 at 5:08 p.m., staff were noted to help Individual #2 walk out of his room and to the kitchen. Individual #2 then obtained a cup, plate, silverware and dycum and took them to the table. At 5:20 a direct care staff assisted him to scoot up to the table. At no time was Individual #2 observed to assist in meal preparation as directed by his dietary guidelines.</p> <p>b. Individual #2's guidelines stated staff were to provide verbal praise to Individual #2 for passing food.</p>	W 249			

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W 249	<p>Continued From page 100</p> <p>During an observation on 8/4/14 at approximately 5:31 p.m., DCS E was noted to pass a plate of pork chops in front of Individual #2 to Individual #4. Individual #4 then took a pork chop off the plate and passed the plate back in front of Individual #2 to DCS E. At no time was Individual #2 prompted to pass the plate.</p> <p>When asked about the observation and program, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the individuals should be participating as much as possible.</p> <p>The facility failed to ensure Individual #2 received training and services consistent with his dietary guidelines.</p> <p>3. The facility's Admissions policy, dated 2/14/12, stated the IDT was to have a pre-admission review. The policy stated once the pre-admission information was received, the facility was to conduct an "IDT Review Meeting." The policy stated the IDT was to review the appropriateness of placement. If it was determined placement in the facility was appropriate, the IDT was to "begin discussion regarding the Initial Plan of Care." The policy stated "An initial plan of care must be in place prior to admission and should address those key areas needed to ensure the health and safety of the individual." The following areas were to be addressed within the initial plan of care:</p> <ul style="list-style-type: none"> <li>- Orders for evaluations;</li> <li>- Initial habilitation programs;</li> <li>- Initial health care programs;</li> <li>- Initial behavioral management programs;</li> </ul>	W 249		

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W 249	<p>Continued From page 101</p> <ul style="list-style-type: none"> <li>- Initial psychotropic medication plans; and</li> <li>- Social-recreational activities.</li> </ul> <p>The policy stated "After the initial plan of care is developed, the IDT will meet to review implementation of the plan before the individual arrives. This includes, but is not limited to identifying staff training needs, scheduling and implementation of such training...that must be immediately implemented to provide for the health and safety of the individual and staff."</p> <p>The facility's policy was not implemented, as follows:</p> <p>Individual #5's 7/29/14 Tentative Treatment Plan documented she was a 63 year old female whose diagnoses included profound intellectual disability. She had been residing in a sister facility within the company and was admitted to the facility on 7/29/14.</p> <p>Individual #5's Tentative Treatment Plan included various sections, such as daily living skills, psycho/social, speech, OT/PT, etc. Each section stated the goal was to assess Individual #5's capabilities in each of the listed areas. No other information related to staff interventions, training, etc., in accordance with the facility's policy, was present in Individual #5's Tentative Treatment Plan.</p> <p>Individual #5 was observed at the facility on 8/4/14 and 8/5/14 for a cumulative 5 hours and 10 minutes. During the observations, staff were not observed to have the basic knowledge and skills necessary to meet Individual #5's needs. Examples included, but were not limited to, the following:</p>	W 249		

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W 249	Continued From page 102  a. An observation was conducted at the facility on 8/4/14 from 5:10 - 6:20 p.m. During that time, dinner was observed. The dinner menu included a broiled pork chop, brown rice pilaf, spinach salad, pineapple, ice cream and milk.  At 5:28 p.m., DCS F stated she had not seen Individual #5 eat before and asked the lead worker what to do. The lead worker told DCS F to place a clothing protector on Individual #5. The lead worker stated it would need to be secured as Individual #5 did not like it.  At 5:34 p.m., DCS F added a liquid substance to the meat on Individual #5's plate and stirred the meat and liquid together. DCS F was then observed to assist Individual #5 with her meal. It was noted Individual #5 was eating rapidly. DCS F asked the lead worker if she should block Individual #5's hand. The lead worker did not respond to the question. DCS F asked again and the lead worker stated she was not sure and they were trying different things.  At 5:41 p.m., DCS F was observed serving Individual #5 a scoop of ice cream. Individual #5's participation in serving herself was not elicited. When Individual #5 was finished eating, she was offered a drink. Individual #5 held the glass to her mouth, drank the liquid, then continued holding the glass to her mouth. At 5:46 p.m., DCS F again asked the lead worker, what she should do. The lead worker instructed DCS F to remove the glass, which she did. DCS F was not observed to follow the prompt hierarchy when removing the glass. After the meal, DCS F took Individual #5's dishes to the kitchen sink. Individual #5's participation was not elicited.	W 249			

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W 249	<p>Continued From page 103</p> <p>When asked, at 5:55 p.m., the lead worker stated they had only received Individual #5's Tentative Treatment Plan. She stated they did not have programs, an active treatment schedule, etc. for Individual #5. She stated they were trying different things with Individual #5 during meals, such as only putting a small amount of food on her plate and then offering her a drink, and then placing more on her plate, but they were not sure what to do.</p> <p>During an interview on 8/5/14 from 8:55 - 9:02 a.m., the QIDP stated information related to Individual #5 from the sister facility was not incorporated into Individual #5's plan as it was company policy to start over with programming and treat each admission like a brand new admission. The QIDP stated Individual #5 had no objectives, no active treatment schedule, and that staff had not received inservice training from Individual #5's previous facility.</p> <p>The facility failed to ensure Individual #5 had an initial plan of care to address key areas needed to ensure the health and safety, per the facility's policy.</p> <p>4. Individual #4's PCLP, dated 5/28/14, documented a 37 year old male whose diagnoses included moderate intellectual disability.</p> <p>His record contained Dietary Guidelines, dated 5/14/14, which documented staff were to "assist [Individual #4] to prepare some part of his meal (such as - pouring a food item into a pan, getting a pan or a bowl, getting food items out of the refrigerator, freezer or pantry etc.)."</p>	W 249		

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W 249	<p>Continued From page 104</p> <p>However, during an observation on 8/4/14 from 5:08 - 6:20 p.m., DCS F was observed to prepare the meal, but was not noted to assist Individual #4 in his meal preparation as directed in his dietary guidelines.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., QIDP stated staff were to be using every opportunity to prompt individuals to participate in functional, meaningful activities.</p> <p>The facility failed to ensure Individual #4 received training and services consistent with his dietary guidelines.</p> <p>5. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>His record contained a Dietary Guidelines, dated 9/21/13, which documented staff were to "assist [Individual #3] to prepare some part of his meal (such as - pouring a food item into a pan, getting a pan or a bowl, getting food items out of the refrigerator, freezer or pantry etc.)."</p> <p>However, during an observation on 8/4/14 from 5:08 - 6:20 p.m., DCS F was observed to prepare the meal, but was not noted to assist Individual #3 in his meal preparation as directed in his dietary guidelines.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., QIDP stated staff were to be using every opportunity to prompt individuals to participate in functional, meaningful activities.</p>	W 249		

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W 249	Continued From page 105 The facility failed to implement Individual #3's dietary guidelines.	W 249			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION  The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop active treatment schedules which were consistent and reflective of individuals' needs for 4 of 5 individuals (Individuals #1 - #3 and #5) whose active treatment schedules were reviewed. This had the potential to impede the implementation of individuals' active treatment plans and services. The findings include:  1. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.  Individual #3's Weekday Residential Active Treatment Schedule, undated, was reviewed and compared to Individual #3's assessments, objectives and programs. The Active Treatment Scheduled did not include updated, accurate information. Examples included, but were not limited to, the following:  a. The Active Treatment Schedule for 8:00 - 8:30 a.m. documented Individual #3 was to work on his toileting program. However, the Formal Programs section of his IPP documented his	W 250			

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W 250	<p>Continued From page 106</p> <p>toileting program had been discontinued on 6/11/14.</p> <p>b. The Active Treatment Schedule for 9:00 - 9:15 a.m. documented Individual #3 was to work on washing his hands by rubbing his hands together for 10 seconds. However, the Formal Programs section of his IPP documented he was to wash his hands at the appropriate time with a specific verbal prompt.</p> <p>c. The Active Treatment Schedule for 9:30 - 9:45 a.m. documented Individual #3 was to work on cutting his meat with his fork and knife. However, the Formal Programs section of his IPP documented he had met criteria on 3/11/14.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated Individual #3's active treatment schedule needed to be revised.</p> <p>The facility failed to ensure Individual #3's active treatment schedule was accurate.</p> <p>2. Individual #1's IPP, dated 9/4/13, documented a 53 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #1's Weekday Residential Active Treatment Schedule, undated, was reviewed and compared to Individual #1's assessments, objectives and programs. The Active Treatment Scheduled did not include updated, accurate information. Examples included, but were not limited to, the following:</p> <p>a. The Active Treatment Schedule for 7:15 - 7:30 a.m. documented Individual #1 was to work on</p>	W 250		

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W 250	<p>Continued From page 107</p> <p>shutting the bathroom door when using the restroom, taking his clothes to the laundry room after showering and choosing a shirt to wear for the day as part of his dressing routine.</p> <p>However, Individual #1's QIDP notes, dated 5/2014, documented the status of his toileting objective as "This was the 3rd consecutive month that [Individual #1] was unable to meet criteria... Therefore, this program will be discontinued."</p> <p>Additionally, Individual #1's IPP included a handwritten note, dated 4/7/14, which documented Individual #1's dressing objective had been revised to choosing a pair of socks.</p> <p>b. The Active Treatment Schedule for 7:45 - 8:00 a.m. documented Individual #1 was to work on applying soap during handwashing, staying seated until his medications were taken and washing his hands and/or assisting with the morning meal.</p> <p>However, Individual #1's IPP included a handwritten note, dated 1/28/14, which documented Individual #1's medication administration objective had been revised to putting his empty cup in the trash after taking his medications.</p> <p>c. The Active Treatment Schedule for 4:15 - 4:30 p.m. documented staff were to offer sensory items to Individual #1. The schedule stated "Use [Individual #1's] sensory box for different items and ideas, he has squeeze balls and various items that can be offered..."</p> <p>However, Individual #1's Occupational Therapy</p>	W 250			

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W 250	<p>Continued From page 108</p> <p>program, dated 10/18/12, documented "[Individual #1] has been provided with sensory items in the past such as squish balls, throw balls, bean pillow, etc. but he does not like them and will throw them if you give them to him. These are not items that he will choose to use."</p> <p>When asked about Individual #1's Active Treatment Schedule, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated it needed to be updated.</p> <p>The facility failed to develop an active treatment schedule for individual #1 which was accurate and reflective of his current programming and preferences.</p> <p>3. Individual #5's 7/29/14 Tentative Treatment Plan documented she was a 63 year old female whose diagnoses included severe intellectual disability. She had been residing in a sister facility within the company and was admitted to the facility on 7/29/14.</p> <p>The facility's Admissions policy, dated 2/14/12, stated the IDT was to have a pre-admission review. The policy stated once the pre-admission information was received, the facility was to conduct an "IDT Review Meeting." The policy stated the IDT was to review the appropriateness of placement. If it was determined placement in the facility was appropriate, the IDT was to "begin discussion regarding the Initial Plan of Care." The policy stated "An initial plan of care must be in place prior to admission and should address those key areas needed to ensure the health and safety of the individual."</p> <p>The policy stated "After the initial plan of care is</p>	W 250			

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W 250	<p>Continued From page 109</p> <p>developed, the IDT will meet to review implementation of the plan before the individual arrives. This includes, but is not limited to identifying staff training needs, scheduling and implementation of such training...that must be immediately implemented to provide for the health and safety of the individual and staff."</p> <p>Individual #5's Tentative Treatment Plan included various sections, such as daily living skills, psycho/social, speech, OT/PT, etc. Each section stated the goal was to assess Individual #5's capabilities in each of the listed areas. No other information related to staff interventions, training, etc., in accordance with the facility's policy, was present in Individual #5's Tentative Treatment Plan.</p> <p>When asked, at 5:55 p.m., the lead worker stated they had only received Individual #5's Tentative Treatment Plan. She stated they did not have other information, including an active treatment schedule, for Individual #5.</p> <p>During an interview on 8/5/14 from 8:55 - 9:02 a.m., the QIDP stated information related to Individual #5 from the sister facility was not incorporated into Individual #5's plan as it was company policy to start over with programming and treat each admission like a brand new admission. She further stated Individual #5 had no objectives or directions to staff regarding her habilitation.</p> <p>The facility failed to develop an active treatment schedule for Individual #5.</p>	W 250			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 262			

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W 262	<p>Continued From page 110</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the written approval from the facility's HRC for 3 of 5 individuals (Individual #1 - #3) whose consents were reviewed. This resulted in a delay in HRC approvals and the potential for individual rights to be violated. The findings include:</p> <p>1. During an observation on 8/4/14 at 3:15 p.m., cameras were noted to be mounted to the ceiling in all common areas of the facility. When asked about the cameras during an interview with DCS E and DCS F on 8/4/14 at 4:00 p.m., they stated they thought the cameras were operational and recorded the activities in the facility. The direct care staff stated they believed management staff reviewed the recordings on the weekends.</p> <p>Individual #1 - #3's records included consent for the use of video monitoring in the common areas of the home signed by the individuals' guardians as follows:</p> <p>a. Individual #1's consent was signed by his guardian on 12/26/12.</p> <p>b. Individual #2's consent was signed by his guardian on 11/11/12.</p>	W 262			

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W 262	Continued From page 111  c. Individual #3's consent was signed by his guardian on 11/3/12.  However, the HRC committee did not meet and approve Individual #1 - #3's consents for video monitoring until 6/14/13.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the Program Manager stated the previous QIDP had overlooked the consents.	W 262		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES  The facility failed to ensure HRC approval was obtained in a timely manner.  The facility must ensure that specific client behavior and facility practices requirements are met.  This CONDITION is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include:  1. Refer to W268 as it relates to the facility's failure ensure policies were developed and practices were implemented that promoted the growth and development of individuals.	W 266		

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W 266	Continued From page 112  2. Refer to W285 as it relates to the facility's failure to ensure that techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the safety, welfare and civil and human rights of individuals.  3. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into each individual's program plan.  4. Refer to W290 as it relates to the facility's failure to ensure standing or as needed programs were not used.  5. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed.  6. Refer to W313 as it relates to the facility's failure to ensure the severity of an individual's maladaptive behavior outweighed the potential risk of behavior modifying drugs.  The cumulative effect of these deficient practices significantly impeded the facility's ability to develop, consistently implement and closely monitor individuals' behavioral interventions.	W 266			
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT  These policies and procedures must promote the growth, development and independence of the client.	W 268			

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W 268	Continued From page 113  This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure policies were developed and practices were implemented that promoted the growth and development of individuals for 7 of 7 individuals (#1 - #7) residing at the facility. This resulted in a lack of opportunities for individuals to exercise choice and maximize their independence. The findings include:  1. Observations were conducted on 8/4/14 and 8/5/14 for a cumulative 5 hours and 10 minutes. During those times, individuals were not offered the opportunity to participate in activities or provided opportunities to engage in activities of their choice which promoted growth, development, and independence. Examples included, but were not limited to, the following:  a. Observations were conducted of Individuals #1 - #7 on 8/4/14 from 3:15 - 4:20 p.m. and from 5:10 - 6:20 p.m. During the observations, DCS F was noted to prepare the evening meal. Individuals #1 - #7 were not observed to be prompted or encouraged to assist in all facets of the meal preparation.  b. On 8/4/14 from 5:10 - 5:30 p.m., Individual #1 was sitting in a chair in a corner of the living room, rocking back and forth. Staff were not observed to offer him choices or elicit his participation in activities.  c. On 8/4/14 at 5:30 p.m., Individual #1 washed his hands, went into the kitchen, and obtained a plate of pureed food. Individual #1 was not given	W 268			

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - MALLARD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER 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 268	Continued From page 115 his hands would be free. Individual #7 was not offered the opportunity to leave the toys home or offered an appropriate carrying method for the toys.  When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if the facility had policies and procedures in place to promote the growth, development and independence of individuals, the Program Manager stated there was no specific policy.  The facility failed to ensure policies were developed and practices were implemented that promoted the growth and development of individuals.	W 268			
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.  This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the health and human rights for 2 of 4 individuals (Individuals #1 and #3) whose restrictive interventions were reviewed. This resulted in a lack of adequate protections being provided to individuals. The findings include:	W 285			

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W 285	Continued From page 116 1. Refer to W290 as it relates to the facility's failure to ensure restrictive interventions were removed as soon as they were determined to be unnecessary.  2. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs.	W 285			
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR  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.  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 4 individuals (Individual #1) whose behavior intervention plans were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program strategies. The findings include:  1. Individual #1's 9/4/13 IPP stated he was a 53 year old male whose diagnoses included severe intellectual disability. Individual #1's Behavior Intervention Plans for self-abuse, revised 5/7/14, self stimulation, revised 3/13/14, and socially offensive behavior, revised 3/13/14, were	W 289			

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W 289	<p>Continued From page 117 reviewed. The plans did not include sufficient instructions to staff, as follows:</p> <p>a. Individual #1's Behavior Assessment stated he engaged in self-abuse and self-stimulating behavior which were "essentially the same behavior" with self-abuse leaving an injury and self stimulation not resulting in injury. Both behaviors included hitting his head, biting his fingers, poking his chest, and hitting his shin with his heel. The assessment stated he engaged in the behaviors as a way to meet his sensory needs. The assessment also stated "it has been noted to increase during allergy season. This may be due to the increase [sic] sinus pressure. [Individual #1] does take routine allergy medication in addition to routine pain medications."</p> <p>The assessment stated Individual #1 engaged in Socially Offensive Behavior which included taking off his clothes, spitting, and urinating in inappropriate places, to express his wants. The assessment further stated "Additionally, he is unable to communicate his needs regarding his health status such as pain from his allergies."</p> <p>However, Individual #1's behavior intervention plans did not include instructions to staff regarding intervening for potential pain issues.</p> <p>b. The "Dislikes" section on page 1 of his 9/3/13 CFA and the "Dislikes" section of his Behavior Assessment stated he did not like "continuous cuing." The CFA and Behavior Assessment did not include specific assessment information related to prompting Individual #1 (e.g. amount of time to wait between prompts, frequency of prompts, etc.). Additionally, the "Following</p>	W 289			

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W 289	<p>Continued From page 118</p> <p>Instructions" section on page 18 of the CFA stated individual #1 would independently comply with requests within 0 - 60 seconds.</p> <p>However, Individual #1's behavior intervention plans did not include instructions to staff regarding over-cuing.</p> <p>c. Individual #1's CFA stated in multiple places that "All his tasks have to be quick and he requires lots of breaks for anything that's not" and "He may get upset if it's not quick."</p> <p>However, Individual #1's behavior intervention plans did not include instructions to staff regarding his need for quick tasks and frequent breaks.</p> <p>d. Individual #1's Communication program, revised 5/7/14 stated he "...demonstrates frustration by rocking, biting his hand, and deeper breathing."</p> <p>However, Individual #1's behavior intervention plans did not include instructions to staff regarding his demonstrations of frustration including rocking and deeper breathing.</p> <p>When asked, during an interview on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the information should be included in Individual #1's behavior intervention plans.</p> <p>The facility failed to ensure Individual #1's behavior intervention plans included sufficient information.</p>	W 289			
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 290			

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W 290	<p>Continued From page 119</p> <p>Standing or as needed programs to control inappropriate behavior are not permitted.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were removed as soon as they were determined to be unnecessary for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a bite release being incorporated into an individual's behavior plan and not being used. The findings include:</p> <p>1. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>His record contained a Behavior Intervention Plan, dated 11/26/13. The plan stated staff were to use a bite release if Individual #3 bit his hand.</p> <p>However, his QIDP Tracking Form documented the bite release technique had not been used from 9/2013 - 7/2014.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she intended to take the bite release out of his plan.</p> <p>The facility failed to ensure restrictive interventions were removed from Individual #3's behavior intervention plan as soon as they were determined to be unnecessary.</p>	W 290			
W 312	483.450(e)(2) DRUG USAGE	W 312			

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W 312	Continued From page 120  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individual's IPP that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs without the implementation of a plan related to how the drugs may be changed in relation to progress or regression. The findings include:  1. Individual #1's IPP, dated 9/4/13, documented a 53 year old male whose diagnoses included severe intellectual disability.  Individual #1's Physician's Order, dated 4/2014, documented he received Risperdal (an antipsychotic drug) 2 mg in the morning and 3 mg at bedtime, Zyprexa (an antipsychotic drug) 5 mg in the morning and 7.5 mg at bedtime, and Clonidine (an antihypertensive drug) 0.05 mg three times a day and Zoloft (an antidepressant drug) 50 mg daily.  Individual #1's medication reduction plan was cited during a recertification survey dated 10/3/13.	W 312			

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W 312	<p>Continued From page 121</p> <p>At the time of the 10/3/13 survey Individual #1 was receiving Risperdal 2 mg in the morning and 3 mg at bedtime for SIB and self-stimulating behavior caused by his autism diagnosis. He was also receiving Zyprexa 5 mg in the morning and 7.5 mg at bedtime, Zoloft 50 mg in the morning, and Clonidine 0.05 mg three times a day for SIB and self-stimulating behavior caused by his mood disorder.</p> <p>Individual #1's reduction criteria at the time of the 10/3/13 survey stated the team would discuss a reduction in the medications when Individual #1 displayed 1 or less instances of self-abuse per month for 3 consecutive months and he displayed self-stimulating behaviors 800 or less times per month for 3 consecutive months."</p> <p>Individual #1's QIDP monthly summaries documented he had met the criteria as follows:</p> <p>10/13: SIB 0 times, self-stimulation 643 times 11/13: SIB 0 times, self-stimulation 766 times 12/13: SIB 0 times, self-stimulation 534 times</p> <p>Individual #1's IPP documented on 1/9/14 his SIB criteria was extended from displaying 1 or less incidents of SIB per month for 3 consecutive months to demonstrating 1 or less incidents per month for 6 consecutive months.</p> <p>Individual #1's IPP further documented on 1/9/14 his objective criteria for self-stimulation was revised from 850 or less incidents per month to 650 or less incidents per month.</p> <p>Individual #1's 1/30/14 Psychiatric Update notes documented Individual #1 had been stable and recommended a reduction of Clonidine on the top</p>	W 312			

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W 312	<p>Continued From page 122 of the Update form. However, the changes section at the bottom of the form documented Individual #1's Ambien (taken for sleep disturbance) would be decreased. Additional information related to a decrease in Individual #1's Clonidine could not be found.</p> <p>Individual #1's 1/14 QIDP monthly summaries documented he had 0 incidents of SIB and 870 incidents of self-stimulation. His 1/04 QIDP notes stated it was the fourth consecutive month Individual #1 had met criteria for SIB. The QIDP notes stated it was the first month Individual #1 had not met criteria for self-stimulation. However, staff were retrained on data collection on 1/2/14, which resulted in the increase.</p> <p>The QIDP notes did not reflect the IPP change in objective criteria documented on 1/9/14.</p> <p>Individual #1's QIDP monthly summaries documented in 2/14 he had engaged in SIB 0 times and self-stimulation 797 times. His 2/14 QIDP notes stated it was the fifth consecutive month Individual #1 had met criteria for SIB. The QIDP notes stated it was the second month Individual #1 had not met criteria for self-stimulation.</p> <p>The QIDP notes did not reflect the IPP change in objective criteria documented on 1/9/14. Further, his IPP documented on 3/13/14 his SIB criteria was extended from displaying 1 or less incidents of SIB per month for 6 consecutive months to demonstrating 0 incidents per month for 6 consecutive months.</p> <p>Additionally, his medication reduction plan, dated 3/27/14, stated decreases in his medication</p>	W 312			

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W 312	<p>Continued From page 123</p> <p>would be considered when he engaged in 1 or less incidents of self-abuse for 6 consecutive months and 650 or less incidents of self-stimulatory behavior for 3 consecutive months.</p> <p>No additional information related to the changes in objective or reduction criteria could be found in Individual #1's record.</p> <p>Individual #1's QIDP monthly summaries documented in 3/14 he engaged in SIB 0 times and self-stimulation 824 times. His 3/14 QIDP notes stated it was the sixth consecutive month he had met criteria, but it would continue to be tracked due to the objective being tied to a medication. The QIDP notes stated it was the third month Individual #1 had not met criteria for self-stimulation. However, since the staff were taking more accurate data, the objective may need to be revised.</p> <p>Individual #1's QIDP monthly summaries documented in 4/14 he had engaged in SIB 0 times and self-stimulation 753 times. His 4/14 QIDP notes stated it was the seventh consecutive month Individual #1 had met criteria for SIB and his objective would be revised to 0 incidents for 12 consecutive months. The QIDP notes stated it was the fourth month Individual #1 had not met criteria for self-stimulation.</p> <p>Individual #1's IPP documented his SIB criteria was extended to 0 incidents of SIB for 12 consecutive months on 5/7/14. Additionally, his medication reduction plan was updated on 5/7/14 to extend the SIB criteria to 0 incidents of SIB for 12 consecutive months. Further, his criteria for self-stimulatory behavior was increased to 650</p>	W 312			

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W 312	Continued From page 124 incidents or less per month for 12 consecutive months.  Information related to the extension of the medication reduction criteria could not be found in Individual #1's record.  When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., how the IDT was establishing criteria for a reduction in Individual #1's medications, the QIDP stated it was based on IDT discussion, but it was not documented.  The facility failed to ensure Individual #1's medication reduction plan was developed and implemented to ensure his medications were used only to the extent that they were necessary.	W 312			
W 313	483.450(e)(3) DRUG USAGE  Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs for 1 of 3 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs without the necessary justification. The findings include:	W 313			

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W 313	<p>Continued From page 125</p> <p>1. Individual #1's IPP, dated 9/4/13, documented a 53 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #1's Physician's Order's, dated 4/2014, documented he received Risperdal (an antipsychotic drug) 5 mg, Zyprexa (an antipsychotic drug) 12.5 mg, Clonidine (an antihypertensive drug) 0.05 mg three times a day and Zoloft (an antidepressant drug) 50 mg daily.</p> <p>Individual #1's Written Informed Consent for Risperdal, dated 9/3/13, documented under Possible Risks or Complications of the Medication that potential side effects included, but were not limited to, fast or uneven heartbeats, confusion, tremor, seizures, body aches, white patches or sores inside the mouth or on the lips, trouble swallowing, feeling hot or cold and sleep problems.</p> <p>Individual #1's Written Informed Consent for Zoloft, dated 9/3/13, documented under Possible Risks or Complications of the Medication that potential side effects included, but were not limited to, fast or uneven heartbeats, agitation, tremors, feeling unsteady, shallow breathing or breathing that stops, loss of coordination, drowsiness, dizziness and sleep problems.</p> <p>Individual #1's Written Informed Consent for Clonidine, dated 9/3/13, documented under Possible Risks or Complications of the Medication that potential side effects included, but were not limited to, fast or pounding heartbeats, rapid weight gain, tremor, feeling short of breath even with mild exertion, hallucinations, feeling tired or irritable, ear pain, dizziness and sleep problems.</p>	W 313			

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W 313	<p>Continued From page 126</p> <p>Individual #1's Written Informed Consent for Zyprexa, dated 9/3/13, documented under Possible Risks or Complications of the Medication that potential side effects included, but were not limited to, fast or uneven heartbeats, twitching or uncontrollable movements of the eyes, lips, tongue, face, arms or legs, urinating less than usual or not at all, high fever, unusual thoughts or behavior, thoughts about hurting oneself, drowsiness, dizziness and breast swelling or discharge for any gender.</p> <p>The Written Informed Consent of each medication documented Individual #1 "uses a combination of psychotropic medications together to address his self-abusive behavior and self-stimulating behavior. [Medication name] is used for these maladaptive behaviors..."</p> <p>Individual #1's Behavior Assessment, dated 3/13/14, defined self-stimulating behavior as hitting/slapping his head without leaving a red mark, biting his fingers without injury, poking his chest without injury, gagging himself or repeatedly hitting his shin without injury.</p> <p>The assessment defined Individual #1's self-abusive behaviors as hitting his head against walls or doors, hitting/stapping his head hard enough to leave a red mark, biting his fingers with injury, poking his chest with injury or repeatedly hitting his shin with injury.</p> <p>However, Individual #1's QIDP Tracking Form documented Individual #1 had not engage in any instances of self-abuse from 10/2013 - 7/2014.</p> <p>Individual #1's record did not provide documented</p>	W 313			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - MALLARD			STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642	
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W 313	Continued From page 127 evidence that the risks of his self-stimulating behavior outweighed the potential side effects of the psychotropic drugs.  When asked, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if there was documentation which demonstrated that Individual #1's self-stimulatory behavior outweighed the potential negative side effects of the medication he was taking, the QIDP stated there was not.  The facility failed to ensure Individual #1's psychoactive drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs.	W 313		
W 318	483.460 HEALTH CARE SERVICES  The facility must ensure that specific health care services requirements are met.  This CONDITION is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure adequate health care monitoring and follow up occurred for the individuals residing in the facility. This resulted in the potential for the individuals' physical well being to be negatively impacted. The findings include:	W 318		
W 322	483.460(a)(3) PHYSICIAN SERVICES  1. Refer to W345 as it relates to the facility's failure to ensure the registered nurse was utilized appropriately to perform health services as indicated by the individuals' health needs.	W 322		

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W 322	Continued From page 128 The facility must provide or obtain preventive and general medical care.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 3 of 4 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in individuals not receiving medical care based on their individualized health needs. The findings include:  1. Refer to W326 as it relates to the facility's failure to ensure an individual received special studies as necessary.  2. Refer to W338 as it relates to the facility's failure to ensure an individual received appropriate referrals according to his needs.  3. Refer to W353 as it relates to the facility's failure to ensure a periodic comprehensive dental evaluation was accomplished for an individual.  4. Refer to W363 as it relates to the facility's failure to ensure irregularities in the individuals' drug regimen reviews were reported to the prescribing physician and the IDT.	W 322		
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed.	W 326		

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W 326	<p>Continued From page 129</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility's Nursing Policies and Procedures Manual, record review and staff interview, it was determined the facility failed to obtain special studies as recommended for 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted in an individual not receiving a bone density screening as recommended and in accordance with his needs. The findings include:</p> <p>1. The facility's Nursing Policies and Procedures Manual, revised 3/23/10, documented "...The facility will provide nursing services in accordance with client needs...Nursing will take any necessary action, including referral to a physician to address client health problems..." The policy was not implemented as follows:</p> <p>Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability, seizure disorder, and stroke.</p> <p>Individual #2's medical record included at 10/4/12 DXA test which stated "...Fracture risk is high. A follow up DXA test is recommended in one year to monitor response to therapy." However, Individual #2's record did not include a DXA test for 2013 or 2014.</p> <p>During an interview on 8/14/14 from 2:00 - 2:40 p.m., the RN stated the LPNs reviewed Individual #2's 2012 DXA test follow-up recommendation and said the follow-up within one year was missed.</p> <p>The facility failed to ensure a follow-up DXA test was completed as recommended for Individual #2</p>	W 326			

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W 326	Continued From page 130	W 326			
W 331	<p>who was at high risk for fractures.</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure nursing services were provided as needed for 3 of 4 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in individuals' not receiving adequate intervention and follow up necessary to meet their health needs. The findings include:</p> <p>1. The facility's LPN Job Description, updated 5/14/14, stated the LPN's purpose was to "assist in coordinating health care services on the basis of each client's individual needs and administering total nursing care for each client. Ensures [sic] a high standard of nursing care is met and maintained in compliance with Federal and State Regulations."</p> <p>The LPN Job Description listed multiple "Essential Duties and Responsibilities" which included, but were not limited to, the following:</p> <p>a. "Provides general and preventative nursing care as needed, and in accordance with need, ensuring all assessments, appointments and evaluations are updated. Appointments include: annual History and Physical, vision, dental, neurology, psychiatric, audiology, podiatry, and other appointments as needed."</p>	W 331			

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W 331	<p>Continued From page 131</p> <p>However, the LPN did not ensure evaluations were completed. Examples include, but were not limited to, the following:</p> <p>i. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability. Records of his auditory assessments were reviewed from 9/7/12 - 8/30/13 and did not include consistent information, as follows:</p> <ul style="list-style-type: none"> <li>- His record contained a physician's report, dated 9/7/12, documenting he had retracted tympanic membranes bilaterally and that his communication was limited by impaired hearing.</li> <li>- His record contained a Speech and Language Annual Review, dated 6/30/13, which stated he experienced ear infections but "These infections have not caused a hearing impairment." The report further stated "[Individual #3] continues to demonstrate comprehension of simple language use."</li> <li>- The Communication section of his CFA, dated 8/19/13, documented he had poor hearing and that he was deaf. The "Hears spoken language" column was marked "Yes and No."</li> </ul> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she was unsure of his auditory acuity.</p> <p>However, an appointment to test Individual #3's hearing had not been conducted.</p> <p>The LPN failed to ensure an evaluation of Individual #3's auditory function had occurred.</p>	W 331			

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W 331	<p>Continued From page 132</p> <p>ii. Individual #1's 9/4/13 IPP stated he was a 53 year old male diagnosed with autistic disorder, mood disorder, and severe intellectual disability.</p> <p>Individual #1's 9/3/14 Annual Nursing Summary stated, on 5/13/08, Individual #1 began receiving Clonidine, 1 mg 1/2 tab three times a day and routine medication of Tylenol and Ibuprofen had been initiated for possible pain. The nursing summary stated the Clonidine and pain medication "have been very helpful. His SIB has significantly decreased."</p> <p>The summary also stated Individual #1 had been seen by a dentist and had heavy teeth clenching and grinding with clinical wear with close proximity to the pulp on numerous teeth. The concern was discussed with the IDT and the decision was made to extract Individual #1's teeth. The summary stated his upper teeth were extracted on 1/8/13 and his lower teeth were extracted on 9/8/13.</p> <p>Individual #1's 3/27/14 Physician's Orders documented he received ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if Individual #1's pain medication had been re-evaluated after his tooth extractions, LPNA</p>	W 331		

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W 331	<p>Continued From page 133</p> <p>and LPN B both stated they were not aware of a re-evaluation. When asked if Individual #1's routine standing orders had been re-evaluated in light of his routine pain medications, LPN A stated the physician had signed the routine standing orders, but a specific discussion regarding the as needed pain medication had not occurred. When asked about the origin of Individual #1's current pain LPN A, LPN B and the QIDP were not able to say where Individual #1's pain was originating from or if he was experiencing chronic pain which warranted the use of the 3 routine pain medications.</p> <p>The LPN failed to ensure Individual #1's pain levels and pain medication were re-evaluated.</p> <p>iii. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability and stroke.</p> <p>Individual #2's 8/30/12 Vitamin D 25-OH laboratory value was 24.3 ng/mL. The reported documented values in the 20-29 range indicated a relative insufficiency of Vitamin D 25-OH.</p> <p>Individual #2's quarterly nursing reviews, dated 1/1/14, 4/2/14, and 7/7/14, did not include documentation related to his Vitamin D insufficiency.</p> <p>During interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., LPN B stated the quarterly nursing reviews were only physical assessments of the individuals and did not include health status such as a Vitamin D insufficiency.</p> <p>The facility failed to ensure Individual #2's health</p>	W 331			

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W 331	<p>Continued From page 134 status was comprehensively reviewed.</p> <p>b. The "Essential Duties and Responsibilities" of the LPN Job Description stated the LPN was responsible for "Notification of the physician for change in condition, medication changes, and dietary recommendations." The LPN Job Description further stated the LPN was responsible for participating on the IDT.</p> <p>However, the LPN did not ensure notifications were completed. Examples included, but were not limited to, the following:</p> <p>i. Individual #3's Physician's Order, dated 7/2014, stated his BPs were to be checked Tuesdays and Fridays in the morning and in the evening.</p> <p>When asked on 8/13/14 at 2:00 p.m., the RN stated there were no specific instructions or protocols regarding when staff should contact the nurse based on Individual #3's BP readings. The RN stated they would go with "normal" parameters.</p> <p>The Mayo Clinic website (mayoclinic.org) includes information related to high blood pressure and separates high blood pressures into 4 categories ranging from "normal" to stage 2 hypertension, as follows:</p> <p>Systolic 120 or below and diastolic below 80: Normal blood pressure.</p> <p>Systolic 120 - 139 or diastolic 80 - 89: Prehypertension. Recommendations included maintaining or adopting a health lifestyle.</p> <p>Systolic 140 - 159 or diastolic 90 - 99: Stage 1</p>	W 331			

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W 331	<p>Continued From page 135</p> <p>hypertension. Recommendations included talking with a physician if a blood pressure goal was not achieved.</p> <p>Systolic 160 or more or diastolic 100 or more: Stage 2 hypertension. Recommendations included talking with a physician.</p> <p>Individual #3's BP monitoring from 1/3/14 - 7/29/14 was reviewed. The records documented his BP had been taken and documented on 119 occasions during that time frame. The records documented Individual #3's BP was normal 43% of the time, he was prehypertensive 54% of the time, and experienced Stage 1 hypertension 3% of the time, as follows:</p> <ul style="list-style-type: none"> <li>- 4/11/14: 129/90 on the a.m. shift</li> <li>- 4/15/14: 131/90 on the a.m. shift and 130/90 on the p.m. shift.</li> <li>- 7/29/14: 118/94 on the a.m. shift</li> </ul> <p>However, no documentation could be found that the nurse had been notified of the above BP readings.</p> <p>When asked on 8/14/14 at 8:50 a.m., the LPN verified there were no specific instructions regarding when the staff should contact the nurse based on Individual #3's BP readings. The LPN stated they would go with "normal" parameters of 140 (systolic) over 90 (diastolic). When asked about baseline measures specific to Individual #3's usual BP, the LPN stated they did not have such information.</p> <p>The facility failed to ensure BP parameters were established for Individual #3 based on his individualized needs. Without such information,</p>	W 331			

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W 331	Continued From page 136 the IDT would not be able to ensure appropriate reporting and follow up was completed.  The facility failed to ensure nursing services were provided in accordance with individuals' needs.	W 331			
W 338	2. Refer to W322 as it relates to the facility's failure to ensure individuals received health care services in accordance with their needs. 483.460(c)(3)(v) NURSING SERVICES  Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).  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 individual's health problems were reviewed to address the needs of 1 of 4 individuals (Individual #2) whose medical records were reviewed. This resulted a delay in treatment. The findings include:  1. The facility's Nursing Policies and Procedures Manual, revised 3/23/10, documented "...The facility will provide nursing services in accordance with client needs...Nursing will take any necessary action, including referral to a physician to address client health problems..." The policy was not implemented as follows:  Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included history of obsessive compulsive	W 338			

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W 338	<p>Continued From page 137</p> <p>disorder, autistic disorder, severe intellectual disability, right sided hemiparesis, GERD, seizure disorder, hypothyroidism, chronic left hand tremor, and stroke.</p> <p>Individual #2's medical record included at 8/13/13 Physician History and Physical Examination Report documented he was diagnosed with osteoporosis and a 10/4/12 DXA test documented his "...Fracture risk is high..."</p> <p>Further, Individual #2's 8/30/12 Vitamin D 25-OH laboratory value was 24.3 ng/mL. The reported documented values in the 20-29 range indicated a relative insufficiency of Vitamin D 25-OH.</p> <p>Individual #2's "Consultant Pharmacist's Medication Regimen Review," dated 6/20/14, documented "...This resident is receiving...Alendronate [an antiosteoporotic drug]. According to the manufacturer's specifications, Bisphosphonates require concomitant therapy of adequate calcium and vitamin D...This resident should have an order for Calcium and Vitamin D. Would you seek an order for the following; Calcium +D3 and minerals (600 mg Ca and 800 IU VitD/tablet)..."</p> <p>His 7/14/14 Nursing Progress Notes documented the facility received Individual #2's quarterly pharmacy review and the pharmacist recommended he take a Calcium and Vitamin D supplement. The order request was faxed to his physician on 7/14/14.</p> <p>On 7/14/14, the physician signed the fax and ordered Calcium + D3 and minerals (600 mg Ca and 800 IU VitD/tablet) 1 tab by mouth twice daily for 12 months.</p>	W 338		

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W 338	<p>Continued From page 138</p> <p>Individual #2's MAR documented he did not receive his first administration of Calcium 600 mg and Vitamin D3 800 IU until 7/21/14 at 8:00 p.m.</p> <p>In summary, the pharmacist recommended Calcium and Vitamin D3 for Individual #2 on 6/20/14. On 7/14/14, twenty-four days later, the facility faxed the pharmacist's recommendation to his physician. On 7/21/14 (thirty-one days after the pharmacist's recommendation was made and 7 days after the physician's order was obtained) Individual #2 received the Calcium and Vitamin D3.</p> <p>When asked about Individual #2's Calcium and Vitamin D, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., LPNA stated when the facility would receive a physician's order, the facility would then notify the pharmacy which was located in a different state.</p> <p>During a subsequent interview on 8/13/13 from 2:00 - 2:40 p.m., the RN and the Program Manager were asked about the pharmacist's review completed on 6/20/14 and the delay in reporting to the physician (on 7/14/14). Both the RN and the Program Manager stated when the Pharmacist came to the facility for the quarterly reviews, the pharmacist discussed with the facility any irregularities found before leaving. After leaving the facility, the pharmacist then would follow-up with the written report.</p> <p>However, no documentation related to the reason for the delay in treatment could be found in Individual #2's record.</p> <p>The facility failed to ensure Individual #2's</p>	W 338			

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W 338	Continued From page 139	W 338			
W 345	<p>treatments were not delayed.</p> <p>483.460(d)(3) NURSING STAFF</p> <p>The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.</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 the RN was utilized as per this standard and as required by state law. This directly impacted 6 of 7 individuals (Individual #1 - #6) residing in the facility and had the potential to impact all individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for individuals to experience negative impacts to their health. The findings include:</p> <p>1. The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state, at IDAPA 23.01.01.401.02.(f.)vi) that the RN is for "Providing information and making recommendations to patients and others in accordance with employer policies..."</p> <p>The facility's Director of Nursing job description, updated 8/1/14, stated, in the "Essential Duties and Responsibilities" section, that the RN was "Directly responsible for the oversight of the nursing staff and medical assistants." The job description stated the RN had multiple other responsibilities which included, but were not limited to, the following:</p> <p>- Assist as needed in the development of programs, policy and practices.</p>	W 345			

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W 345	<p>Continued From page 140</p> <ul style="list-style-type: none"> <li>- Provide development and oversight of a quality assurance program and practices.</li> <li>- Provide evaluation and feedback to the team on a regular basis.</li> <li>- Maintain long lasting results to assure that any inspection or resulting evaluations by licensing, federal or state agencies are successful.</li> <li>- Develop a schedule of regular chart audits and oversee the scheduling of outside services to assure medical needs of clients are met.</li> </ul> <p>The RN failed to ensure compliance with the IDAPA 23.01.01 and that the facility's job description was achieved as follows:</p> <p>a. The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state at IDAPA 23.01.01.401.02.(f) that the RN is responsible to maintain "safe and effective nursing care..." by "Acting as a patient's advocate" (as stated in IDAPA 23.01.01.401.02.(f).(iii) and by collaborating with other health professionals (as stated in IDAPA 23.01.01.401.02.h).</p> <p>IDAPA 23.01.01.401 states that in addition to providing hands on care, licensed Registered Nurses are responsible for "delegation, management, administration, teaching and case management...[and]...are expected to exercise competency in judgement, decision making, implementation of nursing interventions, delegation of function or responsibilities, and administering of medications and treatments prescribed by legally authorized persons."</p> <p>IDAPA 23.01.01.400.02 states "When delegating nursing care, the licensed nurse retains accountability for the delegated acts and the consequences of delegation." Additionally,</p>	W 345			

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W 345	<p>Continued From page 141</p> <p>IDAPA 23.01.01.400.02.c stated the licensed nurse must "Exercise professional judgement to determine the safety of the delegated activities, to whom the acts may be delegated, and the potential for harm."</p> <p>IDAPA 23.01.01.400.03.(a) states that subsequent to delegation the licensed nurse shall "Evaluate the patient's response and the outcome of the delegated act, and take such further actions as necessary..." and IDAPA 23.01.01.400.03.(b) states that subsequent to delegation, the licensed nurse shall "Determine the degree of supervision required and evaluate whether the activity is completed in a manner that meets acceptable outcomes. The degree of supervision shall be based upon...the knowledge and competence of the individual to whom the activity is delegated."</p> <p>When asked about training during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., LPN A stated he had "shadowed" LPN B for approximately a week and was then working on his own, but could call the other LPNs or the RN if he had questions. When asked about nursing delegations, LPN A and LPN B stated they were not aware of any written nursing delegations. LPN A stated he had received general orientation and training but nothing specific to delegation. When asked about oversight and monitoring of nursing services, LPN A and LPN B both stated they completed individual chart audits and reported the results to the RN.</p> <p>During a subsequent interview on 8/11/14 at 1:40 p.m., the RN was asked about written delegation of nursing services. The RN stated he did not</p>	W 345			

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W 345	<p>Continued From page 142</p> <p>have written delegations and had not seen any written delegation in any place he had worked. When asked how he was monitoring nursing services, the RN stated he spoke with the LPNs and completed chart reviews.</p> <p>On 8/11/14 documentation of monitoring was requested from the RN. The RN provided several forms titled "ICF/MR Record Review Form." The RN stated, on 8/11/14 at 3:05 p.m., that he, LPN A and LPN B completed the "ICF/MR Record Review Form[s]."</p> <p>The "ICF/MR Record Review Form[s]" were not dated as to when the review was completed and the forms did not include consistent information as follows:</p> <ul style="list-style-type: none"> <li>- A review form was not completed for Individual #4.</li> </ul> <p>When asked, during an interview on 8/13/14 at 2:00 p.m., the RN stated a review for Individual #4 was probably completed by the company's QA person, so a record review form was not completed for him by nursing staff.</p> <ul style="list-style-type: none"> <li>- Individual #1 - #2 and Individual #6 - #7's review forms included information in the "Immunizations" section indicating their records documented immunizations met recommendations or their was documentation from the physician regarding absent immunizations. No information was included in the "Immunizations" section for Individual #3.</li> <li>- Individual #1 - #3 and Individual #6 - #7's review forms included "NKDA" next to the "Allergies" section. No other information related to allergies</li> </ul>	W 345		

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W 345	<p>Continued From page 143</p> <p>was included on the form. However, Individual #1's Behavior Assessment stated he engaged in self-abuse and self-stimulating behavior which were "essentially the same behavior" with self-abuse leaving an injury and self stimulation not resulting in injury. Both behaviors included hitting his head, biting his fingers, poking his chest, and hitting his shin with his heel. The assessment also stated "it has been noted to increase during allergy season. This may be due to the increase sinus pressure. [Individual #1] does take routine allergy medication in addition to routine pain medications."</p> <p>The review form did not include any additional information regarding Individual #1's seasonal allergies or his routine pain medication.</p> <p>- Individual #2's form included the date 5/8/14 next to the "Dental" section of the form. No additional information was include regarding Individual #2's dental services.</p> <p>However, Individual #2's record documented dental visits on 11/7/13 and 5/8/14, but his record did not contain a dental note indicating when his most recent x-rays were obtained.</p> <p>During an interview on 8/13/14 from 2:00 - 2:40 p.m., the RN stated a telephone call was made to Individual #2's dentist and according to the dentist he had not had a dental x-ray. The RN said all attempts to obtain x-rays had been unsuccessful. When asked what was being done to obtain x-rays for Individual #2, the RN stated Individual #2 was taken to a dentist. When asked what decision was made by Individual #2's guardian and the IDT to determine the best possible course of action since the dentist could not obtain</p>	W 345			

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W 345	<p>Continued From page 144</p> <p>dental x-rays, the RN stated no action had been taken to address the dentist's unsuccessful attempts to obtain dental x-rays for Individual #2.</p> <p>- Individual #1 - #3 and Individual #6's review forms included dates next to the "Quarterly Pharmacy Reviews" section of the form. No information was included in the "Quarterly Pharmacy Reviews" section for Individual #7.</p> <p>When asked, during an interview on 8/13/14 at 2:00 p.m., the RN stated a review was probably completed by the company's QA person, so it was not completed on the review forms.</p> <p>- Individual #1's review form included the dates 3/25/14, 2/1/13, 9/25/13, and 6/5/13 next to the "Quarterly Pharmacy Reviews" section of the form, but no additional information related to the reviews was present.</p> <p>However, Individual #1's 6/20/14 pharmacy review stated "Aspirin and Ibuprofen can independently increase risk if [sic] a GI bleed. These is some evidence to suggest that the SSRI's (seraline) can also increase this risk. As [Individual #1] is on both classes of medications, it is recommended that GI bleed be considered during his routine visits with PCP and if he has any signs or symptoms during regular nursing review."</p> <p>No information related to the pharmacist's recommendation was included on the form. Additionally, when asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., if the IDT, including the physician and Individual #1's guardian had been informed of the pharmacist's recommendations, the LPN stated</p>	W 345			

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W 345	<p>Continued From page 145 they had not.</p> <p>- Individual #3's review form included the dates 3/25/14, 2/1/13, 9/25/13, and 6/5/13 next to the "Quarterly Pharmacy Reviews" section of the form, but no additional information related to the reviews was present.</p> <p>However, Individual #3's 6/20/14 pharmacy review stated "the risk of nephrotoxicity [destructive to kidney cells] to either ACE Inhibitors or NSAID's, including hyperkalemia [elevated potassium level], may be increased by this drug combination...Periodic measurement of renal function and potassium concentrations may be necessary."</p> <p>When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the IDT, guardian, or physician had not been notified of the pharmacist's recommendation.</p> <p>It was not clear what information was to be reviewed and documented on the "ICF/MR Record Review Form[s]" in order to ensure individual health needs were being met.</p> <p>When asked, during an interview on 8/13/14 at 2:00 p.m., the RN stated the review forms were an internal document he used for monitoring. When asked for information related to how the forms were to be completed, the facility submitted "RN QA Checklist Instructions" dated 10/8/10, which stated the RN was to review the PRN Record on the current MAR in the home, review the physician's orders, dietary and speech therapy recommendations regarding dietary texture, and review the most current physician</p>	W 345			

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W 345	Continued From page 146 recap orders in each individual's chart. The instructions did not include all areas of the record review form.  The RN failed to develop and implement programs, policy and practices to establish clear nursing delegations and monitoring necessary to ensure individuals received appropriate health services. Additionally, the RN failed to develop an effective quality assurance program, including a schedule of regular chart audits and oversight of outside services as specified in the facility's Director of Nursing Job Description.	W 345			
W 353	2. Refer to W331 as it relates to the RN's failure to provide sufficient monitoring and oversight to ensure individuals received nursing services in accordance with their needs. 483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE  Comprehensive dental diagnostic services include periodic examination and diagnosis performed including radiographs when indicated and detection of manifestations of systemic disease.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a periodic comprehensive dental evaluation was accomplished for 1 of 5 individuals (Individual #2) whose dental records were reviewed. This resulted in the potential for an individual's dental needs to be unidentified and untreated. The findings include:	W 353			

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W 353	Continued From page 147 1. Individual #2's PCLP, dated 12/11/13, documented a 60 year old male whose diagnoses included severe intellectual disability and stroke.  Individual #2's record documented dental visits on 11/7/13 and 5/8/14. However, an x-ray report was not in his record. His record did not contain a dental note indicating when the most recent x-rays were obtained.  During an interview on 8/13/14 from 2:00 - 2:40 p.m., the RN stated a telephone call was made to Individual #2's dentist and according to the dentist, he had not had a dental x-ray. The RN said all attempts to obtain x-rays had been unsuccessful. The RN was then asked what decision was made by Individual #2's guardian and the IDT to determine the best possible course of action since the dentist could not obtain dental x-rays. The RN stated no action had been taken to address the dentist's unsuccessful attempts to obtain dental x-rays for Individual #2.  The facility failed to ensure a comprehensive dental examination had been obtained for Individual #2.	W 353			
W 363	483.460(j)(2) DRUG REGIMEN REVIEW  The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure irregularities in individuals' drug regimens were reported to the prescribing physician and IDT for	W 363			

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W 363	<p>Continued From page 148</p> <p>2 of 4 individuals (Individuals #1 and #3) whose pharmacy records were reviewed. This resulted in the physician and IDT not being informed of individuals receiving medication combinations which resulted in increased risks to their physical health. The findings include:</p> <p>1. Individual #3's IPP, dated 9/20/13, documented a 65 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #3's Physician's Order, dated 7/2014, documented he received lisinopril (an antihypertensive drug) 20 mg daily. The document also included an order for ibuprofen (an NSAID) 400 mg twice daily as needed.</p> <p>However, Individual #3's 6/20/14 pharmacy review stated "the risk of nephrotoxicity [destructive to kidney cells] to either ACE Inhibitors or NSAID's, including hyperkalemia [elevated potassium level], may be increased by this drug combination...Periodic measurement of renal function and potassium concentrations may be necessary."</p> <p>A Nursing Progress Notes entry, dated 7/14/14, documented "Received [Individual #3's] quarterly pharmacy review from [pharmacist name]. Concerns noted re: antihypertensive's and NSAIDs."</p> <p>However, Individual #3's record did not include documentation that his IDT and physician had been notified of the pharmacist's findings.</p> <p>When asked during interviews conducted on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the IDT and physician</p>	W 363			

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W 363	<p>Continued From page 149</p> <p>had not been notified of the pharmacist's findings.</p> <p>The facility failed to ensure the the physician and IDT were notified of Individual #3's increased risks as identified by the pharmacist.</p> <p>2. Individual #1's IPP, dated 9/4/13, documented a 53 year old male whose diagnoses included severe intellectual disability.</p> <p>Individual #1's 3/27/14 physician's Orders documented he received received Risperdal (an antipsychotic drug) 5 mg, Zyprexa (an antipsychotic drug) 12.5 mg, Clonidine (an antihypertensive drug) 0.05 mg three times a day and Zoloft (an antidepressant drug) 50 mg daily for behavior modification purposes.</p> <p>The physician's orders also documented he received ASA 325 mg daily at 8:00 p.m., Ibuprofen 200 mg 2 tabs daily at 12:00 p.m. and Tylenol 650 mg 2 tabs daily at 8:00 am, 2:00 p.m. and 8:00 p.m. Additionally, his routine standing orders, dated 3/6/09, stated he could receive Acetaminophen (or Tylenol) 650 mg every 4 hours as needed for pain or fever and Ibuprofen (or generic) 400 mg every 4 to 6 hours as needed for fever or pain.</p> <p>Individual #1's 6/20/14 pharmacy review stated "Aspirin and Ibuprofen can independently increase risk if [sic] a GI bleed. These is some evidence to suggest that the SSRI's (seraline) can also increase this risk. As [Individual #1] is on both classes of medications, it is recommended that GI bleed be considered during his routine visits with PCP and if he has any signs or symptoms during regular nursing review."</p>	W 363			

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W 363	Continued From page 150 However, Individual #1's record did not include documentation that his IDT and physician had been notified of the pharmacist's findings.  When asked during interviews conducted on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated the IDT and physician had not been notified of the pharmacist's findings.  The facility failed to ensure the the physician and IDT were notified of Individual #1's increased risks as identified by the pharmacist.	W 363		
W 434	483.470(f)(3) FLOORS  The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions.  This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure the facility floor was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the environment being kept in ill-repair and a potential increase in fall risks. The findings include:  1. During an observation on 8/4/14 from 2:15 - 4:20 p.m., the condition of the dining room vinyl flooring was noted. The vinyl was scratched multiple times under the dining room table and in the area from the table to the back door. There was a gouge approximately 24 inches long and a black hole approximately the size of a nickel between the table and the back door. The black underlining of the vinyl was exposed. The vinyl between the entrance to the kitchen and the back	W 434		

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W 434	Continued From page 151 door was wavy, detached from the subflooring, and did not lay flat.  During interviews about the condition of the vinyl flooring on 8/4/14 at 4:09 p.m., the leadworker stated the vinyl was old.  During an interview about the condition of the vinyl flooring on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated last year the vinyl flooring was replaced in the kitchen but not in the dining room.  The facility failed to ensure the dining room vinyl flooring was maintained in a manner that promoted safe and sanitary conditions.	W 434			
W 459	483.480 DIETETIC SERVICES  The facility must ensure that specific dietetic services requirements are met.  This CONDITION is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure appropriate dietary monitoring and services were provided to the individuals residing at the facility. This resulted in individuals not dining in a manner consistent with their developmental level and a lack of opportunities being provided to develop and practice normalized dining skills. The findings include:  1. Refer to W460 as it relates to the facility's failure to ensure individuals were provided with adequate nutrition.	W 459			

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W 459	Continued From page 152 2. Refer to W481 as it relates to the facility's failure to ensure menus of food actually served were kept for 30 days.  3. Refer to W486 as it relates to the facility's failure to ensure individuals were provided monitoring and support to promote appropriate dining behaviors.	W 459			
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES  Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure each individual received modified diets as prescribed for 1 of 5 individuals (Individual #5) whose nutritional records were reviewed. This resulted in the potential for an individual's health and dietary goals to be negatively impacted. The findings include:	W 460			
W 463	483.480(a)(4) FOOD AND NUTRITION SERVICES  The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets.	W 463			

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W 463	Continued From page 153 This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure the physician prescribed each individual's modified diet for 1 of 5 individuals (Individual #5) whose nutritional records were reviewed. This resulted in a lack of clear direction to staff regarding an individual's food texture. The findings include:  1. Individual #5's record included a Tentative Treatment Plan, dated 7/29/14. The speech section documented Individual #5 should receive a mechanical soft diet. However, the dietary section of the plan stated she was to receive a regular texture diet but "is unable to chew raw vegetable; they will need to be cooked until soft."  Additionally, her record did not contain a physician's order for a modified texture diet.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated she was not sure what texture Individual #5's diet should be.  The facility failed to ensure Individual #5's diet texture was appropriately assessed and prescribed by the physician.	W 463			
W 474	483.480(b)(2)(iii) MEAL SERVICES  Food must be served in a form consistent with the developmental level of the client.	W 474			

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W 474	Continued From page 154  This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to provide sufficient training, supervision, and monitoring necessary to ensure an individual received food consistent with her prescribed diet for 1 of 5 individuals (Individual #5) reviewed, who received a regular diet. This resulted in an individual receiving modified food without justification. The findings include:  1. Individual #5's record included a Tentative Treatment Plan, dated 7/29/14. The speech section documented Individual #5 should receive a mechanical soft diet. However, the dietary section of the plan documented she was to receive a regular texture diet but "is unable to chew raw vegetable; they will need to be cooked until soft."  Additionally, her record did not contain a physician's order for a modified texture diet.  During an observation on 8/4/14 from 5:08 - 6:20 p.m., DCS F was observed to use a blender to prepare pork chops and rice. Individual #5 was then observed to eat the pork chop and rice that had been in the blender.  When asked during a follow up visit to the facility on 8/8/14 from 2:40 - 3:20 p.m., DCS F stated the texture of the food served to Individual #5 during dinner on 8/4/14 had been shredded in the blender.  When asked during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the	W 474		

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W 474	Continued From page 155 QIDP stated she was not sure what texture Individual #5's diet should be.	W 474			
W 481	The facility failed to ensure Individual #5's dietary texture needs were clearly identified. 483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days.  This STANDARD is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 1 of 7 individuals (Individual #5) residing at the facility. This resulted in the potential for an individual to not receive an adequate variety or amount of food. The findings include:  Individual #5's 7/29/14 Tentative Treatment Plan documented she was a 63 year old female whose diagnoses included severe intellectual disability. She had been residing in a sister facility within the company and was admitted to the facility on 7/29/14.  When asked about Individual #5's menu documentation on 8/15/14 at approximately 2:30 p.m., the Administrator stated they had not planned on keeping track of Individual #5's food served until after her initial assessments were completed.	W 481			
W 486	The facility failed to ensure a record of food served was kept for Individual #5. 483.480(d)(4) DINING AREAS AND SERVICE  The facility must direct self-help dining	W 486			

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W 486	Continued From page 156 procedures.	W 486			
W 488	<p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure individuals were provided monitoring and support to promote appropriate dining behaviors for 7 of 7 individuals (Individuals #1 - #7) observed during meals. This resulted in a lack of appropriate social and dining behaviors being modeled to individuals. The findings include:</p> <p>1. Refer to W488 as it relates to the facility's failure to ensure individuals were provided the opportunity to develop and practice appropriate, normalized dining skills.</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided dining opportunities consistent with their developmental level which directly impacted 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of opportunity for individuals to develop new skills and practice existing skills. The findings include:</p> <p>1. A dinner observation was conducted at the facility on 8/4/14 from 5:10 - 6:20 p.m. The dinner menu included a broiled pork chop, brown</p>	W 488			

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W 488	<p>Continued From page 157</p> <p>rice pilaf, spinach salad, pineapple, ice cream and milk. During the observation, staff were not observed to consistently provide individuals with the opportunity to engage in appropriate normalized dining, as follows:</p> <p>a. From 5:10 - 5:19 p.m., DCS F was observed preparing food in the kitchen.</p> <p>Individuals #1 - #7 were not observed to be prompted or encouraged to assist in the meal preparation.</p> <p>b. At 5:14 p.m., DCS F was observed preparing food in a blender in the kitchen. At this time, Individuals #2, #4, #5, and #6 were sitting at the dining room table. Individual #1 was sitting in a chair in the corner of the living room. Individual #3 was sitting on a couch in the living room.</p> <p>Individuals #1 - #6 were not observed to be prompted or encouraged to assist in the meal preparation.</p> <p>c. At 5:19 p.m., DCS F was observed in the kitchen placing pureed rice onto individual plates.</p> <p>Individuals #1 - #6 were not observed to be prompted or encouraged to assist in plating the food.</p> <p>d. At 5:24 p.m., DCS E was observed to obtain a rocker knife for Individual #2.</p> <p>Individual #2's participation in obtaining his own knife was not elicited.</p> <p>e. At 5:26 p.m., DCS F was observed placing a plate of meat on the dining room table and also</p>	W 488			

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W 488	<p>Continued From page 158</p> <p>placed a piece of meat on Individual #6's plate. Individual #6 told the DCS F she did not want to eat the meat.</p> <p>DCS F was not observed to elicit Individual #1 - #7's participation in placing the food on the table and DCS F was not observed to elicit Individual #6's participation in serving her meat.</p> <p>f. At 5:30 p.m., Individual #1 was observed going into the kitchen. He then went into the dining room with a plate of food in his hands. He sat down at the dining room table and began to eat his food.</p> <p>DCS F was not observed to elicit Individual #1's participation in serving himself food.</p> <p>g. At 5:31 p.m., DCS E was noted to pass a plate of pork chops to Individual #4 reaching over Individual #2's plate. Individual #4 then passed the plate of pork chops back to DCS E.</p> <p>DCS E did not elicit Individual #2's participation in passing the pork chops.</p> <p>h. At 5:34 p.m., DCS F was observed pouring salad dressing into a serving utensil and Individual #6 placed the salad dressing on her salad. DCS F added a liquid substance to the meat on Individual #5's plate and stirred the meat and liquid together.</p> <p>DCS F was not observed to elicit Individual #6's participation in pouring the dressing into the utensil and DCS F did not elicit Individual #5's participation in adding the liquid to her meat.</p> <p>i. At 5:39 p.m., DCS F was observed placing</p>	W 488			

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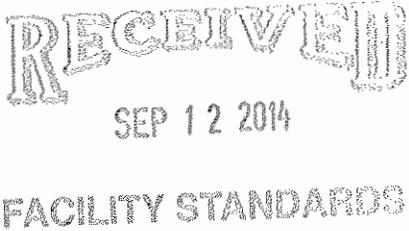
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W 488	<p>Continued From page 159 pineapple chunks on Individual #5's plate.</p> <p>DCS F did not elicit Individual #5's participation in serving herself.</p> <p>j. At 5:40 p.m., DCS G was observed serving Individual #3 and Individual #2 a scoop of ice cream.</p> <p>DCS G was not observed to elicit Individual #3 or Individual #2's participation in serving their ice cream.</p> <p>k. At 5:41 p.m. DCS F was observed serving Individual #5 a scoop of ice cream.</p> <p>DCS F did not elicit Individual #5's participation in serving herself.</p> <p>When asked about the observations, during interviews on 8/11/14 from 9:05 a.m. - 12:00 p.m. and 1:08 - 2:40 p.m., the QIDP stated staff were to engage the individuals to help themselves during dining to the extent possible.</p> <p>The facility failed to ensure staff promoted appropriate, normalized dining.</p>	W 488			

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensing survey conducted from 8/4/14 to 8/14/14.  The survey was conducted by:  Jim Troutfetter, QIDP, Team Leader Karen Marshall, MS, RD, LD	M 000		
MM112	16.03.11.050.01(d) Residential Facility  The residential facility is to admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. This Rule is not met as evidenced by: Refer to W223.	MM112		
MM164	16.03.11.075.04 Development of Plan of Care  To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164		
MM177	16.03.11.075.09 Protection from Abuse and Restraint	MM177		

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

TITLE

(X6) DATE

*[Signature]*

*Program Manager*

10/21/14

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MM177	Continued From page 1  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).  This Rule is not met as evidenced by: Refer to W285.	MM177		
MM191	16.03.11.075.09(c) Last Resort  Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy.  This Rule is not met as evidenced by: Refer to W290 and W313.	MM191		
MM194	16.03.11.075.10(a) Approval of Human Rights Committee  Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194		

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MM197	Continued From page 2	MM197		
MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W312.	MM197		
MM203	16.03.11.075.12(a) Treated with Consideration  Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W268.	MM203		
MM212	16.03.11.075.17(a) Maximize Developmental Potential  The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W195, W196, W242, W249 and W266.	MM212		
MM238	16.03.11.080.03(h) Access to Resident's Records  To be given access to all of the resident's records that pertain to his active treatment, subject to the requirements specified in Idaho Department of Health and Welfare Rules, Section 05.01.300 through Subsection 05.01.301,06, and Sections 05.01.310 through 05.01.339, "Rules Governing Protection and Disclosure of Department	MM238		

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MM238	Continued From page 3  Records." This Rule is not met as evidenced by: Refer to W250.	MM238		
MM298	16.03.11.100.06(e) Storage Areas, Attics, Basements  Storage areas, attics, basements, and grounds must be kept free from refuse, litter, weeds, or other items detrimental to the health, safety, or welfare of the residents. This Rule is not met as evidenced by: Refer to W434.	MM298		
MM512	16.03.11.200 Administration  The administration of ICF/ID facilities must provide for individual program planning, implementation and evaluation. Individual programs must be based on relevant assessment of needs and problems and must reflect the participation of the individual, the service providers, and where possible, the individual's family or surrogate. Individual program planning must include provisions for total program coordination and continuous, self-correcting processes for review and program revision. Programming for individuals must incorporate the resident's legal rights of due process, appropriate care, training and treatment.  This Rule is not met as evidenced by: Refer to W100.	MM512		
MM520	16.03.11.200.03(a) Establishing and Implementing policies	MM520		

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MM520	Continued From page 4  The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W102 and W104.	MM520		
MM539	16.03.11.210.01(d) Resident's Record  All entries in the resident's record must be legible, dated, and authenticated by the signature and professional designation of the individual making the entry. This Rule is not met as evidenced by: Refer to W114.	MM539		
MM620	16.03.11.230.05(b) Upgrading of Competencies  The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W190.	MM620		
MM622	16.03.11.230.05(d) Proper Instruction  Instruction in the proper management of seizure disorders, physical handicaps, special communication needs and physically injurious behaviors. This instruction must be provided before personnel are assigned to work with individuals who may be affected by the above disorders, handicaps, needs and behaviors; and This Rule is not met as evidenced by: Refer to W194.	MM622		

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MM650	16.03.11.250.03 Dietary Services  Consultation must be obtained on a regularly scheduled basis from a Registered Dietician or, if no dietician is available, from a person with at least a bachelor's degree in foods and nutrition. The dietician's duties will include: This Rule is not met as evidenced by: Refer to W217.	MM650		
MM654	16.03.11.250.03(d) Liaison  Serving as liaison between physicians, nurses, and those preparing or serving food relative to dietary orders, special prescriptions and related matters. This Rule is not met as evidenced by: Refer to W463.	MM654		
MM672	16.03.11.07(a) Menu Preparation  Menus must be prepared at least a week in advance. Menus must be corrected to conform with food actually served. (Items not served must be deleted, and food actually served must be written in.) The corrected copy of the menu and diet plan must be dated and kept on file for thirty (30) days. This Rule is not met as evidenced by: Refer to W481.	MM672		
MM678	16.03.11.250.08(c) Individual Resident's Needs  Foods must be served in a form to meet individual resident's needs: This Rule is not met as evidenced by: Refer to W460.	MM678		

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MM679	Continued From page 6	MM679		
MM679	16.03.11.250.08(c)(i) Pureed or Ground Meat  Food must be cut, ground, or pureed only for those who require it. Pureed or ground food must be the same foods as the menu for that meal; leftovers are not to be used for this purpose; This Rule is not met as evidenced by: Refer to W474.	MM679		
MM724	16.03.11.270.01(a) Assessments  As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225 and W234.	MM724		
MM725	16.03.11.270.01(b) QMRP  The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement.  This Rule is not met as evidenced by: Refer to W159, W486 and W488.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives  The individual treatment plan must state specific	MM729		

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MM729	Continued From page 7  objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data  Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		
MM735	16.03.11.270.02 Health Services  The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W318 and W322.	MM735		
MM755	16.03.11.270.02(f)(ii)(a) Resident unable to Self-Administrate  If the resident is not capable of self-administration of medications under staff supervision, this fact must be documented in the resident's assessment. Such residents cannot be accepted by facilities unless a licensed nurse is on duty to administer and record such medications. This Rule is not met as evidenced by: Refer to W216.	MM755		

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MM760	<p>16.03.11.270.03 Nursing Services</p> <p>Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W331.</p>	MM760		
MM821	<p>16.03.11.270.06(b)(i)(a) Evaluation and Screening</p> <p>Evaluation and screening of residents' speech and hearing functions This Rule is not met as evidenced by: Refer to W220.</p>	MM821		
MM836	<p>16.03.11.270.07 Physical and Occupational Therapy Services</p> <p>Physical and Occupational Therapy Services. Physical and occupational therapy services must be made available to any resident in need of such treatment.  This Rule is not met as evidenced by: Refer to W218.</p>	MM836		
MM859	<p>16.03.11.270.08(f)(i) Supervision of Training and Habilitation</p> <p>Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and  This Rule is not met as evidenced by: Refer to W120.</p>	MM859		

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MM859	Continued From page 9	MM859		