



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

September 17, 2013

COPY

Rick Carter, Administrator
Preferred Community Homes - Cornerstone
7091 W Emerald
Boise, ID 83704

RE: Preferred Community Homes - Cornerstone, Provider #13G056

Dear Mr. Carter:

This is to advise you of the findings of the Initial Medicaid/Licensure survey of Preferred Community Homes - Cornerstone, which was conducted on September 12, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Rick Carter, Administrator
September 17, 2013
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **September 30, 2013**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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

This request must be received by September 30, 2013. If a request for informal dispute resolution is received after September 30, 2013, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pt
Enclosures

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2013
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - CORNERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2028 EAST 2975 SOUTH WENDELL, ID 83355
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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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 9/9/13 - 9/12/13.</p> <p>The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Trish O'Hara, RN, HFS</p> <p>Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disabilities Professional CP - Cerebral Palsy IDT - Interdisciplinary Team NOS - Not Otherwise Specified PCLP - Person Centered Lifestyle Plan PDD - Pervasive Developmental Disorder QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</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 privacy during personal cares. This failure directly impacted 1 of 5 individuals (Individual #1) observed, and had the potential to impact 5 of 5 individuals (Individual #1 - #5) residing in the facility. This resulted in an individual's incontinence brief being changed in view of others. The findings include:</p>	W 130	<p style="text-align: right;">RECEIVED OCT - 4 2013 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rick Carter</i>	TITLE Program Supervisor	(X6) DATE 10-4-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2013
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - CORNERSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 2028 EAST 2975 SOUTH WENDELL, ID 83355	
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W 130	Continued From page 1 1. Individual #1's 6/14/13 PCLP stated he was an 7 year old male diagnosed with severe intellectual disability, CP, and seizure disorder. He required the use of a wheelchair for mobility. During an observation on 9/10/13 from 2:30 - 4:35 p.m., Individual #1 was observed in the common area of the facility. At 3:25 p.m., a direct care staff took Individual #1 to his bedroom and laid him on his bed. The direct care staff proceeded to change Individual #1's incontinence brief. However, the direct care staff did not close the bedroom door or cover Individual #1 in any way. Individual #1's genitals and buttocks were exposed and visible to anyone standing in or walking down the hallway during the process. During an interview on 9/10/13 at 6:15 p.m., the direct care staff who changed Individual #1's incontinence brief stated the facility had provided training related to protection of privacy to include closing bedroom and bathroom doors during cares. The direct care staff stated she should have closed the bedroom door during Individual #1's personal cares to protect his privacy. The facility failed to ensure Individual #1 was afforded privacy during personal cares.	W 130		
W 199	483.440(b)(2) ADMISSIONS, TRANSFERS, DISCHARGE Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.	W 199		

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W 199	<p>Continued From page 2</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 admission decisions were based on a preliminary evaluation of an individual that was conducted or updated by the facility for 1 of 2 individuals (Individual #3) admitted within the past year. This failure resulted in potential for an individual to be admitted without indications the facility could meet their needs. The findings include:</p> <p>1. Individual #3's 3/7/13 PCLP stated she was a 62 year old female whose diagnoses included profound intellectual disability, PPD, and mood disorder NOS. She was admitted to the facility on 2/8/13 from a Residential Habilitation (ResHab) facility in another town.</p> <p>Individual #3's record contained assessment information obtained after her admission on 2/8/13. However, the record did not contain preliminary evaluation information indicating individual #3's needs could be met by the facility.</p> <p>During an interview on 9/12/13 from 8:30 - 9:00 a.m., the QIDP and AQIDP both stated they were unaware of any pre-admission preliminary evaluations or plans being completed. The QIDP stated the facility's parent company also ran the ResHab facility where Individual #3 had been living and the company may have viewed the move as a transfer rather than a new admission.</p> <p>The facility failed to ensure Individual #3's record included preliminary assessment information on which to base her admission decision.</p>	W 199		
W 207	483.440(c)(2) INDIVIDUAL PROGRAM PLAN	W 207		

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W 207	Continued From page 3 Appropriate facility staff must participate in interdisciplinary team meetings. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure appropriate facility staff participated in the PCLP meetings for 1 of 3 individuals (Individual #1) whose PCLPs were reviewed. This resulted in the potential for a lack of comprehensive information being provided in the development of a PCLP and a lack of opportunities for the IDT members to consult with one another and to exchange information. The findings include: 1. Individual #1's PCLP, dated 6/14/13, documented a 7 year old male diagnosed with severe intellectual disability, CP, and seizure disorder. There was no signature sheet attached to his PCLP documenting which members of the IDT attended the PCLP meeting on 6/14/13. During an interview, on 9/19/13 from 8:30 - 9:00 a.m., the AQIDP stated there was no signature sheet for attendance at the meeting. She confirmed it was not possible to determine who had been at the meeting. The facility failed to ensure appropriate facility staff were in attendance and documented for Individual #1's PCLP meeting.	W 207			
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440			

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W 440	<p>Continued From page 4 quarterly for each shift of personnel.</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 evacuation drills were conducted quarterly for each shift for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include:</p> <p>1. The facility's evacuation drills were reviewed and did not include documentation that evacuation drills had been completed for each shift during each quarter, as follows:</p> <p>- For the evening shift (3:00 - 11:00 p.m.) of the fourth quarter (October - December) of 2012.</p> <p>During an interview on 9/12/13 from 8:30 - 9:00 a.m., the Program Director stated the drill had not been completed.</p> <p>The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.</p>	W 440		
W 455	<p>483.470(I)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and</p>	W 455		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - CORNERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 2028 EAST 2876 SOUTH WENDELL, ID 83355
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W 455	<p>Continued From page 5</p> <p>control infection and/or communicable diseases. This failure directly impacted 3 of 5 individuals (Individuals #3 - #5) residing in the facility and had the potential to impact all individuals (Individuals #1 - #5) residing in the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:</p> <p>1. An environmental review was completed on 9/10/13 from 3:45 - 4:36 p.m. During that time, the following was observed:</p> <ul style="list-style-type: none"> - Individual #3's grooming kit contained 2 uncovered toothbrushes, a comb, 3 fingernail files, a fingernail clipper, and an ink pen. - Individual #4's grooming kit contained 1 uncovered toothbrush and a container of deodorant. - Individual #5's grooming kit contained 1 uncovered toothbrush, a bottle of Nair hair remover, a container of deodorant, a comb, and ear plugs. <p>The Program Director, who was present during the environmental review, stated individuals' tooth brushes should be covered. The Program Director removed the uncovered tooth brushes at that time.</p> <p>The facility failed to ensure infection control procedures were sufficiently implemented.</p>	W 455		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2013
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 9/9/13 - 9/12/13. The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Trish O'Hara, RN, HFS	M 000		
MM109	16.03.11.050.01(a) Admission, Transfer, and Release Admission, transfer, and release must be consistent with the following provisions: Admission. Upon admission of a resident to an ICF/ID, there must be written evidence that a conference has been held including a representative from the Adult and Child Development Center, the medical/ social review team, and the interdisciplinary team from the facility and written recommendations from those participating members. No resident can be admitted or retained for whom the facility does not have the capability and services to provide appropriate care. This Rule is not met as evidenced by: Refer to W199.	MM109	So	
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 W130.	MM203		

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OCT - 4 2013
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X8) DATE

Bureau of Facility Standards

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MM266	Continued From page 1	MM266		
MM266	16.03.11.100.03(a) Garbage Containers	MM266		
	<p>All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers must be provided with tight-fitting lids.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all containers used for storage of garbage and refuse were provided with tight-fitting lids. This failure directly impacted 5 of 5 Individuals (Individuals #1 - #5) residing in the facility. This resulted in the potential for individuals to be exposed to contaminated items. The findings include:</p> <p>1. During an environmental review on 9/10/13 from 3:45 - 4:35 p.m., the following was noted:</p> <ul style="list-style-type: none"> - The garbage can in the bedroom shared by Individual #1 and Individual #2 was missing a lid. The garbage can contained refuse from both individuals' incontinence briefs. - The garbage can in the dining area was missing a lid. The garbage can contained used rubber gloves and napkins. <p>The Program Director, who was present during the environmental review, stated the garbage cans should have lids.</p> <p>The facility failed to ensure garbage cans were provided with tight-fitting lids.</p>			

BUREAU OF FACILITY STANDARDS

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MM769	Continued From page 2	MM769		
MM769	<p>16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio</p> <p>Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures.</p> <p>This Rule is not met as evidenced by: Refer to W455.</p>	MM769		

W130 438.420 (a) (7) Protection of Client Rights

The facility will ensure that appropriate facility staff participates in Privacy Training to ensure the policies pertaining to resident privacy are understood. The AQIDP will provide the Privacy Training at the staff meeting on October 4, 2013. The Program Supervisor will create a Privacy checklist to be used to conduct random weekly checks. Corrective action will be taken if needed during these spot checks. Random checks will start the week of October 7, 2013.

Completion date: 10/04/2013

Persons responsible: Program Manager, Program Supervisor, AQIDP

W199 483.440 (b) (2) Admissions, transfers, discharges

The facility will ensure that the Pre-admission/Admission information is obtained and available for all residents prior to admit to include all preliminary evaluation indicating that the individuals needs can be met by the facility. A admissions checklist has been added to the admit process by the AQIDP to ensure this information is obtained. This check list will be used during all future admissions to the facility. Additionally; an Admissions section has been added to the QIDP review document used during Quality Assurance Reviews conducted quarterly.

Completion date: 10/04/2013

Persons responsible: Program Manager, Program Supervisor, QIDP, AQIDP

W207 438.440 (c) (2) Individual Program Plan

The facility will ensure that appropriate facility staff participates in all resident PCLP and IDT meetings, and that documentation of the meeting will be obtained. The AQIDP/QIDP has created a check list to include the IPP sign-in sheet that will be used at all future PCLP/IPP. A section has also been added to the QIDP Review document that is used during the Quality Assurance review done quarterly; in addition a random check of the IPP section of the Q book will be conducted monthly by the Program Manager to ensure all residents have a sign in sheet attached to their most current PCLP/IPP.

Completion date: 10/04/2013

Persons responsible: Program Manager, Program Supervisor, QIDP, AQIDP

W440 483.470 (i) (1) Evacuation Drills

The Program Supervisor will ensure that the times of all evacuation drills are understood by the appropriate facility staff and that the proper documentation is accurately for every shift. The evacuation drill data will be reviewed quarterly during the Quality Assurance review.

Completion date: 10/25/2013

Persons responsible: Program Manager, Program Supervisor

The facility will ensure that appropriate facility staff participates in infection control training. The AQIDP will provide training for infection control on October 4, 2013. The Program Supervisor will create a checklist to be used to conduct random weekly checks. Corrective action will be taken if needed during these spot checks.

Completion date: 10/09/2013

Persons responsible: Program Manager, Program Supervisor

W455 483.470 (I) (1) Infection Control

The facility will ensure that appropriate facility staff participates in infection control training. The AQIDP will provide training for infection control on October 4, 2013. The Program Supervisor will create a checklist to be used to conduct random weekly checks. Corrective action will be taken if needed during these spot checks.

Completion date: 10/09/2013

Persons responsible: Program Manager, Program Supervisor, AQIDP

MM109 16.03.11.050.01 (a) Admissions, Transfers, and Release

Please refer to W199

MM203 16.03.11.075.12 (a) Treated with Consideration

Please refer to W130

MM266 16.03.270.03 (a) Garbage Containers

Please refer to W455

MM 769 16.03.11.270.03 (c) (vi) Control of Communicable Disease and Infection

Please refer to W455

Aspire -Preferred Community Homes {cornerstone} P O C

MM266

MM266

The facility will ensure that appropriate facility staff participates in a training on garbage cans need tight fitting lids. The AQIDP will provide training for garbage cans and tight fitting lids on October 4, 2013. The Program Supervisor will create a checklist to be used to conduct random weekly checks. Corrective action will be taken if needed during these spot checks.

Completion date: 10/09/2013

Persons responsible: Program Manager, Program Supervisor, AQIDP

Rick Carter

Program Supervisor 10/7-13

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OCT 07 2013

FACILITY STANDARDS