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 - Courtyard
7091 W Emerald
Boise, ID 83704

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

Dear Mr. Carter:

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

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 A Case, LSW

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

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	The following deficiencies were cited during the recertification 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 Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactivity Disorder AQIDP - Assistant Qualified Intellectual Disabilities Professional HRC - Human Rights Committee IDT - Interdisciplinary Team IED - Intermittent Explosive Disorder LPN - Licensed Practical Nurse MAR - Medication Administration Record PCLP - Person Centered Lifestyle Plan PDD - Pervasive Developmental Disorder PRN - As needed QIDP - Qualified Intellectual Disabilities Professional		RECEIVED OCT - 4 2013 FACILITY STANDARDS	
W 207	483.440(c)(2) INDIVIDUAL PROGRAM PLAN 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 2 of 3 individuals (Individuals #2 and #3) whose PCLPs were reviewed. This resulted in the potential for a lack of comprehensive information being provided in the development of PCLPs and a lack of opportunities for the IDT	W 207		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rick Cook	Program Supervisor	10-4-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 207	Continued From page 1 members to consult with one another and to exchange information. The findings include: 1. Individual #2's PCLP, dated 9/17/12, documented a 22 year old male diagnosed with profound intellectual disability and autism. There was no signature sheet attached to his PCLP documenting which members of the IDT attended the PCLP meeting on 9/17/12. During an interview, on 9/19/13 from 9:00 - 10:00 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. 2. Individual #3's PCLP, dated 9/12/12, documented a 22 year old male with diagnoses including mild intellectual disability, autism, and ADHD. There was no signature sheet attached to his PCLP documenting which members of the IDT attended the PCLP meeting on 9/12/12. There was no signature sheet attached to his PCLP documenting which members of the IDT attended the PCLP meeting on 9/12/12. During an interview, on 9/19/13 from 9:00 - 10:00 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 #2 and Individual #3's PCLP meetings.	W 207		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 225	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 record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was completed for 2 of 3 individuals (Individuals #1 and #3) who were of age to be involved in vocational training. Without a comprehensive assessment, the facility would be unable to assist individuals with vocational training needs through the development of objectives designed to optimize the individuals' abilities. The findings include: 1. The facility utilized a Vocational Assessment tool that included 21 probes related to vocational tasks (e.g., "When shown or instructed, participant can learn a new job or task involving one-step," etc.). The Vocational Assessment tool included narrative sections for additional information, and had sections for past, present, and future employment, work interests, work-related behaviors, vocational strengths, vocational needs, limitations, and adaptive equipment. The Vocational Assessments did not contain sufficient information, as follows: a. Individual #1's 7/9/13 PCLP stated she was a 23 year old female whose diagnoses included intellectual disability "unable to specify," PDD, autism, and IED. She attended a home based vocational program Monday through Friday.	W 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 225	Continued From page 3 The narrative section of Individual #1's Vocational Assessment, dated 7/2/13, documented "volunteer" in both the Past Employment and Present Employment sections. No additional information was included. Additionally, the sections for Future Employment, Work Interests, and Work-related Behavior were all blank. Individual #1's Vocational Assessment did not contain information related to work interests, attitudes, work-related behaviors, or future employment options. b. Individual #3's 9/12/12 PCLP stated he was a 22 year old male whose diagnoses included moderate intellectual disability, PDD, autism, ADHD and seizure disorder. He attended a home based vocational program Monday through Friday. The narrative section of Individual #3's Vocational Assessment, updated 8/9/13, stated "Salvation Army, dog walking" under Past Employment and "lawn care" under Present Employment. The Work-related Behaviors section stated "difficulty staying on task." The Vocational Needs section stated "Better understanding of money" and the Limitations section stated "Educational" and "difficulty staying on task." No additional information was included. Additionally, the Future Employment and Work Interest sections of the assessment were blank. Individual #1's Vocational Assessment did not contain information related to work interests or future employment options. During an interview on 9/12/13 from 9:00 - 10:00	W 225		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 225	Continued From page 4 a.m., the QIDP and AQIDP both stated there was no additional information related to Individual #1 or Individual #3's vocational needs. The QIDP stated the vocational assessments needed to be updated. The facility failed to ensure Individual #1 and Individual #3's Vocational Assessments contained complete and comprehensive information regarding their vocational needs.	W 225		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE 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. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 3 individuals (Individual #1) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's 7/9/13 PCLP stated she was a 23 year old female whose diagnoses included intellectual disability "unable to specify," PDD, autism, and IED. Individual #1's MAR documented she received the following PRN drugs prior to medical	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 262	Continued From page 5 procedures: - 9/24/12, Diazepam (an anxiolytic drug) 20 mg - 7/30/13, Diazepam 20 mg - 8/19/13, Diazepam 5 mg Individual #1's record contained an HRC approval form for a one time use of the drug on 7/30/13, but did not include approval for the use on 9/24/12 or 8/19/13. During an interview on 9/12/13 from 9:00 - 10:00 a.m., the QIDP and AQIDP both stated HRC approval for the drug use on 9/24/12 and 8/19/13 was missed due to an oversight. The facility failed to ensure HRC approval was obtained prior to the use of Individual #1's PRN Diazepam.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure guardian consent was obtained prior to the implementation of restrictive interventions for 1 of 3 individuals (Individual #1) whose records were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's 7/9/13 PCLP stated she was a	W 263		

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 263	Continued From page 6 23 year old female whose diagnoses included intellectual disability "unable to specify," PDD, autism, and IED. Individual #1's MAR documented she received the following PRN drugs prior to medical procedures: - 9/24/12, Diazepam (an anxiolytic drug) 20 mg - 7/30/13, Diazepam 20 mg - 8/19/13, Diazepam 5 mg Individual #1's record contained guardian consent for a one time use of the drug on 7/30/13, but did not include consent for the use on 9/24/12 or 8/19/13. During an interview on 9/12/13 from 9:00 - 10:00 a.m., the QIDP and AQIDP both stated consent for the drug use on 9/24/12 and 8/19/13 was missed due to an oversight. The facility failed to ensure guardian consent was obtained prior to the use of Individual #1's PRN Diazepam.	W 263		
W 312	483.450(e)(2) DRUG USAGE 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	W 312		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 312	Continued From page 7 comprehensive part of an individual's PCLP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drug was employed for 1 of 3 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's 7/9/13 PCLP stated she was a 23 year old female whose diagnoses included intellectual disability "unable to specify," PDD, autism, and IED. Individual #1's MAR documented she received the following PRN drugs prior to medical procedures: - 9/24/12, Diazepam (an anxiolytic drug) 20 mg - 7/30/13, Diazepam 20 mg - 8/19/13, Diazepam 5 mg However, Individual #1's record did not include a plan of how the use of the PRN drug prior to medical procedures would be reduced and eventually eliminated. During an interview on 9/12/13 from 9:00 - 10:00 a.m., the QIDP and LPN both stated the drug was initially intended for a one time use only. The QIDP stated a medication reduction plan should have been developed when the use of the drug was repeated. The facility failed to ensure Individual #1's PRN Diazepam was appropriately incorporated into a plan.	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 455	Continued From page 8	W 455		
W 455	483.470(i)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. 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 control infection and/or communicable diseases. This failure directly impacted 3 of 5 individuals (Individuals #2, #3 and #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: 1. An environmental review was completed on 9/10/13 from 4:45 - 5:20 p.m. During that time the following was observed: - Individual #2's grooming kit contained an uncovered toothbrush stored with toothpaste, a comb, and a rusted can of spray deodorant. - Individual #3's grooming kit contained an uncovered toothbrush stored with toothpaste, a hair brush and deodorant. - Individual #5's grooming kit contained an uncovered toothbrush stored with toothpaste and deodorant. The Program Director, who was present during the environmental review, stated individuals' tooth brushes should be covered. The Program	W 455		

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(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 455	Continued From page 9 Director removed the uncovered tooth brushes at that time. The facility failed to ensure infection control procedures were sufficiently implemented.	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - COURTYA

STREET ADDRESS, CITY, STATE, ZIP CODE: 615 SECOND AVENUE WEST, WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the 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		
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		
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196		
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	RECEIVED OCT - 4 2013 FACILITY STANDARDS	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good	MM380		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G067		09/12/2013

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - COURTY/

STREET ADDRESS, CITY, STATE, ZIP CODE: 615 SECOND AVENUE WEST, WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 1 repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. During an environmental review conducted with the Program Director on 9/10/13 from 4:45 - 5:20 p.m., the following was noted: Kitchen: - There was a large skillet and a large sauce pan that had chipped an peeling non-scratch coating. Individual #1's bedroom: - The baseboard along the wall behind the bed was missing for half the length of the wall. Bedroom shared by Individual #2 and #3: - The window blind had two broken slats. It did not have a wand to open the blind, allowing light and a view. - The top drawer of Individual #2's dresser had a broken runner that allowed the drawer to fall forward and down when it was opened. Individual #5's bedroom: - The window blind did not have a wand to open the blind, allowing light and view.	MM380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - COURTYA

STREET ADDRESS, CITY, STATE, ZIP CODE: 515 SECOND AVENUE WEST, WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM360	Continued From page 2 Bathroom shared by individuals #2, #3, and #5: - The toilet seat bolts were broken and the seat was not attached to the bowl. - The toilet tank lid was chipped leaving sharp edges of porcelain. - There was a hole in the wall to the left of the toilet measuring approximately 9 inches x 9 inches. - There were loose tiles on the lip of the shower floor. The facility failed to ensure environmental repairs were maintained.	MM360		
MM724	16.03.11.270.01(a) Assesments 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 W207 and W225.	MM724		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by:	MM769		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G057		09/12/2013

NAME OF PROVIDER OR SUPPLIER: PREFERRED COMMUNITY HOMES - COURTYA

STREET ADDRESS, CITY, STATE, ZIP CODE: 615 SECOND AVENUE WEST, WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM769	Continued From page 3 Refer to W455.	MM769		

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/IPPs. 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

W225 483.440 (c) (3) (v) Individual Program Plan

The facility will ensure that the Vocational information for all residents is complete and accurate. The vocational sections of the CFA for all current residents have been corrected by the AQIDP to include past, present and future employment, interests, needs and work related behaviors. The CFA Vocational section has been added to the QIDP review document that will be used during the Quality Assurance review done quarterly in addition a random check will be completed monthly by the Program Manager to ensure all residents' vocational needs are being met.

Completion date: 10/04/2013
Persons responsible: Program Manager, Program Supervisor, QIDP, AQIDP

W262 483.440 (f) (3) (i) Program Monitoring Changes

The facility will ensure that program monitoring and changes are done for all residents. Upon receipt of a new prescription for PRN medications the team will discuss the use of this medication to include the appropriateness, past/present use and less restrictives that may be available to that resident. The AQIDP will then generate a consent based on the information provided at this team meeting. The team will then obtain HRC approval. The consent will then be provided to the Nurse and attached to the Health Status for the related appointment to be reviewed by the Med Passer. In addition a random sample of consents will be taken monthly by the Program Manager and all consents will be reviewed during the Quality Assurance review quarterly.

Completion date: 10/04/2013
Persons responsible: Program Manager, Program Supervisor, QIDP, AQIDP

W262 483.440 (f) (3) (ii) Program Monitoring Changes

The facility will ensure that program monitoring and changes are done for all residents. Upon receipt of a new prescription for PRN medications the team will discuss the use of this medication to include the appropriateness, past/present use and less restrictives that may be available to that resident. The AQIDP will then generate a consent based on the information provided at this team meeting. The team will then obtain Guardian approval. The consent will then be provided to the Nurse and attached to the Health Status for the related appointment to be reviewed by the Med Passer. In addition a random

during the Quality Assurance review quarterly.

Completion date: 10/04/2013
Persons responsible: Program Manager, Program Supervisor, QIDP, AQIDP

W312 483.450 (e) (2) Drug Usage

The facility will ensure that appropriate steps are followed to ensure behavior modification drugs are being used properly for all residents. The AQIDP will generate a Med Reduction Plan every time a new PRN medication is prescribed. This plan will be part of the team discussion each time a PRN is needed. A Med Reduction check section has been added to the QIDP review document for use during the Quality Assurance review quarterly.

Completion date: 10/04/2013
Persons responsible: Program Manager, Program Supervisor, QIDP, AQIDP

W455 483.470 (l) (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

MM194 16.03.11.075.10 (a) Approval of Human Rights Committee
Please refer to W262

MM196 16.03.11.075.10 (c) Consent of parent or guardian
Please refer to W263

MM197 16.03.11.075.10 (d) Written Plans
Please refer to W312

MM380 16.03.11.120.03 (a) Building and Equipment
The noted environmental issues dealing with the building in ill repair will be fixed/repaired by October 28, 2013. The Program Supervisor will perform environmental checks and review the maintenance request log monthly to ensure homes are kept in good repair.

MM724 16.03.11.270.01 (a) Assessments
Please refer to W207 and W225

MM769 16.03.270.03 (c) (vi) Control of Communicable Diseases and Infection
Refer to W455