



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

October 15, 2014

Cathy Morales, Administrator
Preferred Community Homes - Milliken
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Milliken, Provider #13G053

Dear Ms. Morales:

This is to advise you of the findings of the complaint survey of Preferred Community Homes - Milliken, which was conducted on September 29, 2014.

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

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Cathy Morales, Administrator
October 15, 2014
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6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **October 27, 2014**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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 27, 2014. If a request for informal dispute resolution is received after October 27, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,


ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 10/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MILLIKEN			STREET ADDRESS, CITY, STATE, ZIP CODE 7904 ARLINGTON DRIVE NAMPA, ID 83686	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation conducted from 9/22/14 to 9/29/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: ABC - Antecedent, Behavior, Consequence AQIDP - Assistant Qualified Intellectual Disabilities Professional DCS - Direct Care Staff PCLP - Person Centered Lifestyle Plan PRN - As needed	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review, staff interview and a review of the facility's compliance history, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This failure resulted in the governing body providing insufficient direction and control over the facility necessary to ensure individuals' needs were met. The findings include: 1. The governing body failed to provide sufficient	W 104		

RECEIVED
OCT 28 2014
FACILITY STANDARDS

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

TITLE

(X6) DATE

Tom Mura

Program Manager

10/29/14

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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W 104	<p>Continued From page 1</p> <p>monitoring and oversight to ensure facility and individual needs were met, as follows:</p> <p>a. During an interview on 9/22/14 from 4:10 - 4:21 p.m., DCS F stated the facility van tires were discovered to be balding after a recent trip out-of-state.</p> <p>In an interview on 9/22/14 from 4:25 - 4:43 p.m., DCS G stated the front tires of the facility van were bald and the van had recently been taken out of the state. DCS G stated she reported the issue to the Administrator on 9/16/14 and afterwards another direct care staff was still required to drive the van on a trip out-of-town.</p> <p>On 9/25/14 at 9:30 a.m., the facility van was observed. The front two tires were both noted to be bald on the outer edges.</p> <p>When asked, during an interview on 9/25/14 from 11:03 - 11:15 a.m., the Administrator stated she was aware of the bald tires. The Administrator stated she contacted the company that the facility used for van up-keep. She stated the company reported that they needed approval from the facility's corporate office prior to making the repair.</p> <p>The facility failed to ensure facility transportation was maintained in optimal working condition.</p> <p>b. Facility As Worked Schedules, dated 5/1/14 - 9/20/14, were reviewed. The As Worked Schedule form included spaces for resident names, a column which asked "At any time on this day was the client checked in or out of the facility?" and two additional columns for the sign-out and sign-in times. The remainder of the</p>	W 104			

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W 104	<p>Continued From page 2</p> <p>form was used to indicate which staff were present on morning (6:00 a.m. - 2:00 p.m.), afternoon (2:00 - 10:00 p.m.) and night (10:00 p.m. - 6:00 a.m.) shift, as well as the times each staff clocked in and out. The schedules did not include comprehensive, accurate information. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - During an interview on 9/22/14 at approximately 10:00 a.m., the Administrator of a sister facility stated morning and afternoon shifts required 4 staff, but the preferred number to have on shift was five. She stated the night shift was staffed with 2 employees. <p>However, the As Worked Schedules documented only 1 staff worked the night shift on the evening of 6/13/14, 7/11/14, 7/12/14, 8/5/14, 8/8/14, 8/9/14, 8/25/14, 8/27/14, 9/6/14 and 9/13/14.</p> <p>During an interview on 9/26/14 at 2:18 p.m., the Administrator of the facility stated staff did not work alone on nights as often as the As Worked Schedules indicated. She stated she would check additional documentation to verify which employees worked which shifts.</p> <p>In a follow-up interview on 9/29/14 at approximately 12:50 p.m., the Administrator stated only 1 staff worked the night shift on 7/11/14, 7/12/14, 8/8/14 and 8/9/14. She stated the remaining dates were documented incorrectly on the schedules.</p> <ul style="list-style-type: none"> - The column to indicate if each resident was checked in or out of the facility was blank for all residents on the following days: 5/1/14, 5/2/14, 5/7/14 - 5/9/14, 5/12/14 - 5/15/14, 5/21/14, 	W 104			

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W 104	<p>Continued From page 3</p> <p>5/29/14, 6/2/14, 6/16/14 - 6/18/14, 6/22/14, 6/28/14 - 6/30/14, 7/2/14, 7/4/14 - 7/6/14, 7/14/14 - 7/23/14, 7/29/14, 8/2/14, 8/4/14, 8/5/14, 8/7/14, 8/8/14, 8/11/14 - 8/13/14, 8/16/14 - 8/18/14, 8/21/14, 8/22/14, 8/24/14 - 8/29/14, 9/2/14, 9/13/14 and 9/15/14.</p> <p>- DCS D did not document a clock-out time, and her name was not listed as a staff of the subsequent shift, for the following days: 5/13/14, 5/14/14, 5/27/14, 7/2/14, 7/9/14, 7/18/14, 7/22/14, 7/29/14, 8/1/14, 8/9/14, 8/12/14 and 8/15/14.</p> <p>- DCS E did not document a clock-out time, and her name was not listed as a staff of the subsequent shift, for the following days: 5/1/14, 5/10/14, 5/25/14, 6/6/14, 6/21/14, 7/6/14, 7/16/14, 7/17/14, 7/23/14, 8/6/14, 8/7/14, 8/13/14, 8/14/14, 8/24/14, 8/27/14, 9/2/14, 9/4/14, 9/10/14, 9/11/14 and 9/15/14.</p> <p>- The 5/23/14 As Worked Schedule documented Individual #1 was signed out at 4:30 p.m. Additionally, the As Worked Schedule for 5/30/14 documented Individual #1 was signed out at 5:30 p.m. However, there was no documentation on the As Worked Schedules regarding when Individual #1 checked back in to the facility between 5/23/14 and 5/30/14.</p> <p>- The 8/14/14 As Worked Schedule documented Individual #1 was signed out at 7:00 p.m. Additionally, the As Worked Schedule for 8/23/14 documented Individual #1 was signed out at 11:15 a.m. However, there was no documentation on the As Worked Schedules regarding when Individual #1 checked back in to the facility between 8/14/14 and 8/23/14.</p>	W 104			

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W 104	<p>Continued From page 4</p> <p>The As Worked Schedules did not include comprehensive, accurate information to ensure a sufficient number of staff were present to meet individuals' needs.</p> <p>During an interview on 9/26/14 from 10:20 - 10:44 a.m., the AQIDP stated the facility recognized that staff were struggling with completing the necessary documentation on the As Worked Schedules and had revised the form. She stated the identified documentation concerns had taken place on the old form and stated staff may have forgotten to utilize the revised version.</p> <p>The facility failed to keep a complete, accurate record of individuals present each shift, each day in the facility.</p> <p>c. On 9/25/14 at approximately 8:13 a.m. DCS B stated it took a long time to get facility repairs completed. DCS B stated the company had been without maintenance personnel for a few weeks.</p> <p>During an interview on 9/29/14 at 1:05 p.m., the Program Manager confirmed the facility was without a maintenance person.</p> <p>The facility's maintenance records from 8/16/14 to 9/25/14 were reviewed. The records documented the last repair at the facility was completed by the maintenance person on 8/18/14. The maintenance requests included the following:</p> <p>- 8/31/14: The chemical cabinet door broke. On 9/25/14 at approximately 8:20 a.m., the cabinet door was observed to be broken. A direct care staff present at the time stated the staff had moved all chemicals to an alternative location.</p>	W 104			

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W 104	<p>Continued From page 5</p> <p>- 9/13/14: A light would not turn on in the bathroom shared by Individual #1, Individual #3 and Individual #5. On 9/25/14 at approximately 8:20 a.m., the light was observed to not illuminate.</p> <p>- 9/14/14: The paint in the living room was chipped off the wall in no less than five spots clustered on the lower half of the west wall. On 9/25/14 at approximately 8:20 a.m., the chipped spots were observed. The areas missing paint varied in size, from less than an inch to approximately four inches in diameter.</p> <p>- 9/14/14: The laundry room door was cracked in two different places. On 9/25/14 at approximately 8:20 a.m., the laundry room door was observed to have two cracks across the width of the door.</p> <p>- 9/16/14: The dishwasher to the right of the kitchen sink had an unpleasant odor of unknown source. On 9/25/14 at approximately 8:20 a.m., the dishwasher was observed to have an unpleasant odor. A direct care staff present at the time stated staff were only using the dishwasher to the left of the kitchen sink.</p> <p>The facility failed to ensure repairs were made in a timely manner.</p> <p>c. Refer to W420 as it relates to the governing body's failure to ensure individuals were provided with sufficient, functional furniture to meet their needs.</p> <p>d. Refer to W434 as it relates to the governing body's failure to ensure the facility flooring was maintained in a safe and sanitary manner.</p>	W 104			

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W 104	Continued From page 6 The facility failed to ensure facility and individual needs were met 2. The governing body failed to provide sufficient monitoring and oversight necessary to achieve and sustain regulatory compliance, as follows: a. The facility was previously cited at W104 during the annual recertification survey, dated 5/1/12. b. Refer to W149 as it relates to the governing body's failure to ensure policies governing abuse, neglect and mistreatment were consistently implemented. The facility was previously cited at W149 during the annual recertification survey, dated 5/1/12.	W 104			
W 111	The governing body failed to take actions that identified and resolved systematic problems. 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 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in a lack of documentation to ensure sufficient staff were provided to meet individuals' needs. The findings include:	W 111			

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W 111	Continued From page 7 1. Facility As Worked Schedules, dated 5/1/14 - 9/20/14, were reviewed. The As Worked Schedule form included spaces for resident names, a column which asked "At any time on this day was the client checked in or out of the facility?" and two additional columns for the sign-out and sign-in times. The remainder of the form was used to indicate which staff were present on morning (6:00 a.m. - 2:00 p.m.), afternoon (2:00 - 10:00 p.m.) and graveyard (10:00 p.m. - 6:00 a.m.) shift, as well as the times each staff clocked in and out. The schedules did not include comprehensive, accurate information. Examples included, but were not limited to, the following: a. During an interview on 9/22/14 at approximately 10:00 a.m., the Administrator of a sister facility stated morning and afternoon shifts required 4 staff, but the preferred number to have on shift was five. She stated the graveyard shift was staffed with 2 employees. However, the As Worked Schedules documented only 1 staff worked the graveyard shift on the evening of 6/13/14, 7/11/14, 7/12/14, 8/5/14, 8/8/14, 8/9/14, 8/25/14, 8/27/14, 9/6/14 and 9/13/14. During an interview on 9/26/14 at 2:18 p.m., the Administrator of the facility stated staff did not work alone on graveyards as often as the As Worked Schedules indicated. She stated she would check additional documentation to verify which employees worked which shifts. In a follow-up interview on 9/29/14 at approximately 12:50 p.m., the Administrator	W 111			

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W 111	<p>Continued From page 8</p> <p>stated only 1 staff worked the graveyard shift on 7/11/14, 7/12/14, 8/8/14 and 8/9/14. She stated the remaining dates were documented incorrectly on the schedules.</p> <p>b. The column to indicate if each resident was checked in or out of the facility was blank for all residents on the following days: 5/1/14, 5/2/14, 5/7/14 - 5/9/14, 5/12/14 - 5/15/14, 5/21/14, 5/29/14, 6/2/14, 6/16/14 - 6/18/14, 6/22/14, 6/28/14 - 6/30/14, 7/2/14, 7/4/14 - 7/6/14, 7/14/14 - 7/23/14, 7/29/14, 8/2/14, 8/4/14, 8/5/14, 8/7/14, 8/8/14, 8/11/14 - 8/13/14, 8/16/14 - 8/18/14, 8/21/14, 8/22/14, 8/24/14 - 8/29/14, 9/2/14, 9/13/14 and 9/15/14.</p> <p>c. DCS D did not document a clock-out time, and her name was not listed as a staff of the subsequent shift, for the following days: 5/13/14, 5/14/14, 5/27/14, 7/2/14, 7/9/14, 7/18/14, 7/22/14, 7/29/14, 8/1/14, 8/9/14, 8/12/14 and 8/15/14.</p> <p>d. DCS E did not document a clock-out time, and her name was not listed as a staff of the subsequent shift, for the following days: 5/1/14, 5/10/14, 5/25/14, 6/6/14, 6/21/14, 7/6/14, 7/16/14, 7/17/14, 7/23/14, 8/6/14, 8/7/14, 8/13/14, 8/14/14, 8/24/14, 8/27/14, 9/2/14, 9/4/14, 9/10/14, 9/11/14 and 9/15/14.</p> <p>e. The 5/23/14 As Worked Schedule documented Individual #1 was signed out at 4:30 p.m. Additionally, the As Worked Schedule for 5/30/14 documented Individual #1 was signed out at 5:30 p.m. However, there was no documentation on the As Worked Schedules regarding when Individual #1 checked back in to the facility between 5/23/14 and 5/30/14.</p>	W 111			

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W 111	Continued From page 9 f. The 8/14/14 As Worked Schedule documented Individual #1 was signed out at 7:00 p.m. Additionally, the As Worked Schedule for 8/23/14 documented Individual #1 was signed out at 11:15 a.m. However, there was no documentation on the As Worked Schedules regarding when Individual #1 checked back in to the facility between 8/14/14 and 8/23/14. The As Worked Schedules did not include comprehensive, accurate information to ensure a sufficient number of staff were present to meet individuals' needs. During an interview on 9/26/14 from 10:20 - 10:44 a.m., the AQIDP stated the facility recognized that staff were struggling with completing the necessary documentation on the As Worked Schedules and had revised the form. She stated the identified documentation concerns had taken place on the old form and stated staff may have forgotten to utilize the revised version. The facility failed to keep a complete, accurate record of individuals present each shift, each day in the facility.	W 111			
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, record review and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and	W 149			

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MILLIKEN			STREET ADDRESS, CITY, STATE, ZIP CODE 7904 ARLINGTON DRIVE NAMPA, ID 83686	
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W 149	<p>Continued From page 10</p> <p>detection of abuse, neglect and mistreatment and incident and accident reporting were sufficiently implemented and monitored. That failure directly impacted 4 of 5 individuals (Individuals #1 - #4) whose behavior data was reviewed and had the potential to impact all individuals residing in the facility. This resulted in a lack of comprehensive documentation and review of incidents of potential abuse, neglect and mistreatment. The findings include:</p> <p>1. The facility's Incident and Accident Reporting policy, dated 7/15/12, documented direct care staff were to record incidents including, but not limited to, "Client injury due to an incident" and "Client abuse, neglect, mistreatment or exploitation" on an Incident/Accident Report. The policy defined "Client injury due to an incident" as "Any injury to a client due to the actions of themselves and/or another..." Additionally, the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, documented self-abuse "includes but is not limited to intentional injury to oneself resulting in tissue damage, head banging..." The policies were not implemented and monitored, as follows:</p> <p>a. The facility's ABC Behavior Logs from 4/12/14 - 9/23/14 were reviewed. Behavior logs documented incidents for which no corresponding Incident/Accident Report could be found, as follows:</p> <p>- On 5/19/14 at 10:55 p.m., an ABC Behavior Log for Individual #2 documented "...before we could get the helmet...head banged x 4 in hall..."</p> <p>- On 5/9/14 at 11:00 a.m., an ABC Behavior Log for Individual #3 documented "...On way home</p>	W 149		

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W 149	<p>Continued From page 11</p> <p>[Individual #3] started to kick the pasager [passenger] seat, took off his seat belt, started to hit his head and also the van windows...he continue to hit his head...hit his head on window..."</p> <p>- On 6/29/14 at 5:00 p.m., an ABC Behavior Log for Individual #4 documented "...He slipped and fell on the floor in the shower a bit hurt but no injuries apparent and said he was fine..."</p> <p>When asked about the documentation during an interview on 9/25/14 from 2:24 - 2:48 p.m., the Administrator stated the incidents should have been documented on Incident/Accident Reports and she would search to see if the documentation occurred. The AQIDP, also present during the interview, stated in the past, Incident/Accident Reports and ABC Behavior Logs were tracked separately. The AQIDP stated the company realized the review process had problems and the documents were now being reviewed and tracked together.</p> <p>During a follow-up interview on 9/26/14 from 10:20 - 10:44 a.m., the Administrator stated she was unable to locate Incident/Accident Reports for the identified ABC Behavior Logs.</p> <p>The facility failed to ensure incidents and accidents were documented as indicated in policy.</p> <p>2. The facility's Incident and Accident Reporting policy, dated 7/15/12, documented after an Incident/Accident Report was completed "The following staff members will review these reports daily on weekdays...Verifying review by their initials, date and time on the Incident/Accident</p>	W 149		

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W 149	<p>Continued From page 12</p> <p>report...The Administrator or designee will complete the Investigation Report on the back..."</p> <p>The policy listed the staff required to review the reports the following business day, which included the Administrator. The policy was not implemented and monitored, as follows:</p> <p>Incident/Accident Reports from 4/12/14 - 9/23/14 were reviewed. The reports included incidents for which documentation of timely Administrator review could not be found, as follows:</p> <ul style="list-style-type: none"> - On 7/30/14 at 4:00 p.m., Individual #2 was kneeling walls and injured himself. The Investigation Report documented administrative review was completed on 9/22/14 at 12:00 p.m. by the Administrator of a sister facility. - On 8/6/14 at 11:05 a.m., staff documented the use of an emergency restraint for Individual #2. The Investigation Report documented administrative review was completed on 9/22/14 at 12:20 p.m. by the Administrator of a sister facility. - On 8/10/14 at 2:30 p.m., Individual #2 was hit in the back by another individual. The Investigation Report documented administrative review was completed on 9/22/14 at 1:05 p.m. by the Administrator of a sister facility. - On 8/20/14 at 12:45 p.m., Individual #1's right wrist was bit by another individual. The attached Investigation Report documented administrative review was completed on 9/22/14 at 3:30 p.m. - On 8/22/14 at 1:45 p.m., Individual #2 bit his left hand. The Investigation Report documented administrative review was completed on 9/22/14 	W 149			

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W 149	<p>Continued From page 13 at 1:30 p.m. by the Administrator of a sister facility.</p> <p>- On 8/31/14 at 4:45 p.m., Individual #2 had a swollen left cheek. The attached Investigation Report documented administrative review was completed on 9/22/14 at 3:00 p.m.</p> <p>- On 9/8/14 at 3:35 p.m., Individual #2 had bruising to his right ear. The attached Investigation Report documented administrative review was completed on 9/22/14 at 4:15 p.m.</p> <p>- On 9/10/14 at 7:10 a.m., Individual #2 bit his right index finger. The attached Investigation Report documented administrative review was completed on 9/22/14 at 4:45 p.m.</p> <p>During an interview on 9/22/14 at approximately 2:00 p.m., the Administrator stated in the past few weeks she had worked multiple floor shifts and Incident/Accident Report review had gone to the side.</p> <p>On 9/26/14, during an interview from 10:20 - 10:44 a.m., the Program Manager stated a new system was implemented for the company on 9/25/14. The Program Manager stated the new method required supervisors to work in pairs to ensure the review and completion of Incident/Accident Reports.</p> <p>The facility failed to ensure Incident/Accident Reports were reviewed by administrative staff as indicated in policy.</p> <p>The facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment, were</p>	W 149		

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W 149	Continued From page 14	W 149			
W 186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide sufficient direct care staff to manage and supervise individuals in accordance with their PCLPs for 5 of 5 individuals (Individuals #1 - #5) whose PCLPs were reviewed. This had the potential to impede staffs' ability to consistently meet individuals' identified active treatment needs. The findings include:</p> <p>1. During an interview on 9/22/14 at approximately 10:00 a.m., the Administrator of a sister facility stated morning and afternoon shifts required 4 staff, but the preferred number to have on shift was five. She stated the night shift was staffed with 2 employees.</p> <p>Facility As Worked Schedules, dated 5/1/14 - 9/20/14, were reviewed and documented night shifts were worked with only 1 direct care staff on the evening of 6/13/14, 7/11/14, 7/12/14, 8/5/14, 8/8/14, 8/9/14, 8/25/14, 8/27/14, 9/6/14 and 9/13/14.</p> <p>During an interview on 9/26/14 at 2:18 p.m., the</p>	W 186			

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W 186	<p>Continued From page 15</p> <p>Administrator of the facility stated staff did not work alone on nights as often as the As Worked Schedules indicated. She stated she would check employee timesheets to verify which employees worked which shifts.</p> <p>In a follow-up interview on 9/29/14 at approximately 12:50 p.m., the Administrator stated only 1 staff worked the night shift on 7/11/14, 7/12/14, 8/8/14 and 8/9/14. She stated the remaining dates were documented incorrectly on the schedules.</p> <p>Individual #1 - #5's PCLPs were reviewed. They documented nighttime needs, as follows:</p> <ul style="list-style-type: none"> - Individual #1's PCLP, dated 6/4/14, documented he did not have special nighttime needs (e.g. toileting assistance, sleep medications, etc.). - Individual #2's PCLP, dated 3/5/14, documented he required a one-to-one staff with line-of-sight supervision for behavioral needs. Direct care staff were instructed to close Individual #2's bedroom door at night and complete 15 minute checks. If at any point Individual #2 woke up, he was to receive line-of-sight supervision. - Individual #2's PCLP documented he required physical assistance with toileting. - Individual #2's PCLP documented he had a sleep disturbance which was managed with medications, including a PRN medication to be administered if Individual #2 was unable to sleep through the evening. - Individual #3's PCLP, dated 10/2/13, documented he was occasionally incontinent at 	W 186			

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W 186	<p>Continued From page 16 night and included a PRN medication for difficulty sleeping.</p> <p>- Individual #4's PCLP, dated 7/9/14, documented he did not have special nighttime needs.</p> <p>- Individual #5's PCLP, dated 12/24/13, documented he did not have special nighttime needs.</p> <p>If any individual(s) awoke on the night shift, it was unclear how one staff was sufficient to meet the needs of all individuals in the facility.</p> <p>Sleep tracking from 5/1/14 - 9/26/14 for Individuals #1 - #5 was reviewed. The tracking documented individuals woke on the night shift (10:00 p.m. - 6:00 a.m.). Examples included, but were not limited to, the following:</p> <p>- 7/11/14: Individual #1 was on a home visit. Individuals #2 - #5 were all at the facility. Individual #4 was asleep throughout the night shift. Individual #2 woke up at 4:15 a.m. to use the restroom. Individual #3 was awake between 5:00 and 5:15 a.m. Individual #5 was awake between 3:15 and 3:45 a.m. He woke up for the day at 5:00 a.m.</p> <p>- 8/8/14: Individuals #1 - #5 were all at the facility. Individual #1 was asleep throughout the night shift. Individual #5 was awake until 11:00 p.m., Individual #2 was awake until 11:15 p.m., Individual #4 was awake until 12:15 a.m. and Individual #3 was awake until 12:30 a.m. Additionally, Individuals #2 and #3 were incontinent at 4:00 a.m. requiring staff assistance and Individual #4 was awake between 4:00 and 4:30 a.m.</p>	W 186		

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W 186	Continued From page 17			W 186			
W 420	<p>On 9/26/14 from 2:35 - 2:46 p.m. the direct care staff assigned to night shift were interviewed. DCS H stated when Individual #5 woke up, it was usually early in the morning and Individual #5 would keep to himself in the kitchen. The staff stated while assisting an individual with incontinence, the bedroom door was left open to listen for the other individuals. DCS C stated working alone was difficult and assistance provided to an individual with incontinence had to be done as quickly as possible.</p> <p>During the exit conference on 9/29/14 from 1:58 - 2:20 p.m., the Program Manager confirmed understanding and stated the night shift would not be staffed with less than two employees in the future.</p> <p>The facility failed to ensure the individuals' were provided with sufficient direct care staff.</p> <p>483.470(b)(4)(iv) CLIENT BEDROOMS</p> <p>The facility must provide each client with functional furniture, appropriate to the clients 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 functional furniture, appropriate to individual needs was selected for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in individuals not having appropriate, functional furniture. The findings include:</p> <p>1. On 9/25/14 at approximately 8:20 a.m., the</p>			W 420			

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W 420	<p>Continued From page 18</p> <p>living room furniture was observed to include one loveseat, with the left arm broken and separated from the seat at an approximately 45-degree angle, and 4 circular folding chairs. DCS A stated one of the folding chairs was removed from Individual #3's bedroom for additional seating.</p> <p>During interviews on 9/25/14, DCS A stated the facility had been without a couch for 3 - 4 months. She further stated the left arm of the remaining loveseat had been completely broken off, the Administrator had been notified and price quotes had been obtained multiple times. DCS B, also present during the interview, stated the living room furniture had been broken and/or missing for longer than 3 - 4 months.</p> <p>On 9/25/14 at 12:03 p.m., during an interview the Administrator stated she was aware of the need for new furniture for the facility living room. She stated she had submitted three requests, the first in approximately March 2014, for money to purchase new living room furniture. The Administrator stated the first two requests were denied because new furniture was not in the company budget. The third request, submitted September 2014, was approved and the check was on its way from the company's corporate office, located out-of-state.</p> <p>When asked about the financial approval process on 9/26/14 from 12:05 - 12:11 p.m., the City Director stated Administrators or maintenance personnel were required to submit written requests for funding for needed items/repairs. The City Director stated the requests were submitted to the Program Manager for sign-off, then to her (the City Director) for sign-off, then to the financial person in the local office. The</p>	W 420			

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W 420	Continued From page 19 financial person then submitted the request to the company's corporate office out-of-state. The City Director stated requests would be denied if there was a lack of information or concerns with the request, but she was unsure why the furniture requests had been denied.	W 420		
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 interview, it was determined the failed to ensure the facility floor was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in a potential increase in fall risks and the creation of unsanitary conditions. The findings include: 1. On 9/25/14 at approximately 8:13 a.m. DCS B stated it took a long time to get facility repairs completed. DCS B stated the company had been without maintenance personnel for a few weeks. During an interview on 9/29/14 at 1:05 p.m., the Program Manager confirmed the facility was without a maintenance person. The facility's maintenance records from 8/16/14 to 9/25/14 were reviewed. The records documented the last repair at the facility was	W 434		

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W 434	<p>Continued From page 20 completed by the maintenance person on 8/18/14. The maintenance requests included the following:</p> <p>The facility's maintenance records from 8/16/14 to 9/25/14 were reviewed. The records included a request, dated 9/16/14, which documented the kitchen floor had a crack which needed repair.</p> <p>- 9/16/14: The kitchen floor had a crack which needed repair. Upon review on 9/25/14, the crack existed. The vinyl had a seam in front of the stove which had peeled apart approximately 1/4 of an inch.</p> <p>On 9/25/14, it was noted that the flooring crack still existed. The vinyl had a seam in front of the stove which had peeled apart approximately 1/4 of an inch. DCS C, present during the observation of the flooring, stated the seam had been cracked for approximately three months.</p> <p>During an interview on 9/25/14 at approximately 8:13 a.m. DCS B stated it took a long time to get facility repairs completed. DCS B stated the company had been without maintenance personnel for a few weeks.</p> <p>The facility failed to ensure the kitchen vinyl flooring was maintained in a safe and sanitary condition.</p>	W 434			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: **PREFERRED COMMUNITY HOMES - MILLIKEN**
STREET ADDRESS, CITY, STATE, ZIP CODE: **7904 ARLINGTON DRIVE NAMPA, ID 83686**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint investigation conducted from 9/22/14 to 9/29/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Jim Troutfetter, QIDP	M 000		
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W149.	MM177		
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		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good	MM380		

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OCT 28 2014
FACILITY STANDARDS

Bureau of Facility Standards

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

Tom Nuss

TITLE

Program Manager

(X6) DATE

10/28/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MILLIKEN	STREET ADDRESS, CITY, STATE, ZIP CODE 7904 ARLINGTON DRIVE NAMPA, ID 83686
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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) COMPLETE DATE
MM380	<p>Continued From page 1</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. On 9/25/14 at approximately 8:13 a.m. DCS B stated it took a long time to get facility repairs completed. DCS B stated the company had been without maintenance personnel for a few weeks.</p> <p>During an interview on 9/29/14 at 1:05 p.m., the Program Manager confirmed the facility was without a maintenance person.</p> <p>The facility's maintenance records from 8/16/14 to 9/25/14 were reviewed. The records documented the last repair at the facility was completed by the maintenance person on 8/18/14. The maintenance requests included the following:</p> <p>- 8/31/14: The chemical cabinet door broke. On 9/25/14 at approximately 8:20 a.m., the cabinet door was observed to be broken. A direct care staff present at the time stated the staff had moved all chemicals to an alternative location.</p> <p>- 9/13/14: A light would not turn on in the bathroom shared by Individual #1, Individual #3</p>	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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MM380	<p>Continued From page 2</p> <p>and Individual #5. On 9/25/14 at approximately 8:20 a.m., the light was observed to not illuminate.</p> <p>- 9/14/14: The paint in the living room was chipped off the wall in no less than five spots clustered on the lower half of the west wall. On 9/25/14 at approximately 8:20 a.m., the chipped spots were observed. The areas missing paint varied in size, from less than an inch to approximately four inches in diameter.</p> <p>- 9/14/14: The laundry room door was cracked in two different places. On 9/25/14 at approximately 8:20 a.m., the laundry room door was observed to have two cracks across the width of the door.</p> <p>- 9/16/14: The dishwasher to the right of the kitchen sink had an unpleasant odor of unknown source. On 9/25/14 at approximately 8:20 a.m., the dishwasher was observed to have an unpleasant odor. A direct care staff present at the time stated staff were only using the dishwasher to the left of the kitchen sink.</p> <p>Additionally, the following environmental concerns were observed:</p> <p>- On 9/25/14 at 4:12 p.m., it was noted approximately 6 inches of rubber floor board was peeling back from wall at end of hall near Individual #2's bedroom.</p> <p>- On 9/25/14 at approximately 8:20 a.m., it was noted the toilet paper holder in Individual #5's bathroom was broken.</p> <p>- On 9/25/14 at approximately 8:20 a.m., Individual #5's dresser was observed to be missing all the drawers.</p>	MM380		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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MM380	Continued From page 3 The facility failed to ensure environmental repairs were completed and maintained.	MM380		
MM412	16.03.11.120.04(m) Furniture and Equipment All furniture and equipment must be maintained in a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents. This Rule is not met as evidenced by: Refer to W420.	MM412		
MM513	16.03.11.200.01 Governing Body Each facility will be organized and administered under one authority which may be a proprietorship, partnership, association, corporation, or governmental unit. If administered by other than a single owner or partnership, the facility will have a governing board which assumes full legal responsibility for the overall conduct of the facility and for full compliance with these rules. This Rule is not met as evidenced by: Refer to W104.	MM513		
MM602	16.03.11.230.02(b) Work Schedules Daily work schedules, reflecting the daily adjustments of employees, shall be kept in writing, showing the personnel on duty at any given time for the previous three (3) month period. Personnel shall be identified by first and last names, including professional designation (R.N., L.P.N., Q.M.R.P., etc.), and position.	MM602		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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MM602	Continued From page 4 This Rule is not met as evidenced by: Refer to W111.	MM602		
MM857	16.03.11.270.08(e) Qualified Training There must be sufficient appropriately qualified training and habilitation personnel and necessary supporting staff available to carry out the residents' training and habilitation program. This Rule is not met as evidenced by: Refer to W186.	MM857		



10/27/14
Revised: 10/31/14

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

RECEIVED
OCT 31 2014

FACILITY STANDARDS

RE: Milliken Heights, Provider #13G053

Dear Ashley Henscheid:

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

W104

1. The Van tires have been replaced for the facility vehicle. The Milliken Heights home has implemented a revised system for keeping complete and accurate records to document staff individuals present each shift and each day in the facility. The facility has hired a maintenance person to begin work on facility repairs.
2. All individuals living in the facility will be effected by the revised system for storing and reviewing as worked schedules. All individual living in the facility will be effected positively by having new tires on the facility van. All individuals will also be effected by the hiring of the new maintenance person in that the repairs will be made and the home will be kept in good repair.
3. 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 maintenance staff person that is supervised by the Program Manager of the facility. Monthly van checks to be completed to verify that the facility van is in good repair. In addition, the Program Manager will have additional assistance to meet the needs of each individual.

4. The policy and procedure revision will affect all individuals being served by Aspire Human Services in the ICF/ID setting.
5. Person Responsible: Program Manager, Program Supervisor, Maintenance Supervisor
6. Completion Date: 11/30/14

Please refer to the responses given under W420, W434 and W 149.

W111

1. The Milliken Heights home as implemented a revised system for keeping complete and accurate records to document staff individuals present each shift and each day in the facility. With the revised system the As Worked Schedules come to the facility office on a weekly basis and are revised for accuracy. The Program Supervisor is contacted anytime there are discrepancies and corrections are made. Once it has been verified that the forms are accurate they will be kept in a file at the facility office for review.
2. All individuals living in the facility will be effected by the revised system for storing and reviewing as worked schedules.
3. With the revised system the As Worked Schedules come to the facility office on a weekly basis and are revised for accuracy. The Program Supervisor is contacted anytime there are discrepancies and corrections are made. Once it has been verified that the forms are accurate they will be kept in a file at the facility office for review.
4. Anytime the As Worked Schedules are late or given to the office incomplete the Program Manager is contacted to facilitate immediate corrections.
5. Person Responsible: Program Manager, Program Supervisor
6. Completion Date: 11/30/14

W149

1. Currently the QIDP and LPN are reviewing ABC data sheets and Health Status sheets to verify that incidents and health issues are being tracked correct forms according to policy. On 11/5/14 there is a scheduled training and the LPN's, QIDP's, Director of Nursing and Program Supervisors will be provided with additional training in relation to reviewing the logs and health status sheets weekly to verify that incidents are captured on the correct forms. In addition, all of the staff in the home are being re-trained to assure that they completely understand practices related to what is to be documented on an ABC data sheet, Health Status form and Incident and Accident form. In addition, the facilities Incident Reports are now kept at the corporate office, all reports are brought to the office each week from the previous week for review by the Program Manager.
2. After the training on 11/5/14 has occurred all behavior logs and Health Status sheets will be reviewed weekly to verify that an I and A is not needed. If an I and A is needed the home Administrator will be notified immediately to address the concern.
3. At least weekly the LPN and QIDP will review as part of their responsibilities each Health Status sheets and ABC data sheets to verify that the appropriate forms have been completed and contact the Program Supervisor if an Incident and Accident form needs completed.

4. Weekly when nursing notes are made and ABC data sheets are reviewed the LPN's and QIDP's will sign and date the logs to document they have been reviewed. A note will also be made if the form required an Incident and Accident form to be completed. This note will be attached to the Incident & Accident report and monitored by the Program Supervisor.
5. Person Responsible: Program Manager, Program Supervisor
6. Completion Date: 11/30/14

W186

1. Currently the home does not staff less than two staff on the night shift.
2. Assigning no less than two staff at the facility positively affects all individuals residing the facility by being more able to meet their needs.
3. The Program Manager received verbal training on 9/29/14 to schedule and assure that there is always at least two full time staff available on the night shift at the home. The expectation was given to notify the Program Manager if there were scheduling concerns or issues for the home so assistance could be given to prevent the home from having sufficient staff.
4. Currently the facility utilizes a Master Schedule which is available to the Program Manager as well as the Program Supervisors. The Program Manager reviews the Master Schedule at least weekly to verify that sufficient staff is scheduled for the home. In addition, As Worked Schedules are currently being kept at the facility office for review.
5. Person Responsible: Program Manager, Program Supervisor
6. Completion Date: 11/30/14

W420

1. The facility has purchased replacement furniture for the facility living room.
2. All individuals residing in the facility have been impacted in a positive way by having the new furniture in the home.
3. The facility has hired a new maintenance supervisor to assist the facility in keeping the facility safe and in good repair.
4. The facility has implemented a weekly meeting with professionals from the governing body to discuss progress and status of the facilities. Problem areas are identified and addressed. This meeting can assist the governing body to quickly address facility needs and concerns. In addition, the Program Supervisors are completing monthly checklist on the homes to assure they are kept in good repair.
5. Person Responsible: Program Manager, Program Supervisor
6. Completion Date: 11/30/14

W434

1. The kitchen Floor at Milliken Heights has been scheduled to be replaced so it 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 and Program Supervisor
6. Completion Date: 11/30/14

MM177

Please refer to the response given under W149.

MM298

Please refer to the response given under W434.

MM380

1. The identified home repairs at Milliken Heights have been scheduled to be replaced/repaired.
2. All individuals will be affected by the repairs.
3. The facility has a monthly maintenance checklist to be completed by each Program Supervisor. One part of the checklist identifies home repair concerns in the home.
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 and Program Supervisor
6. Completion Date: 11/30/14

MM513

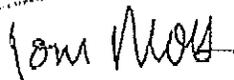
Please see response given under W104.

MM602

Please see response given under W111.

MM857

Please see response given under W186.



Tom Moss
Program Manager
Licensed Social Worker

Cathy Morales
Program Supervisor
Administrator



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

October 15, 2014

Cathy Morales, Administrator
Preferred Community Homes - Milliken
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Milliken, Provider #13G053

Dear Ms. Morales:

On **September 29, 2014**, a complaint survey was conducted at Preferred Community Homes - Milliken. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006626

Allegation #1: The governing body does not provide sufficient oversight to meet the needs of the facility and individuals.

Findings #1: An unannounced, on-site complaint investigation was conducted from 9/22/14 - 9/29/14. During that time, maintenance records, facility policies and procedures and resident records were reviewed and observations and staff interviews were conducted with the following results:

The governing body did not ensure policies were implemented and the environment was maintained, as follows:

a. The facility's behavior data from 4/12/14 - 9/23/14 was reviewed. Behavior documentation included incidents for which no corresponding Incident/Accident Report could be found.

The facility's Incident and Accident Reporting policy, dated 7/15/12, documented direct care staff were to record incidents including, but not limited to, "Client injury due to an incident" and "Client abuse, neglect, mistreatment or exploitation" on an Incident/Accident Report. The policy defined "Client injury due to an incident" as "Any injury to a client due to the actions of themselves and/or another..." Additionally, the facility's Abuse, Neglect, Mistreatment and Injuries of An Unknown Source policy, dated 5/21/13, documented self-abuse "includes but is not limited to intentional injury to oneself resulting in tissue damage, head banging..."

When asked about the documentation during an interview on 9/25/14 from 2:24 - 2:48 p.m., the Administrator stated the incidents should have been documented on Incident/Accident Reports and she would search to see if the documentation occurred. The Assistant Qualified Intellectual Disabilities Professional (AQIDP), also present during the interview, stated in the past, Incident/Accident Reports and behavior data were tracked separately. The AQIDP stated the company realized the review process had problems and the documentation was now being reviewed and tracked together.

The facility Incident and Accident Reporting policy also documented after an Incident/Accident Report was completed "The following staff members will review these reports daily on weekdays... Verifying review by their initials, date and time on the Incident/Accident report... The Administrator or designee will complete the Investigation Report on the back..." The policy listed the staff required to review the reports the following business day, which included the Administrator.

However, Incident/Accident Reports from 4/12/14 - 9/23/14 were reviewed. The reports included no less than eight incidents for which documentation of timely administrator review per facility policy could not be found.

The governing body failed to ensure policies and procedures were sufficiently implemented and monitored.

b. The facility's maintenance records from 8/16/14 to 9/25/14 were reviewed. The records documented the last repair at the facility was completed by the maintenance person on 8/18/14. The records documented no less than six unaddressed maintenance concerns, which were verified through observation on 9/25/14.

Additionally, on 9/25/14 at approximately 8:20 a.m., the living room furniture was noted to include one loveseat, with the left arm broken and separated from the seat at an approximately 45-degree angle, and 4 circular folding chairs. A direct care staff present stated one of the folding chairs was removed from an individual's bedroom for additional seating.

During an interview on 9/25/14 at 12:03 p.m., the Administrator stated she was aware of the need for new furniture for the facility living room. She stated she had submitted three requests, the first in approximately March 2014, for money to purchase new living room furniture. The Administrator stated the first two requests were denied because new furniture was not in the company budget. The third request, submitted September 2014, was approved and the check was on its way from the company's corporate office, located out-of-state.

When asked about the financial approval process on 9/26/14 from 12:05 - 12:11 p.m., the City Director stated administrators or maintenance personnel were required to submit written requests for funding for needed items/repairs. The City Director stated the requests were submitted to the Program Manager for sign-off, then to her (the City Director) for sign-off, then to the financial person in the local office. The financial person then submitted the request to the company's corporate office out-of-state. The City Director stated requests would be denied if there was a lack of information or concerns with the request, but she was unsure why the furniture requests had been denied.

Interviews were conducted with eight direct care staff on 9/22/14 and 9/25/14. During that time, staff stated it took a long time to get facility repairs completed. The staff stated the company had been without maintenance personnel for a few weeks. Multiple staff also stated the facility van needed new tires. When asked, the Administrator stated she contacted the company that the facility used for van up-keep. The Administrator stated the company reported that they needed approval from the facility's corporate office prior to making the repair.

The governing body failed to ensure the environmental needs of the facility were met and maintained.

The governing body failed to ensure policies were implemented and environmental concerns were adequately addressed. Therefore, the allegation was substantiated and deficient practice was cited at W104 and M513.

Conclusion #1: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: Individuals spend long periods of time engaged in non-functional activities.

Findings #2: An unannounced on-site complaint investigation survey was conducted from 9/22/14 - 9/29/14. During that time, records were reviewed and observations were completed with the following results:

During observations on 9/25/14 from 1:30 - 2:10 p.m. and 4:08 - 5:00 p.m. all individuals were noted to be following their active treatment schedules and engaged in activities.

Three individuals were randomly chosen for record review. One of the individuals attended school from 8:30 a.m. - 3:30 p.m. and the other 2 sample individuals worked at the food bank from 9:00 - 11:00 a.m.

The outing records from 9/3/14 - 9/24/14 were reviewed for the sample individuals. The records documented various activities including trips to the movies, to go shopping, and a 45-minute van ride for 2 individuals. When asked about van rides, during interviews from 9/22/14 to 9/25/14 eight direct care staff stated outings occurred on a regular basis. Four of the staff stated van rides were utilized for certain individuals in the facility as a calming technique. Direct care staff stated most van rides had a destination, such as to a walking trail. One direct care staff stated van rides without a destination had occurred approximately two times in the past month.

When asked, during an interview on 9/25/14 from 11:03 - 11:15 a.m., the Administrator stated the certain individuals in the facility found van rides calming and utilized them as a coping skill.

It could not be determined that individuals engaged in non-functional activities. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals are not provided with sufficient staff to meet their needs.

Findings #3: An unannounced, on-site complaint investigation was conducted from 9/22/14 - 9/29/14. During that time records were reviewed and staff interviews were conducted with the following results:

During an interview on 9/22/14 at approximately 10:00 a.m., the Administrator of a sister facility stated five individuals resided in the facility. The Administrator stated morning and afternoon shifts required 4 staff, but the preferred number to have on shift was five. She stated the night shift was staffed with 2 employees.

Facility As Worked Schedules, dated 5/1/14 - 9/20/14, were reviewed and documented night shifts were worked with only 1 direct care staff on the evening of 6/13/14, 7/11/14, 7/12/14, 8/5/14, 8/8/14, 8/9/14, 8/25/14, 8/27/14, 9/6/14 and 9/13/14.

During an interview on 9/26/14 at 2:18 p.m., the Administrator of the facility stated staff did not work alone on nights as often as the As Worked Schedules indicated. She stated she would check employee timesheets to verify which employees worked which shifts.

In a follow-up interview on 9/29/14 at approximately 12:50 p.m., the Administrator stated only 1 staff worked the night shift on 7/11/14, 7/12/14, 8/8/14 and 8/9/14. She stated the remaining dates were documented incorrectly on the schedules.

Each of the five individual's records were reviewed for nighttime needs. Nighttime needs included, but were not limited to, the following:

- One individual required a one-to-one staff with line-of-sight supervision for behavioral needs. Direct care staff were instructed to close the individual's bedroom door at night and complete 15 minute checks. If at any point he woke up, he was to receive line-of-sight supervision.
- Another individual was occasionally incontinent at night and was prescribed a medication for difficulty sleeping.

If any individual(s) awoke on the night shift, it was unclear how one staff was sufficient to meet the needs of all individuals in the facility.

Sleep tracking from 5/1/14 - 9/26/14 for all five individuals was reviewed. The tracking documented individuals woke on the night shift (10:00 p.m. - 6:00 a.m.). Examples included, but were not limited to, the following:

- 7/11/14: One individual woke up at 4:15 a.m. to use the restroom. A second individual was awake between 5:00 and 5:15 a.m. A third individual was awake between 3:15 and 3:45 a.m. He woke up for the day at 5:00 a.m.
- 8/8/14: Two individuals were incontinent at 4:00 a.m. requiring staff assistance. A third individual was awake between 4:00 and 4:30 a.m.

On 9/26/14 from 2:35 - 2:46 p.m. the direct care staff assigned to night shift were interviewed. One direct care staff stated while assisting an individual with incontinence, the bedroom door was left open to listen for the other individuals. A second staff stated working alone was difficult and assistance provided to an individual with incontinence had to be done as quickly as possible.

During the exit conference on 9/29/14 from 1:58 - 2:20 p.m., the Program Manager confirmed understanding and stated the night shift would not be staffed with less than two employees in the future.

The facility failed to ensure the individuals' were provided with sufficient direct care staff as required by the facility. Therefore, the allegation was substantiated and deficient practice was cited at W186 and M857.

Conclusion #3: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #4: Individuals engage in assaultive behavior towards peers daily.

Findings #4: An unannounced, on-site complaint investigation was conducted from 9/22/14 to 9/29/14. During that time, records were reviewed and observations and staff interviews were completed with the following results:

Three individuals were selected for review. Two of the individuals had behavior plans that included instructions to staff related to aggressive behavior. No concerns with the behavior plans were noted.

Observations were conducted on 9/25/14 from 1:30 - 2:10 p.m. and 4:08 - 5:00 p.m. During that time, no client-to-client assaults were observed.

Facility Incident/Accident Reports and investigations, dated 4/11/14 - 9/22/14, were reviewed. Incident/Accident Reports documented 12 instances of individual-to-individual assault. Eleven of the 12 incidents involved one individual, discharged on 8/20/14, aggressing on his peers in the facility. For each of the incidents, staff documented those present at the time, as well as interventions utilized. No concerns were identified.

Facility behavior data, dated 4/11/14 - 9/22/14, was reviewed. The behavior data did not include any additional instances of individual-to-individual assault.

Interviews were conducted with eleven facility staff on 9/22/14 and 9/25/14. All eleven staff stated individual-to-individual altercations were a big concern in the past. Each staff stated after the individual was discharged on 8/20/14, aggressive incidents had decreased significantly and were no longer out-of-control.

Cathy Morales, Administrator
October 15, 2014
Page 7 of 7

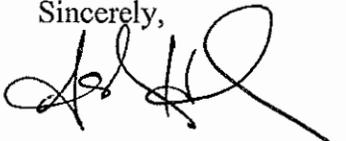
While individual-to-individual altercations had been an issue prior to 8/20/14, after the discharge of one individual, incidents in the facility decreased. Therefore, the allegation was unsubstantiated as it had been addressed.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

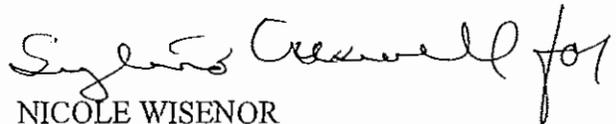
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt