



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3315 1675

October 17, 2014

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

RE: Preferred Community Homes - Sunset, Provider #13G052

Dear Ms. Thomas:

Based on the Complaint survey completed at Preferred Community Homes - Sunset on September 29, 2014, we have determined that Preferred Community Homes - Sunset is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) Conditions of Participation of Governing Body and Management (42 CFR 483.410), Client Protections (42 CFR 483.420) and Client Behavior & Facility Practices (42 CFR 483.450). To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

Megan Thomas, Administrator
October 17, 2014
Page 2 of 4

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

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

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

Such corrections must be achieved and compliance verified by this office, before November 13, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than November 5, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 30, 2014.**

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

Megan Thomas, Administrator
October 17, 2014
Page 3 of 4

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Sunset ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective September 29, 2014, through January 27, 2015. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

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

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **November 14, 2014**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

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

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

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

www.iefmr.dhw.idaho.gov

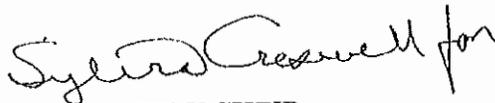
Megan Thomas, Administrator
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Page 4 of 4

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 30, 2014. If a request for informal dispute resolution is received after October 30, 2014 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me 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



10/30/14

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

Dear Ms. Wisenor:

Aspire Human Services – Sunset Oaks alleges that corrections are in process to be compliant with Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions for Conditions of Participation of Governing Body and Management (42 CFR 483.410), Client Protections (42 CFR 483.420) and Client Behavior and Facility Practices (42 CFR 483.450).

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

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


Tom Moss
Program Manager

Effective Date: 12/14/11

Aspire Human Services

Revision Date: 02/12/12, 1/9/13, 10/23/14, 10/30/14

Governing Body

Corporate: Embassy Management, LLC provides financial management, facility budgeting, and fiscal oversight; assistance with development, review, and approval of policies, practices, and systems; philosophical and operating direction of the facility; corporate compliance assurance to all applicable state and federal regulation authorities and offering assistance as needed with difficult scenarios.

Corporate governing body:

- Chief Executive Officer
- Chief Operating Officer
- Senior Vice President
- Chief Financial Officer
- Idaho State Director
- Idaho Operations Manager
- Positive Behavior Support Coordinator

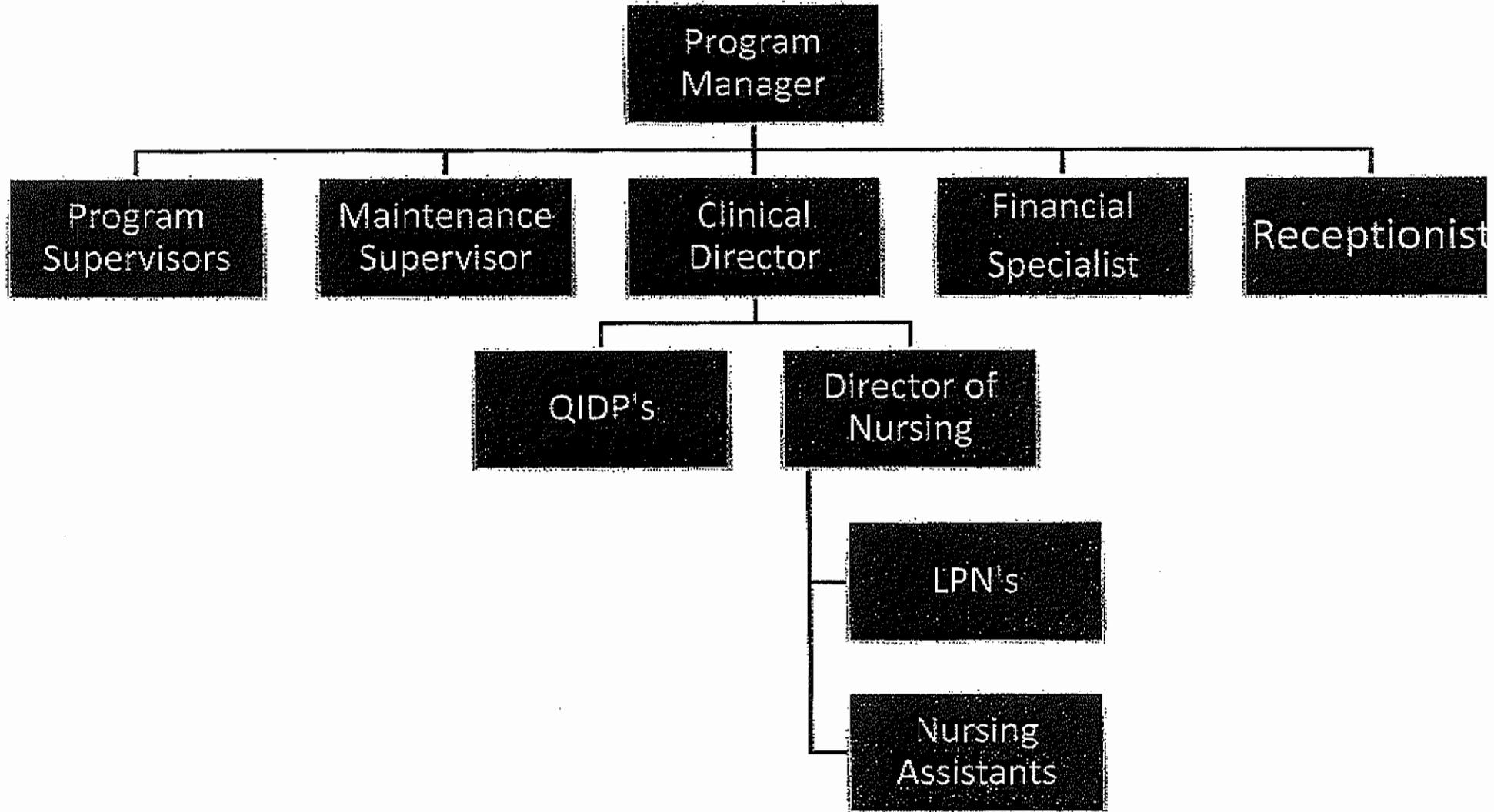
Facility: The facility level governing body has responsibility for the following: compliance with all applicable state and federal regulations; implementation of policies, recommendations for updates and revisions to policies, systems, and operating practices; ensuring necessary staffing, training resources, equipment, and environment to provide individuals with active treatment to provide for their health and safety. This includes responsibility for sanitation, maintenance, and repair of facilities; oversight, direction, and management of staffing; ensuring all outside services are meeting the standard of quality of services and needs of each client; maintenance of a record keeping system that includes a separate record for each client; assurance of confidentiality of client records; monitoring for and addressing condition level deficiencies or repeat, pervasive patterns of deficiencies; input to the development of facility budgets. The facility level governing body is responsible for communicating with the corporate governing body when assistance or additional resources are necessary to accomplish the facility responsibilities.

Facility governing body:

- Program Manager
- Financial Specialist
- Maintenance Technician
- Program Supervisor (for purposes of the policy and procedure book the Program Supervisor is the Administrator)
- Clinical Director
- Director of Nursing
- LPN
- QIDP
- AQIDP
- Any other facility staff designated by the Program Manager.

New employees will receive a copy of the organizational chart at orientation and may request these at any time from his or her direct supervisor.

Aspire Human Services Preferred Community Homes



W102

Please see the plan of correction under W104 as it relates to Governing Body.

W104

1. The Governing Body policy and procedure Policy has been revised to include the Positive Behavior Support Specialist. The Policy and Procedure for Behavior Support is being revised. In addition, the policy and procedure for Incident and Accident reports is also being revised. Both policies now include the facilities practice of utilizing Therapeutic Options. After the Policy and Procedures are revised all of the staff in the home and Administrative Staff will be provided with additional training on the revised policies.
2. All individuals that reside in the facility will be effected by the policy revisions.
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 the facility has a Clinical Director which will be available to support the QIDP's and Director of Nursing.
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, Clinical Director
6. Completion Date: 11/5/14

Please see the plans of correction under W122, W159, W214, W266, and W289.

W122

Please see the plan of correction under W149 as it relates to on-going abuse and psychological harm and W153 as it relates to ensuring incidents of abuse and neglect are reported to the administrator.

W149

1. Individual #5 moved from the facility on 9/24/14 at 2:45pm. All of the staff in the home are receiving training on the abuse and neglect policy specifically related to interactions between the individuals receiving services.
2. All individuals in the home will be effected by the training.
3. Aspire Human Services has revised its structure to provide additional support to the homes. Specifically, the Sunset Oaks home has a Program Supervisor assigned to the home that does not have assignments at other facilities.
4. 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. Please see the attached Organizational Chart.

5. Person Responsible: Program Manager, Program Supervisor, Clinical Director

6. Completion Date: 11/5/14

Please refer to the plan of correction under W153 as it relates to the facility's failure to ensure the abuse policy was sufficiently implemented.

W153

1. Individual #5 moved from the facility on 9/24/14 at 2:45pm. All of the staff in the home are receiving training on the abuse and neglect policy specifically related to notification of the Administrator.
2. All individuals in the home will be effected by the training.
3. Aspire Human Services has revised its structure to provide additional support to the homes. Specifically, the Sunset Oaks home has a Program Supervisor assigned to the home that does not have assignments at other facilities.
4. 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. Please see the attached Organizational Chart.
5. Person Responsible: Program Manager, Program Supervisor, Clinical Director
6. Completion Date: 11/5/14

W159

Please see the plans of correction under WW214, W227, W260, W289, W303, and W407.

W214

1. Individual #1's behavior assessment is being revised to include comprehensive information explaining the need for 1 to 1 supervision. Individual #5 is no longer living at the facility. If she were still living at the facility her behavior assessment would be revised to include information related to her isolation.
2. The behavior assessments for all individuals living at the home have been reviewed and revised to include accurate and comprehensive information.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 11/5/14

W227

1. Individual #5 is no longer living at the facility. If she were still living at the facility her behavior assessment and subsequent programs in her PCLP would be revised to include information related to her isolation.
2. The behavior assessments for all individuals living at the home have been reviewed and revised to include accurate and comprehensive information.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 11/5/14

W260

1. Individual #5 is no longer living at the facility. If she were still living at the facility her assessments would have been revised to include information related to her preferences to stay in her room and eat outside to avoid individual #1.
2. The behavior assessments for all individuals living at the home have been reviewed and revised to include accurate and comprehensive information.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 11/5/14

W266

Please see the plans of correction under WW214, W227, W260, W289, W303 and W407.

W289

1. Individual #5 is no longer living at the facility. If she were still living at the facility her behavior assessments and behavior management plans would be revised to include information related to providing sufficient direction to staff to consistently address her maladaptive behaviors.
2. The behavior assessments for all individuals living at the home have been reviewed and revised to include accurate and comprehensive information.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.

5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
6. Completion Date: 11/5/14

W303

1. Individual #5 is no longer living at the facility. The staff in the home have been re-trained on the importance of capturing an accurate record of restraint for all individuals in the home.
2. All files in the home are being reviewed to verify that accurate restraint data is being captured for observed maladaptive behavior. All staff in the home are being provided with additional training in relation to documenting appropriate behavioral data.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will verify that appropriate data collections systems are created for each individuals programming.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
Completion Date: 11/5/14

W407

1. Individual #5 is no longer living at the facility. The treatment team believes that the housing arrangement promotes the growth of all individuals currently receiving services.
2. All files in the home are being reviewed to verify that individuals that are currently receiving services are being provided with growth opportunities.
3. Aspire Human Services has developed a system for performing QIDP peer reviews. With the review there are specific days in which peer reviews will be occurring. One part of the review will include that individuals' needs are being met. The QIDP's will be able to identify potential concerns with living arrangements that prohibit growth opportunities.
4. In Addition, Aspire Human Services has added a Clinical Director position to the Org Chart. One of the responsibilities of this position will be that a file is maintained that contains all documentation that Plans of Correction have been implemented.
5. Person Responsible: Program Supervisor, Clinical Director, Program Manager & QIDP
Completion Date: 11/5/14

MM126

Please refer to the response under W407.

MM169

Please refer to the response under W153.

MM177

Please refer to the responses under W122 and W149.

MM197

Please refer to the response under W289.

MM212

Please refer to the response under W266.

MM513

Please refer to the responses given under W102 and W104.

MM725

Please refer to the responses given under W159 and W260.

MM729

Please refer to the response given under W227.

MM730

Please refer to the response given under W214.

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2014
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET		STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686	

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)	(X4) COMPLETION DATE
000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation conducted from 9/22/14 to 9/29/14.</p> <p>Immediate Jeopardy was identified at W149 and the facility was notified on 9/24/14 at 1:12 p.m. The facility submitted an Immediate Plan of Correction on 9/24/14 at 2:45 p.m. On-site verification of the plan's implementation was completed on 9/24/14 at 3:57 p.m. and the Immediate Jeopardy was abated.</p> <p>The survey was conducted by:</p> <p>Ashley Henscheld, QIDP, Team Lead Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ABC - Antecedent, Behavior, Consequence ADHD - Attention Deficit Hyperactivity Disorder AOD - Administrator On Duty AQIDP - Assistant Qualified Intellectual Disabilities Professional BMP - Behavior Management Plan DCS - Direct Care Staff HRC - Human Rights Committee IDT - Interdisciplinary Team LPN - Licensed Practical Nurse Mandt - A behavioral intervention NOS - Not Otherwise Specified PCLP - Person Centered Lifestyle Plan PTSD - Post Traumatic Stress Disorder QIDP - Qualified Intellectual Disabilities Professional RAD - Reactive Attachment Disorder SIB - Self-Injurious Behavior</p>	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Madsen TITLE: Program Manager (X4) DATE: 10/30/14

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has implemented 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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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER FERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83656
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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
000	Continued From page 1	W 000		
102	Therapeutic Options - A behavioral intervention 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		
W 104	This CONDITION is not met as evidenced by: Based on observation, policy review, record review, staff interview and a review of the facility's compliance history, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems of a serious and recurrent nature. This failure resulted in inadequate protections and behavioral services being provided to individuals. The findings include: 1. Refer to W104 as it relates to the facility's failure to ensure the governing body provided sufficient operating direction over the facility. 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, policy review, record review and staff interview, it was determined the facility's governing body failed to provide sufficient monitoring and oversight that identified and resolved systematic problems. These failures directly impacted 2 of 5 individuals (Individuals #1	W 104		

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NAME OF PROVIDER OR SUPPLIER REFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE, NAMPA, ID 83686
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(4) ID PREFIX SUFFIX	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)	(X4) COMPLETION DATE
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104	<p>Continued From page 2</p> <p>and #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:</p> <p>1. The facility's policy titled Governing Body, dated 1/9/13, documented the corporate governing body included the City Director, Regional Director, Idaho State Director, Chief Financial Officer, Senior Vice President, Chief Operating Officer and Chief Executive Officer.</p> <p>The facility also employed a Positive Behavior Support Specialist. When asked, the City Director stated on 9/24/14 at 11:55 a.m., the Positive Behavior Support Specialist's direct supervisor was the Idaho State Director. The Idaho State Director, a member of the governing body, failed to provide monitoring and oversight of the Positive Behavior Support Specialist, necessary to ensure Individual #5's IDT received written reports in a timely fashion, as follows:</p> <p>During an interview conducted on 9/23/14 at 4:02 p.m., the Program Supervisor stated that in response to a pattern of negative interactions between Individual #1 and Individual #5 the assistance of the Positive Behavior Support Specialist was requested. She stated the Positive Behavior Support Specialist completed observations in the facility at the end of August 2014, however, a report with recommendations had not yet been received from the Positive Behavior Support Specialist.</p> <p>On 9/24/14 at approximately 9:00 a.m., the Program Supervisor provided a "Positive Behavior Support Observation Report," dated</p>	W 104		
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NAME OF PROVIDER OR SUPPLIER FERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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104	<p>Continued From page 3</p> <p>9/23/14. The report documented the Positive Behavior Support Specialist had conducted observations at the facility on 8/7/14 and 9/2/14. The report did not include information explaining the delay between observations or the delay in generating the written report.</p> <p>During an interview on 9/24/14 from 11:58 a.m. - 12:00 p.m., the Idaho State Director stated he met with the Positive Behavior Support Specialist "on a fairly consistent basis." The Idaho State Director stated he was made aware observations were conducted by the Positive Behavior Support Specialist regardless of the completion of the report. He further stated during a phone interview on 9/23/14, from 12:23 - 12:26 p.m., the results of the observation were dealt with at the City Director level.</p> <p>The facility's governing body failed to provide sufficient monitoring and oversight of the Positive Behavior Support Specialist.</p> <p>2. The facility's Behavior Support Hierarchy & Definitions policy, revised 8/14/14, stated open-handed physical blocking was to be utilized for up to 3 minutes, per Mandt guidelines. It further stated physical release methods included in the Mandt system included bite release, hair pull release, clothing release and finger hold release, as well as, head stabilization principles.</p> <p>However, the supportive restraints section of the policy stated Therapeutic Options supportive restraints were to be used.</p> <p>Additionally, the facility's Incident and Accident Reporting policy, revised 7/15/12, stated staff were required to complete an Incident/Accident</p>	W 104		
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OMB NO. 0938-0391

IDENTIFICATION OF DEFICIENCIES LOCATION OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
NAME OF PROVIDER OR SUPPLIER FERRED COMMUNITY HOMES - SUNSET		STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686	
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)
104	<p>Continued From page 4</p> <p>Report for various incidents including "Supportive Restraint Injury: Any injury that is the result of a supportive restraint (MANDT restraint)."</p> <p>The facility's policies were not consistent in which restraint system (Mandt or Therapeutic Options) was to be used.</p> <p>During a follow-up interview on 10/17/14 at 2:08 p.m., the Program Director stated Therapeutic Options system was used.</p> <p>The facility's governing body failed to ensure policies provided consistent direction to staff.</p> <p>3. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they relate the failure of the governing body to provide sufficient monitoring and oversight to ensure policies were adequately developed, implemented and monitored necessary to ensure individuals were not subjected to on-going abuse and neglect.</p> <p>4. Refer to W159 as it relates to the facility's failure to ensure the QIDP provided sufficient monitoring and oversight for all individuals residing in the facility. The facility was previously cited at W159 during an annual recertification survey dated 4/26/13 and an annual recertification survey dated 3/16/12.</p> <p>5. Refer to W214 as it relates to the facility's failure to ensure individuals' behavior assessments contained comprehensive information. The facility was previously cited at W214 during an annual recertification survey dated 3/16/12.</p>	W 104	

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IDENTIFICATION OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(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 - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83586
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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104	Continued From page 5 6. Refer to W266 Condition of Participation: Client Behavior and Facility Practices and associated standard level deficiencies as they relate to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. The facility was previously cited at W266 during an annual recertification survey dated 3/16/12. 7. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into an individual's plan. The facility was previously cited at W289 during a complaint survey dated 4/11/14 and an annual recertification survey dated 3/16/12.	W 104		
122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, policy review, record review, review of Incident and Accident Reports, and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented. This failure directly impacted 2 of 5 individuals (Individuals #1 and #5) residing in the facility. This resulted in a lack of sufficient protections necessary to ensure individuals were not subjected to on-going abuse and neglect. The findings include:	W 122		

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NAME OF PROVIDER OR SUPPLIER FERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7691 BIRCH LANE NAMPA, ID 83686
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122	Continued From page 6 1. Refer to W149 as it relates to the facility's failure to ensure individuals were not subjected to on-going abuse and psychological harm.	W 122		
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 observation, policy review, record review, review of Incident and Accident Reports, and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect, and mistreatment were sufficiently implemented and monitored. That failure directly impacted 2 of 5 individuals (Individuals #1 and #5) residing in the facility. This resulted in individuals being subjected to on-going abuse and psychological harm, which constituted serious and immediate jeopardy to the individuals' psychological and physical health and safety. The findings include: 1. The facility's "Abuse, Neglect, Mistreatment and Injuries of An Unknown Source" policy, revised 5/21/13, stated "Abuse, neglect, or mistreatment will not be tolerated or allowed at anywhere [sic] or at anytime. It is the responsibility of every employee to ensure that clients are not subjected to physical, verbal, sexual or psychological abuse..." The policy included the following definitions:	W 149		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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149	<p>Continued From page 7</p> <ul style="list-style-type: none"> - "Abuse: The infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish..." - "Threat: Any condition/situation, which could result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals or in their death." - "Verbal Abuse: To any use [sic] of oral, written or gestured language by which abuse occurs. This included pejorative and derogatory terms to describe individuals with disabilities..." - "Emotional or Psychological Abuse: The verbal or nonverbal infliction or anguish, pain, or distress that results in mental or emotional suffering..." - "Neglect: Is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." <p>The policy stated staff were to report "any type of abuse, neglect, or mistreatment..." committed by any person, including incidents of self-abuse and incidents of individuals abusing other individuals.</p> <p>However, the facility's policy was not sufficiently implemented and monitored to ensure Individual #1 was not subjected to on-going abuse from Individual #5 and that interventions were designed and implemented necessary to ensure Individual #5's psychological well-being was not neglected, as follows:</p> <p>Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose</p>	W 149		

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NAME OF PROVIDER OR SUPPLIER REFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83688
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149	<p>Continued From page 8</p> <p>diagnoses included mood disorder, impulse control disorder, depression and mild intellectual disability. The summary documented she had been admitted to the facility on 6/12/10 and on 5/17/14.</p> <p>When asked about the two admission dates, the Program Supervisor provided an email dated 4/6/14, which documented Individual #5 was discharged to her parents in another state in April 2014. The Program Supervisor stated, on 9/24/14 at approximately 9:00 a.m., Individual #5 had been re-admitted to the facility on 5/17/14.</p> <p>Individual #1's PCLP, dated 3/19/14, documented she was a 12 year old female whose diagnoses included mild intellectual disability.</p> <p>During interviews conducted across shifts on 9/23/14 from 10:20 a.m. - 3:10 p.m., staff were asked about Individual #1 and Individual #5's interactions. Staff stated the following:</p> <p>DCS A stated individual #5 could be aggressive to individual #1. The staff stated individual #5 would pick days to be mean or she would just hide in her room to avoid individual #1. Staff stated it was "out of control" and that individual #5 would just hear individual #1's voice and she [individual #5] would threaten her [individual #1].</p> <p>DCS B stated individual #5 could be aggressive towards individual #1, including throwing things at her. Staff stated individual #5 would threaten individual #1 and her family. DCS B stated individual #5 previously chose to eat at the kitchen counter to avoid individual #1 and she now ate outside on the back patio. Staff stated individual #5 went to her bedroom when</p>	W 149		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET		STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83688	

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
149	<p>Continued From page 9 Individual #1 was home.</p> <p>DCS C stated Individual #1 and Individual #5 did not get along. Staff stated Individual #5 came out of her bedroom when Individual #1 was gone and Individual #5 was in her bedroom when Individual #1 was home.</p> <p>The facility's Incident/Accident Reports from 4/12/14 - 9/22/14 were reviewed. The reports documented the following:</p> <ul style="list-style-type: none"> - 8/3/14 at 10:15 a.m.: Individual #5 became upset when she saw Individual #1 and began engaging in SIB. The report documented she had "...hit her head on the house 2 times and hit herself with an open hand 2 times." The "Conclusion and Corrective Action Taken" section of the report stated "[Individual #5] eats at the picnic table to avoid [Individual #1] as she does not like her...She is still in a transition period from visiting her parents." No other corrective actions related to the relationship between Individual #1 and Individual #5 were documented on the report. - 8/3/14 at 10:46 a.m.: Individual #5 became upset when she saw Individual #1 and began engaging in SIB. The report documented she "...got upset and went after another resident after said resident came within view. [Individual #5] was not able to get to the resident so head-tapped x9 against wall." The report documented "[Individual #5] became upset when she saw [Individual #1] and she head tapped 9 times against house [sic]." The "Conclusion and Corrective Action Taken" section of the report stated "Did [sic] staff training on sitting right next to [Individual #5] while she is eating to block the head hits and prevent any injury." No other 	W 149		

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149	<p>Continued From page 10</p> <p>corrective actions related to the relationship between Individual #1 and Individual #5 were documented on the report.</p> <p>An observation was conducted at the facility on 9/22/14 from 4:45 - 5:30 p.m. During the observation, Individual #1 and Individual #5 were not noted to be in the same areas of the house at the same time. The following was observed:</p> <ul style="list-style-type: none"> - 4:45 - 4:55 p.m.: Individual #1 was seated on the couch in the living room. Individual #5 was not observed. - 4:55 - 5:00 p.m.: Individual #1 was seated at the dining table with direct care staff doing crafts. Individual #5 was in her bedroom with the door closed. At that time, the Program Supervisor stated Individual #5 often stayed in her room because she did not like Individual #1. - 5:05 p.m.: A direct care staff went into Individual #5's bedroom. - 5:10 - 5:12 p.m.: Individual #1 and Individual #5 were in their bedrooms. Individual #5 had the door closed. - 5:12 - 5:15 p.m.: Individual #1 sat on the couch with the facility kitten. Individual #5 remained in her bedroom with the door closed. - 5:15 - 5:17 p.m.: Individual #1 laid down in her bed. Individual #5 remained in her bedroom with the door closed. - 5:17 - 5:30 p.m.: Individual #5 came out of her bedroom and walked down the hall to the restroom. At 5:22 p.m., Individual #5 returned to 	W 149		

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149	<p>Continued From page 11</p> <p>her bedroom and stayed there for the remainder of the observation. Individual #1 remained in her bedroom during this time.</p> <p>Observations were conducted on 9/22/14 and 9/23/14. Individual #1 was at school during the observation periods. When Individual #1 was not present at the facility, Individual #5 engaged in the following:</p> <p>During the observation on 9/22/14 from 2:10 - 3:00 p.m.:</p> <ul style="list-style-type: none"> - 2:10 - 2:30 p.m.: Individual #5 was in her bedroom. - 2:30 p.m.: Direct care staff verbally cued Individual #5 to get ready for a visit to the animal shelter. - 2:37 p.m.: Individual #5 left with Individual #3 and two direct care staff. - 2:38 - 3:00 p.m.: Individual #5 was on an outing. <p>During the observation on 9/23/14 from 1:45 - 2:25 p.m.:</p> <ul style="list-style-type: none"> - 1:45 - 1:53 p.m.: Individual #5 was at the dining table. Two direct care staff were also at the table. Individual #5 was watching videos on her tablet. - 1:53 - 2:07 p.m.: Individual #5 ran back to her bedroom to get her play cell phone. A direct care staff "called" her from the facility phone. Individual #5 stepped onto the front porch to talk to the staff member. Individual #5 was laughing while interacting with the staff. 	W 149		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7891 BIRCH LANE NAMPA, ID 83686
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1) ID PREFIX SUFFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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149	<p>Continued From page 12</p> <p>- 2:07 - 2:25 p.m.: Individual #5 was in her bedroom with the door closed. A direct care staff joined Individual #5 in her bedroom at 2:10 p.m.</p> <p>When asked how long Individual #1 and individual #5's relationship had been strained, during an interview on 9/23/14 from 4:02 - 4:26 p.m., the Program Supervisor estimated at least one year, since approximately May 2013. The Program Supervisor stated Individual #5 and Individual #1 were very close friends in the beginning of their time living together. She stated there was an incident where Individual #1 touched Individual #5's belongings and from that moment on the relationship had declined.</p> <p>The Program Supervisor stated dinnertime was the most difficult as staff had to focus on "damage control" between Individual #1 and Individual #5 more than the mealtime routine itself. She stated Individual #5 had thrown plates, spoons and forks at Individual #1 in the past.</p> <p>During the same interview, the Program Supervisor stated Individual #5 used to bang her head when she heard Individual #1's voice. She stated there had been incidents when Individual #5 saw Individual #1 and began screaming also leading to her banging her head. The Program Supervisor stated Individual #1 and Individual #5's interactions had been the worst since May/June 2014. She stated Individual #5 began verbally threatening to harm Individual #1's family if they visited the facility. The Program Supervisor stated during the summertime, nights and weekends Individual #5 stayed in her bedroom to avoid Individual #1.</p> <p>Individual #1 and Individual #5's behavior logs</p>	W 149		
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149	<p>Continued From page 13</p> <p>from 4/15/14 to 9/7/14 were reviewed. The behavior logs documented multiple incidents of on-going abuse, as follows:</p> <ul style="list-style-type: none"> - 5/22/14 at 7:00 p.m.: Individual #5 saw Individual #1 dancing in the living room, screamed and threw her plate on the floor. Staff escorted Individual #5 to her bedroom while another staff helped block Individual #5's view of Individual #1. - 5/25/14 at 8:45 a.m.: Individual #5 was walking by Individual #1 and "...tried to go after her yelling 'I'm gonna kill you.' Then [Individual #5] slid to the floor. Laid there for a few minutes. [Staff's name] and I helped her back up and into her room." - 5/28/14 at 5:00 p.m.: Individual #5 was asked to come to the dinner table, which she did. Individual #1 and Individual #5 were staring at each other across the table and Individual #5 began "crying, grabbing, getting upset." Individual #5 broke her glasses, threw them across the table, and was walked to her bedroom by three staff. One staff remained in the bedroom with Individual #5 until she calmed down. Individual #5 and the staff then returned to the dinner table and Individual #5 again began crying, hitting staff and attempting to throw things. "[Individual #5] was again assisted back to her room." - 5/29/14 at 4:20 p.m.: Individual #5 was at the dinner table and was staring at Individual #1. Individual #1 made eye contact with Individual #5 and Individual #5 yelled "stop" and threw a napkin toward Individual #1. Individual #1 said "something" and Individual #5 attempted to throw 	W 149		

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149	<p>Continued From page 14 .</p> <p>her cup at Individual #1. The log documented Individual #5 agreed to "take a break..."</p> <p>- 6/5/14 at 8:55 a.m.: Individual #1 was outside and Individual #5 saw Individual #1 through the window. Individual #5 said "stop it." Staff gave Individual #5 a "deep pressure hug" and "started assisting her down to her bedroom..."</p> <p>- 6/19/14 at 4:20 p.m.: Individual #5 saw Individual #1 and attempted to throw a package of trail mix at her. Staff "redirected her to try again for 5 (minutes). She [Individual #5] went back to her room..."</p> <p>- 6/20/14 at 8:00 p.m.: Individual #5 was upset. Individual #1 was going in and out of the kitchen which further upset Individual #5. Individual #5 "was yelling 'I'm going to kill you' and repeatedly kicking, biting and pinching. This went on for over half an hour before [Individual #5] returned to baseline and returned to her room."</p> <p>- 6/24/14 at 7:25 a.m.: Individual #5 saw Individual #1 getting towels from the closet. Individual #5 "started to yell 'I'm going to kill you' [staff's name] & I...ran to back room, [Individual #1] shut herself in closet and I did body hug on [Individual #5] until she was at baseline."</p> <p>- 6/24/14 at 5:35 p.m.: Individual #5 was eating dinner and asked to go to her room. Staff told her she could go to her room if she was done with her meal. Individual #5 kept eating and saying she wanted to go to her room. Individual #1 and Individual #2 started talking loudly and Individual #5 grabbed a cup and attempted to throw it at Individual #1 and Individual #2. Individual #5 was "offered a break" which she</p>	W 149		
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149	<p>Continued From page 15 refused and kept eating.</p> <p>- 6/28/14 at 8:05 p.m.: Individual #5 wanted to eat a snack outside and was told she could not. She heard Individual #1's voice and attempted to throw her cup at Individual #1. Individual #5 began yelling and pinching, scratching, biting and grabbing at staff. The other individuals were "taken from the room by staff." Individual #5 moved her chair across the floor to the back door so she could see Individual #1 through the window. Individual #5 was "screaming "I am going to kill you, kill your mother, stab her with a knife, she is a whore, she is ugly and fat. I am going to kill your whole family. Give me a knife so I can kill her." Individual #5 was physically restrained by staff until she calmed. Staff documented "I believe [Individual #5] would have seriously hurt [Individual #1] if she was not kept still."</p> <p>- 6/29/14 at 8:00 a.m.: Individual #5 threw a plate at Individual #1 and "Yelled "I'm going to kill you! I'm going to break all of your toys. I'm going to rip off your head!" [Individual #5] grabbed and pinched staff."</p> <p>- 6/29/14 at 3:30 p.m.: Individual #1 was getting a towel from the linen closet. Individual #5 saw her and "yelled" and Individual #1 "closed herself" in the closet. Individual #5 continued to yell at Individual #1. Staff were "able to get [Individual #5] back inside her doorway and close the door."</p> <p>- 7/3/14 at 8:12 p.m.: Individual #5 was sitting at the dining room table eating a snack. She was missing her family and wanting to talk to them. Individual #1 started walking around the dining room and staff attempted to use body positioning</p>	W 149		

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149	<p>Continued From page 16</p> <p>to block Individual #5 from seeing Individual #1. "[Individual #5] heard [Individual #1's] voice, hit her head, and yelled, 'I'm going to kill you.' [Staff's name] came over and soothed her and calmed her down."</p> <p>- 7/9/14 at 8:25 p.m.: Individual #1 was staring at Individual #5 through the back door window. Individual #5 saw her and began assaulting staff, engaging in head banging on the floor and "continued to scream out threats to [Individual #1] and her family..."</p> <p>- 7/11/14 at 8:55 a.m.: Individual #1 was getting a towel from the linen closet. Individual #5 told individual #1 she was going to kill her four times.</p> <p>- 7/12/14 at 8:35 a.m.: Individual #5 was "escalating upon seeing [Individual #1] in the hallway." Staff were "able to catch [Individual #5], who was running at [Individual #1] with arms raised..."</p> <p>- 7/15/14 at 8:00 p.m.: Individual #5 saw Individual #1. Individual #5 "made a grunting noise and lunged forward..."</p> <p>- 7/16/14 at 10:06 a.m.: Individual #5 saw Individual #1 and "tried to charge [Individual #1]..."</p> <p>- 7/17/14 at 2:20 p.m.: Individual #5 saw Individual #1, threw a cup of water at her and started screaming.</p> <p>- 7/22/14 at 10:26 a.m.: Individual #5 saw Individual #1, threw a cup and "lightly head tapped on the staff closet door x2."</p>	W 149		
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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149	<p>Continued From page 17</p> <ul style="list-style-type: none"> - 7/22/14 at 7:20 p.m.: Individual #6 saw and heard Individual #1 and began to whine and moan. Individual #6 hit "her head with her hands x3." - 7/24/14 at 5:20 p.m.: Individual #5 saw individual #1 and "head tapped lightly x3 on the hallway wall." Staff assisted Individual #5 to her room where she dropped to the floor and "head tapped the (right) side of her head lightly x2" against her bedroom wall. - 7/24/14 at 6:30 p.m.: Individual #5 heard Individual #1 talking at dinner and "Began to scream and whine and threw fork towards [Individual #1]..." - 7/31/14 at 1:45 p.m.: Individual #5 saw Individual #1 standing by the back door. Individual #5 ran at Individual #1 and "threw her hands up." Individual #1 ran out the back door. - 8/3/14 at 2:15 p.m.: Individual #1 was getting a towel from the linen closet. Individual #5 began to "moan/scream." Individual #5 then became violent towards staff and attempted to head bang. - 8/3/14 at 4:00 p.m.: Individual #5 saw Individual #1 "in hallway while going back to room after snack." Individual #5 "got aggressive and violent. Lunged after [Individual #1]..." - 8/5/14 at 10:30 a.m.: Individual #5 saw Individual #1 and "hit her head on the wall 3 times..." - 8/16/14 at 8:20 a.m.: Individual #5 "ran down hall to [Individual #1] screaming...[Individual #1] ran to her room..." At 8:25 a.m. Individual #1 	W 149		
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPÁ, ID 83686
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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)	(X4) COMPLETION DATE
149	<p>Continued From page 18</p> <p>went outside and began yelling Individual #5's name.</p> <p>- 8/17/14 at 4:10 p.m.: Individual #5 saw Individual #1 and "started to moan and throw her cup of water. She started to get up to go after [Individual #1]. [Individual #1] began taunting [Individual #5] and calling her names. [Individual #5] said she would break all [Individual #1's] toys." A corresponding behavior log documented Individual #1 had called Individual #5 a "bitch" and a "butt head" and stated "I'm allowed to hurt you if you touch me."</p> <p>Additionally, the logs included documentation of a restrictive measure placed on Individual #1 as a result of her interactions with Individual #5, as follows:</p> <p>- 7/24/14 at 4:00 p.m.: Individual #5 saw Individual #1 by the laundry room and "went into behavior." Staff "reminded [Individual #1] that she shouldn't go in the back of the house...she kept going back into the laundry room..." Individual #1 told staff "[Individual #5's] door is closed, I can go back here if I want to."</p> <p>The facility's "Abuse, Neglect, Mistreatment and Injuries of An Unknown Source" policy documented under the instructions for adult and child protection notification "The Administrator, AOD or City Director will notify...immediately under the following circumstances...Repeated resident-to-resident physical or verbal altercations, not resulting in observable physical or mental injury, but constituting an ongoing (sic) pattern of resident behavior that a facility's staff are unable to remedy through reasonable efforts."</p>	W 149		

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STATEMENT OF DEFICIENCIES BY PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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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
149	<p>Continued From page 19</p> <p>When asked during an interview conducted on 9/23/14 at 4:02 p.m., what efforts had been made in response to Individual #1 and Individual #5's altercations, the Program Supervisor stated during the morning routine, staff tried offering Individual #5 time in the office (separate from the residential area of the facility) to use the computer until Individual #1 left for school so Individual #5 did not have to hear her voice. That intervention was successful and still utilized. Additionally, Individual #5 was provided with headphones for her electronic tablet to block the sound of individual #1's voice.</p> <p>The seating at the dining table was altered for Individual #5 and Individual #1 to sit on the same side of the table, at opposite ends, to avoid them seeing each other. However, the intervention failed due to Individual #5 still being able to hear Individual #1. Staff tried serving Individual #5's meals at a table up against the wall in the dining area with her visibility of Individual #1 blocked with a mat, but that also failed. Individual #5 had since chosen to eat outside.</p> <p>Individual #5's bedroom assignment was changed so that she no longer shared a Jack-and-Jill bathroom with Individual #1. Also, staff attempted to utilize a mat to block Individual #1 from Individual #5's line of sight. Staff taught Individual #5 to cover her eyes when she needed to leave her bedroom, such as for medication administration, to avoid seeing Individual #1.</p> <p>Staff encouraged Individual #5 to leave her bedroom as much as possible when Individual #1 was not home. However, the Program Supervisor stated Individual #5 would not come out of her room if she did not believe staff when</p>	W 149		

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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
149	<p>Continued From page 20</p> <p>they said Individual #1 was gone. Monday through Friday while Individual #1 was in school, Individual #5 was out of her bedroom interacting with other individuals in the facility. However, Individual #5 watched the clock and 15 minutes before Individual #1 arrived home from school, Individual #5 returned to her bedroom.</p> <p>Further, the Program Supervisor stated she requested the assistance of the Positive Behavior Support Specialist. He had completed observations at the facility at the end of August 2014. At that time, it was discussed that individual #5 may not be an appropriate fit for the facility. However, a report with recommendations had not yet been received from the Positive Behavior Support Specialist.</p> <p>On 9/24/14 at approximately 9:00 a.m., the Program Supervisor provided a "Positive Behavior Support Observation Report," dated 9/23/14. The report documented the Positive Behavior Support Specialist had completed observations at the facility on 8/7/14 and 9/2/14 and interviews were conducted with the lead staff, AQIDP, Program Supervisor and Individual #5. The report stated "[Individual #5] did not engage in any significant, high-intensity target behaviors during the observation; however, it provided some clear insight as to her triggers and escalation process." However, the report documented "[Individual #5's] housemates were not present the majority of the observation (community outing/school)."</p> <p>The report did not include information explaining the delay between observations or what information was garnered when. For example under the Participant Interview section, the report</p>	W 149		

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149	<p>Continued From page 21</p> <p>documented "[individual #1] exited her room after approximately 1 hour of my observation time." However, the report did not specify if this occurred during the 8/7/14 observation or the 9/2/14 observation. Additionally, the report did not include information regarding when the lead staff, AQIDP, Program Supervisor or individual #5 had been interviewed or if there was a change in reported information over the course of the two observation periods.</p> <p>The "Recommendation(s)" section of the Positive Behavior Support Observation Report included the following:</p> <ul style="list-style-type: none"> - Improve consistency in staff interactions with Individual #5. - The AQIDP/QIDP should communicate with Individual #5's parents to get them "more aligned with the behavior program." - Discuss Individual #5's potential transition to a lower level of care. - Explore alternative placement options for Individual #5. <p>However, no evidence that the recommendations had been implemented could be found.</p> <p>When asked about the report, during an interview on 9/24/14 from 11:05 - 11:14 p.m., the Positive Behavior Support Specialist stated there was no mandate for follow through on recommendations and they were more of a "professional perspective."</p> <p>Additionally, the Program Supervisor provided an email, dated 8/18/14, which she had written to Individual #5's contact in another state. The email documented Individual #5's behaviors were</p>	W 149		

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IDENTIFICATION OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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149	<p>Continued From page 22</p> <p>"affecting the entire house. At this point she is bullying and attempting to hurt a child and that is not ok and is a huge risk for our company. She is not happy here and continues to act out and be verbally and physically aggressive to an individual that is much younger than (sic) her. It has got (sic) to the point that we can't even let this other individuals (sic) mother in the house because (Individual #5) attempts to assault her and threatens to kill her which in turn makes the other resident very upset. It is time that (Individual #5) (sic) parents start looking for other placement for her because (name of company) is no longer able to serve her in a way that benefits her. We will do what ever we need to do to help with this process and we understand that it will not happen tomorrow but we would like her parents to start actively looking..."</p> <p>During an interview on 9/24/14 from 11:35 - 11:45 a.m., the Program Manager stated he was aware that Individual #5 targeted Individual #1. He stated the Program Supervisor had put measures in place to avoid physical assaults. The Program Manager stated he was aware that Individual #5 spent a lot of time in her bedroom and discharging Individual #5 had been discussed.</p> <p>The City Director stated, during an interview on 9/24/14 from 11:48 - 11:55 a.m., there had been struggles between Individual #1 and Individual #5 in the past. She stated the team had discussed if Individual #1 and Individual #5 were appropriate to live together. The City Director stated they had discussed discharging Individual #5, but notice was never given.</p> <p>Per facility policy definitions, Individual #1 was repeatedly subjected to threats and emotional,</p>	W 149		
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149	<p>Continued From page 23</p> <p>psychological and verbal abuse by individual #5. Additionally, the lack of successful intervention with Individual #5 resulted in on-going psychological abuse from isolating herself in her room and had the potential for physical harm from head banging when Individual #1 was present.</p> <p>The facility failed to consistently implement policies and procedures to prohibit abuse, neglect and mistreatment to ensure Individual #1 and Individual #5 were not subjected to on-going abuse and neglect which placed the individuals in immediate jeopardy and at risk of serious harm, impairment and/or death. Immediate jeopardy was identified and the facility was notified on 9/24/14 at 1:12 p.m.</p> <p>Note: The facility provided an immediate plan of correction on 9/24/14 at 2:45 p.m., which stated Individual #5 would be immediately removed from the facility. The plan stated the facility "is in the process of coordinating a safe transition back to (Individual #5's) home state..."</p> <p>Additional information was solicited at the time the plan was received. The Program Supervisor stated direct care staff would be with Individual #5 at all times, including in her travel back to her home state.</p> <p>On-site verification of the plan's implementation was completed and on 9/24/14 at 3:57 p.m. and the immediate jeopardy was abated.</p> <p>2. Refer to W153 as it relates to the facility's failure to ensure the abuse policy was sufficiently implemented necessary to ensure all allegations were immediately reported to the Administrator.</p>	W 149		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on policy review, record review of Incident and Accident reports and staff interview, it was determined the facility failed to ensure all allegations of abuse were immediately reported to the Administrator. This failure directly impacted 2 of 5 Individuals (Individuals #1 and #5) residing in the facility. This resulted in on-going abuse occurring without appropriate corrective action being taken. The findings include: 1. The facility's "Abuse, Neglect, Mistreatment and Injuries of An Unknown Source" policy, revised 5/21/13, stated "Abuse, neglect, or mistreatment will not be tolerated or allowed at anywhere (sic) or at anytime. It is the responsibility of every employee to ensure that clients are not subjected to physical, verbal, sexual or psychological abuse..." The policy included the following definitions: - "Abuse: The infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish..." - "Threat: Any condition/situation, which could result in severe, temporary or permanent injury or harm to the mental or physical condition of individuals or in their death."	W 153		
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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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/ 153	<p>Continued From page 25</p> <ul style="list-style-type: none"> - "Verbal Abuse: To any use (sic) of oral, written or gestured language by which abuse occurs. This includes pejorative and derogatory terms to describe individuals with disabilities..." - "Emotional or Psychological Abuse: The verbal or nonverbal infliction or anguish, pain, or distress that results in mental or emotional suffering..." <p>The policy stated staff were to Immediately report to the Administrator "any type of abuse, neglect, or mistreatment..." committed by any person, including incidents of self-abuse and incidents of individuals abusing other individuals. Staff were to document the incidents and any other pertinent information on an Incident/Accident Report form.</p> <p>a. Individual #1 and Individual #5's behavior logs from 4/15/14 to 9/7/14 were reviewed. The logs documented multiple incidents of Individual #5 being abusive toward Individual #1. However, Incidents/Accident Reports and documentation of immediate Administrator notification could not be found. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 5/25/14 at 8:45 a.m.: Individual #5 was walking by Individual #1 and "...tried to go after her yelling 'I'm gonna kill you.' Then [Individual #5] slid to the floor. Laid there for a few minutes. [Staff's name] and I helped her back up and into her room." - 6/20/14 at 8:00 p.m.: Individual #5 was upset. Individual #1 was going in and out of the kitchen which further upset Individual #5. Individual #5 "was yelling 'I'm going to kill you' and repeatedly kicking, biting and pinching. This went on for 	W 153		
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over half an hour before (Individual #5) returned to baseline and returned to her room."

- 6/24/14 at 7:25 a.m.: Individual #5 saw Individual #1 getting towels from the closet. Individual #5 "started to yell 'I'm going to kill you' [staff's name] & [...ran to back room, (Individual #1) shut herself in closet and I did body hug on (Individual #5) until she was at baseline."

- 6/28/14 at 8:05 p.m.: Individual #5 wanted to eat a snack outside and was told she could not. She heard Individual #1's voice and attempted to throw her cup at Individual #1. Individual #5 began yelling and pinching, scratching, biting and grabbing at staff. The other individuals were "taken from the room by staff." Individual #5 moved her chair across the floor to the back door so she could see Individual #1 through the window. Individual #5 was "screaming 'I am going to kill you, kill your mother, stab her with a knife, she is a whore, she is ugly and fat. I am going to kill your whole family. Give me a knife so I can kill her.'" Individual #5 was physically restrained by staff until she calmed. Staff documented "I believe (Individual #5) would have seriously hurt (Individual #1) if she was not kept still."

- 6/29/14 at 8:20 a.m.: Individual #5 threw a plate at Individual #1 and "Yelled 'I'm going to kill you! I'm going to break all of your toys. I'm going to rip off your head!' (Individual #5) grabbed and pinched staff."

- 6/29/14 at 3:30 p.m.: Individual #1 was getting a towel from the linen closet. Individual #5 saw her and "yelled" and Individual #1 "closed herself" in the closet. Individual #5 continued to yell at

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ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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/ 153	<p>Continued From page 27</p> <p>Individual #1. Staff were "able to get [Individual #5] back inside her doorway and close the door."</p> <p>- 7/3/14 at 8:12 p.m.: Individual #5 was sitting at the dining room table eating a snack. She was missing her family and wanting to talk to them. Individual #1 started walking around the dining room and staff attempted to use body positioning to block Individual #5 from seeing Individual #1. "[Individual #5] heard [Individual #1's] voice, hit her head, and yelled, 'I'm going to kill you.' [Staff's name] came over and soothed her and calmed her down."</p> <p>- 7/11/14 at 8:55 a.m.: Individual #1 was getting a towel from the linen closet. Individual #5 told Individual #1 she was going to kill her four times.</p> <p>- 7/12/14 at 8:35 a.m.: Individual #5 was "escalating upon seeing [Individual #1] in the hallway." Staff were "able to catch [Individual #5], who was running at [Individual #1] with arms raised..."</p> <p>- 7/15/14 at 8:00 p.m.: Individual #5 saw Individual #1. Individual #5 "made a grunting noise and lunged forward..."</p> <p>- 7/16/14 at 10:05 a.m.: Individual #5 saw Individual #1 and "tried to charge [Individual #1]..."</p> <p>- 7/31/14 at 1:45 p.m.: Individual #5 saw Individual #1 standing by the back door. Individual #5 ran at Individual #1 and "threw her hands up." Individual #1 ran out the back door.</p> <p>- 8/3/14 at 4:00 p.m.: Individual #5 saw Individual #1 "In hallway while going back to room after</p>	W 163		
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NAME OF PROVIDER OR SUPPLIER TRANSFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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153	<p>Continued From page 28</p> <p>snack." Individual #5 got aggressive and violent. Lunged after [Individual #1]..."</p> <p>- 8/16/14 at 8:20 a.m.: Individual #5 "ran down hall to [Individual #1] screaming...[Individual #1] ran to her room..."</p> <p>Per facility policy definitions, Individual #1 was repeatedly subjected to threats and emotional, psychological and verbal abuse by Individual #5. However, Incidents/Accident Reports and documentation of Immediate Administrator notification for the above incidents could not be found.</p> <p>Additionally, an ABC Behavior Log documented 8/17/14 at 4:10 p.m., Individual #5 saw Individual #1 and "started to moan and threw her cup of water. She started to get up to go after [Individual #1]. [Individual #1] began taunting [Individual #5] and calling her names. [Individual #5] said she would break all [Individual #1's] toys." A second, corresponding behavior log documented Individual #1 had called Individual #5 a "bitch" and a "butt head" and stated "I'm allowed to hurt you if you touch me."</p> <p>However, Incidents/Accident Reports and documentation of Immediate Administrator notification for Individual #1's abusive behavior toward Individual #5 could not be found.</p> <p>When asked during a follow-up interview on 10/16/14 from 10:04 - 10:10 a.m., the AQIDP stated direct care staff were filling out the paper work at the end of the shift instead of doing it when the incident occurred.</p> <p>During an additional follow-up interview on</p>	W 153		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(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 - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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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
153	<p>Continued From page 29</p> <p>10/17/14 from 2:05 - 2:08 p.m., the AQIDP stated the missing Incident and Accident forms had not been filled out and that she was not notified of those incidents.</p> <p>b. Individual #5's behavior logs from 4/15/14 to 9/7/14 documented Individual #5 engaged in abusive behavior toward herself. However, Incident/Accident Reports and documentation of Immediate Administrator notification could not be found. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 7/9/14 at 8:25 p.m.: Individual #1 was staring at Individual #5 through the back door window. Individual #5 saw her and began assaulting staff, engaging in head banging on the floor and "continued to scream out threats to [Individual #1] and her family..." - 7/22/14 at 7:20 p.m.: Individual #5 saw and heard Individual #1 and began to whine and moan. Individual #5 hit "her head with her hands x3." - 8/5/14 at 10:30 a.m.: Individual #5 saw Individual #1 and "hit her head on the wall 3 times..." <p>When asked during a follow-up interview on 10/16/14 from 10:04 - 10:10 a.m., the AQIDP stated direct care staff were filling out the paper work at the end of the shift instead of doing it when the incident occurred.</p> <p>During an additional follow-up interview on 10/17/14 from 2:05 - 2:08 p.m., the AQIDP stated the missing Incident and Accident forms had not been filled out and that she was not notified of</p>	W 153		

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DEPARTMENT OF DEFICIENCIES DEPARTMENT OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(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 - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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153	Continued From page 30 those incidents. The facility failed to ensure all allegations of abuse were immediately reported to the Administrator.	W 153		
159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight of individuals' behavioral needs. This directly impacted 2 of 5 individuals (Individual #1 and #5) residing in the facility. This failure resulted in a lack of QIDP monitoring and oversight necessary to ensure individuals' behavioral needs were comprehensively addressed and their rights protected. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured individuals' behavior assessments included comprehensive information. 2. Refer to W227 as it relates to the facility's failure to ensure the QIDP ensured an individual had training objectives for all identified needs. 3. Refer to W260 as it relates to the facility's failure to ensure the QIDP ensured an individual's PCLP was updated as needed.	W 159		

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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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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)	(X4) COMPLETION DATE
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159	Continued From page 31 4. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured techniques used to manage inappropriate behavior were sufficiently incorporated into an individual's behavior programs. 5. Refer to W303 as it relates to the facility's failure to ensure the QIDP ensured an individual's record documented a clear understanding of the events before, during and after the use of restraints. 6. Refer to W407 as it relates to the facility's failure to ensure the QIDP ensured housing was arranged to promote the growth of all those residing together.	W 159		
Y 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior assessments contained comprehensive information for 2 of 5 individuals (Individuals #1 and #5) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1 and Individual #5's Behavioral Assessments did not include comprehensive information, as follows: a. Individual #1's PCLP, dated 3/19/14,	W 214		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7881 BIRCH LANE NAMPA, ID 83656
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ID PREFIX SUFFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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214	<p>Continued From page 32</p> <p>documented a 12 year old female whose diagnoses included mild intellectual disability.</p> <p>Individual #1's Behavioral Assessment, revised 3/25/14, stated she engaged in maladaptive behaviors which included physical aggression, SIB, socially offensive behavior, ADHD symptoms and insomnia.</p> <p>- Individual #1's Behavioral Assessment listed her diagnoses as ADHD, RAD - disinhibited type, mood disorder, PTSD, insomnia and mild intellectual disability. The assessment documented Individual #1 "has been diagnosed with Mood Disorder NOS which contributes to her physical aggression" and "has been diagnosed with PTSD...which contributes to her SIB." However, the assessment did not contain additional information regarding how Individual #1's diagnoses impacted her demonstrated maladaptive behaviors.</p> <p>- The "dislikes" section of her Behavioral Assessment stated Individual #1 "does not like being told no, wearing shoes, being redirected from her peers... and not seeing her family." No additional information related to how her dislikes impacted her maladaptive behaviors was present in the assessment.</p> <p>- Individual #1's Behavioral Assessment stated she "takes psychotropic medications to assist with her behaviors." The assessment identified the medications, but did not contain additional information related to how her behavior modifying drugs impacted her behavior.</p> <p>- Individual #1's Behavioral Assessment stated she "is 1:1 line of sight." The assessment did not</p>	W 214		
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(4) ID PREFIX AG	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
214	<p>Continued From page 33</p> <p>contain information explaining the need for 1:1 supervision.</p> <p>b. Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose diagnoses included mild intellectual disability. Individual #5's Behavioral Assessment, revised 9/2014, documented she engaged in maladaptive behaviors which included physical aggression, SiB, socially offensive behavior, destruction of property and uncooperative behavior.</p> <p>- Individual #5's PCLP listed her diagnoses as mood disorder, impulse control disorder, depression, mild intellectual disability, cerebral palsy and hypothyroidism.</p> <p>Individual #5's Behavioral Assessment documented potential causes for maladaptive behavior included "mental conditions." However, the assessment did not contain additional information regarding how Individual #5's diagnoses impacted her demonstrated maladaptive behaviors.</p> <p>- The Behavioral Assessment documented potential external causes of individual #5's maladaptive behavior as "not liking her staff, not wanting to participate, and being told no or to wait." No additional information related to how the causes triggered her, and for which maladaptive behaviors, was present in the assessment.</p> <p>- Individual #5's Behavioral Assessment documented "psychotropic medications are used in conjunctions (sic) with her behavior management plan." The assessment did not</p>	W 214		

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214	<p>Continued From page 34</p> <p>contain additional information related to how her behavior modifying drugs impacted her behavior.</p> <p>c. Individual #1 and Individual #5's behavior logs from 4/15/14 to 9/7/14 were reviewed. The logs documented a pattern of negative interactions between Individual #1 and Individual #5. Incidents included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 5/28/14 at 5:00 p.m.: Individual #5 was asked to come to the dinner table, which she did. Individual #1 and Individual #5 were staring at each other across the table and Individual #5 began "crying, grabbing, getting upset." Individual #5 broke her glasses, threw them across the table, and was walked to her bedroom by three staff. One staff remained in the bedroom with Individual #5 until she calmed down. Individual #5 and the staff then returned to the dinner table and Individual #5 again began crying, hitting staff and attempting to throw things. "(Individual #5) was again assisted back to her room." - 5/29/14 at 4:20 p.m.: Individual #5 was at the dinner table and was staring at Individual #1. Individual #1 made eye contact with Individual #5 and Individual #5 yelled "stop" and threw a napkin toward Individual #1. Individual #1 said "something" and Individual #5 attempted to throw her cup at Individual #1. The log documented she agreed to "take a break..." - 6/20/14 at 8:00 p.m.: Individual #5 was upset. Individual #1 was going in and out of the kitchen which further upset Individual #5. Individual #5 "was yelling 'I'm going to kill you' and repeatedly kicking, biting and pinching. This went on for 	W 214		
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214	<p>Continued From page 35</p> <p>over half an hour before [Individual #5] returned to baseline and returned to her room."</p> <p>- 6/28/14 at 8:05 p.m.: Individual #5 wanted to eat a snack outside and was told she could not. She heard Individual #1's voice and attempted to throw her cup at Individual #1. Individual #5 began yelling and pinching, scratching, biting and grabbing at staff. The other individuals were "taken from the room by staff." Individual #5 moved her chair across the floor to the back door so she could see Individual #1 through the window. Individual #5 was "screaming 'I am going to kill you, kill your mother, stab her with a knife, she is a whore, she is ugly and fat. I am going to kill your whole family. Give me a knife so I can kill her.'" Individual #5 was physically restrained by staff until she calmed. Staff documented "I believe [individual #5] would have seriously hurt [individual #1] if she was not kept still."</p> <p>- 7/3/14 at 8:12 p.m.: Individual #5 was sitting at the dining room table eating a snack. She was missing her family and wanting to talk to them. Individual #1 started walking around the dining room and staff attempted to use body positioning to block Individual #5 from seeing Individual #1. "[Individual #5] heard [Individual #1's] voice, hit her head, and yelled, 'I'm going to kill you.' [Staff's name] came over and soothed her and calmed her down."</p> <p>- 7/24/14: At 6:20 p.m.: Individual #5 saw Individual #1 and "head tapped lightly x3 on the hallway wall." Staff assisted Individual #5 to her room where she dropped to the floor and "head tapped the [right] side of her head lightly x2" against her bedroom wall."</p>	W 214		

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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 214	<p>Continued From page 36</p> <p>- 7/24/14 at 5:20 p.m.: Individual #5 saw Individual #1 and "head tapped lightly x3 on the hallway wall." Staff assisted Individual #5 to her room where she dropped to the floor and "head tapped the (right) side of her head lightly x2" against her bedroom wall.</p> <p>- 8/16/14 at 8:20 a.m.: Individual #5 "ran down hall to [Individual #1] screaming...[Individual #1] ran to her room..." At 8:25 a.m. individual #1 went outside and began yelling Individual #5's name.</p> <p>- 8/17/14 at 4:10 p.m.: Individual #5 saw Individual #1 and "started to moan and threw her cup of water. She started to get up to go after [Individual #1]. [Individual #1] began taunting [Individual #5] and calling her names. [Individual #5] said she would break all [Individual #1's] toys." A corresponding behavior log documented Individual #1 had called Individual #5 a "bitch" and a "butt head" and stated "I'm allowed to hurt you if you touch me."</p> <p>Individual #5's Behavioral Assessment documented potential causes of her maladaptive behavior as not liking her staff, not wanting to participate, being told no or to wait, mental conditions, to get what she wants and/or to avoid something she does not want, fear, a desire for attention and feeling sick.</p> <p>However, Individual #5's Behavioral Assessment did not contain information related to her pattern of interactions related to Individual #1.</p> <p>Additionally, Individual #5's Behavioral Assessment did not include information regarding</p>	W 214		
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W 214	<p>Continued From page 37</p> <p>how her behaviors related to individual #1 affected behavioral tracking and decisions (e.g. medication changes, programmatic development, etc.).</p> <p>For example, when individual #5 went to her room after conflict with individual #1 on 5/28/14, 5/29/14, 6/20/14, 6/28/14, 7/3/14, 7/24/14, 8/16/14, 8/17/14, it was unclear how the facility separated the time from individual #5 being in her room as uncooperative behavior compared to refusing to engage in tasks when she was out of her room (her BMP, dated 9/2014, defined uncooperative as refusing to engage in tasks or activities for periods longer than an hour).</p> <p>During interviews conducted across shifts on 9/23/14 from 10:20 a.m. - 3:10 p.m., staff were asked about individual #1 and individual #5's interactions. Staff stated the following:</p> <p>DCS A stated individual #5 could be aggressive to individual #1. The staff stated individual #5 would pick days to be mean or she would just hide in her room to avoid individual #1. Staff stated it was "out of control" and that individual #5 would just hear individual #1's voice and she (individual #5) would threaten her (individual #1).</p> <p>DCS B stated individual #5 could be aggressive towards individual #1, including throwing things at her. Staff stated individual #5 would threaten individual #1 and her family. DCS B stated individual #5 previously chose to eat at the kitchen counter to avoid individual #1 and she now ate outside on the back patio. Staff stated individual #5 went to her bedroom when individual #1 was home.</p>
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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 214	<p>Continued From page 38</p> <p>DCS C stated Individual #1 and Individual #5 did not get along. Staff stated Individual #5 came out of her bedroom when Individual #1 was gone and Individual #5 was in her bedroom when Individual #1 was home.</p> <p>During an interview conducted on 9/23/14 at 4:02 p.m., the Program Supervisor stated Monday through Friday while Individual #1 attended school, Individual #5 was out of her bedroom interacting with other individuals in the facility. However, Individual #5 watched the clock and 15 minutes before Individual #1 arrived home from school, Individual #5 returned to her bedroom. The Program Supervisor stated during the summertime, nights and weekends Individual #5 stayed in her bedroom to avoid Individual #1.</p> <p>However, Individual #5's Behavioral Assessment did not contain information related to her isolation.</p> <p>In an interview on 9/25/14 from 2:19 - 2:24 p.m., the AQIDP stated updated information related to Individual #5's interactions with Individual #1 and the subsequent interventions had not been included in Individual #5's Behavioral Assessment. The AQIDP stated Individual #5 had engaged in the same maladaptive behaviors prior to her placement at the facility and the effect Individual #1 had on Individual #5's behaviors was a factor that had been missed.</p> <p>During a follow-up interview on 10/2/14 from 1:54 - 1:58 p.m., the AQIDP stated the facility had changed the format of the Behavioral Assessment to ensure more comprehensive information was included. She stated in a recent record review, the QIDP of the facility identified</p>	W 214		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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(4) 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
214	Continued From page 39 that the old Behavioral Assessment was in use and the assessments needed revised.	W 214		
1227	The facility failed to ensure individual #1 and Individual #5's Behavioral Assessments contained comprehensive information on which to base program decisions. 483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's record included objectives to meet the needs for 1 of 4 individuals (Individual #5) whose PCLPs were reviewed. This resulted in a lack of program plans designed to address the needs of an individual. The findings include: 1. Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose diagnoses included mild intellectual disability. During interviews conducted across shifts on 9/23/14 from 10:20 a.m. - 3:10 p.m., staff were asked about Individual #1 and Individual #5's interactions. Staff stated the following: DCS A stated Individual #5 could be aggressive to Individual #1. The staff stated Individual #5 would pick days to be mean or she would just hide in	W 227		

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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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4) 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
1227	<p>Continued From page 40</p> <p>her room to avoid Individual #1. Staff stated it was "out of control" and that Individual #5 would just hear Individual #1's voice and she (Individual #5) would threaten her (Individual #1).</p> <p>DCS B stated Individual #5 could be aggressive towards Individual #1, including throwing things at her. Staff stated Individual #5 would threaten Individual #1 and her family. DCS B stated Individual #5 previously chose to eat at the kitchen counter to avoid Individual #1 and she now ate outside on the back patio. Staff stated Individual #5 went to her bedroom when Individual #1 was home.</p> <p>DCS C stated Individual #1 and Individual #5 did not get along. Staff stated Individual #5 came out of her bedroom when Individual #1 was gone and Individual #5 was in her bedroom when Individual #1 was home.</p> <p>During an interview conducted on 9/23/14 at 4:02 p.m., the Program Supervisor stated Monday through Friday while Individual #1 attended school, Individual #5 was out of her bedroom interacting with other individuals in the facility. However, Individual #5 watched the clock and 15 minutes before Individual #1 arrived home from school, Individual #5 returned to her bedroom. The Program Supervisor stated during the summertime, nights and weekends Individual #5 stayed in her bedroom to avoid Individual #1.</p> <p>However, Individual #5's PCLP was reviewed and did not contain an objective that addressed her isolation.</p> <p>In an interview on 9/25/14 from 2:19 - 2:24 p.m., the AQIDP stated updated information related to</p>	W 227		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83655
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(1) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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227	Continued From page 41 Individual #5's isolation and interactions with Individual #1 and the subsequent interventions had not been included in Individual #5's record. The AQIDP stated Individual #5 had engaged in the same maladaptive behaviors prior to her placement at the facility and the effect Individual #1 had on Individual #5's behaviors was a factor that had been missed.	W 227		
260	The facility failed to ensure Individual #5's PCLP included objectives for all of her identified needs. 483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure PCLPs were revised to reflect and respond to an individual's current needs and functional changes for 1 of 4 individuals (Individual #5) whose PCLPs were reviewed. This resulted in a PCLP which was not reflective of the individual's current status and needs. The findings include: 1. Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose diagnoses included mild intellectual disability. During an interview on 9/23/14 from 4:02 - 4:25 p.m., the Program Supervisor stated Individual #5 and Individual #1 were very close friends in the beginning of their time living together. She stated	W 260		

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NAME OF PROVIDER OR SUPPLIER REFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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260	<p>Continued From page 42</p> <p>there was an incident where Individual #1 touched Individual #5's belongings and from that moment on the relationship had declined.</p> <p>The Program Supervisor stated individual #5 used to bang her head when she heard Individual #1's voice. She stated there had been incidents when Individual #5 saw Individual #1 and began screaming, leading to banging her head. The Program Supervisor stated Individual #1 and Individual #5's interactions had been the worst since May/June 2014. She stated Individual #5 began verbally threatening to harm Individual #1's family if they visited the facility. The Program Supervisor stated during the summertime, nights and weekends Individual #5 stayed in her bedroom to avoid Individual #1.</p> <p>When asked during the same interview, what intervention strategies had been implemented in response to Individual #1 and Individual #5's altercations, the Program Supervisor stated after multiple attempts at alternative mealtime seating, Individual #5 had chosen to eat her meals outside. Additionally, staff encouraged Individual #5 to leave her bedroom as much as possible when Individual #1 was not home. However, Individual #5 would not come out of her room if she did not believe staff when they said Individual #1 was gone.</p> <p>Individual #5's PCLP was reviewed and did not contain any information related to Individual #5's preferences to stay in her bedroom or to eat outside to avoid Individual #1.</p> <p>During an interview on 9/24/14 from 12:18 -12:25 p.m., the QIDP stated she was aware of the isolation preference as well as Individual #5</p>	W 260		
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260	Continued From page 43 eating outside, however, she deferred to the AQIDP for specifics. In an interview on 9/25/14 from 2:19 - 2:24 p.m., the AQIDP stated updated information related to Individual #5's interactions with Individual #1 and the subsequent interventions had not been included in Individual #5's record. The AQIDP stated Individual #5 had engaged in the same maladaptive behaviors prior to her placement at the facility and the effect Individual #1 had on Individual #5's behaviors was a factor that had been missed. The facility failed to ensure Individual #5's PCLP was revised as needed to include updated information.	W 260		
/ 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure individuals' behavior	W 266		

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266	Continued From page 44 assessments included comprehensive information. 2. Refer to W227 as it relates to the facility's failure to ensure an individual had training objectives for all identified needs. 3. Refer to W260 as it relates to the facility's failure to ensure an individual's PCLP was updated as needed. 4. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into an individual's behavior programs. 5. Refer to W303 as it relates to the facility's failure to ensure individuals' records documented a clear understanding of the events before, during and after the use of restraints. 6. Refer to W407 as it relates to the facility's failure to ensure housing was arranged to promote the growth of all those residing together. The cumulative effect of these deficient practices significantly impeded the facility's ability to develop, consistently implement and closely monitor individuals' behavioral needs.	W 266		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.	W 289		

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289	<p>Continued From page 45</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into a program plan for 1 of 4 individuals (Individual #5) whose PCLPs were reviewed. This resulted in a lack of clear instruction to staff regarding how to implement the program strategies. The findings include:</p> <p>1. Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose diagnoses included mild intellectual disability.</p> <p>Individual #5's record included two BMPs, both revised 9/2014, which documented Individual #5 engaged in SIB, physical aggression, socially offensive behavior, destruction of property and uncooperative behavior. Individual #5's behavior plans were reviewed and did not include sufficient instructions to staff, as follows:</p> <p>During interviews conducted across shifts on 9/23/14 from 10:20 a.m. - 3:10 p.m., staff were asked about Individual #1 and Individual #5's interactions. Staff stated the following:</p> <p>DGS A stated Individual #5 could be aggressive to Individual #1. The staff stated Individual #5 would pick days to be mean or she would just hide in her room to avoid Individual #1. Staff stated it was "out of control" and that Individual #5 would just hear Individual #1's voice and she [Individual #5] would threaten her [Individual #1].</p>	W 289		
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - SUNSET		STREET ADDRESS, CITY, STATE, ZIP CODE 7691 BIRCH LANE NAMPA, ID 83688		
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)	(X3) COMPLETION DATE
289	<p>Continued From page 46</p> <p>DCS B stated individual #5 could be aggressive towards individual #1, including throwing things at her. Staff stated individual #5 would threaten individual #1 and her family. DCS B stated individual #5 previously chose to eat at the kitchen counter to avoid individual #1 and she now ate outside on the back patio. Staff stated individual #5 went to her bedroom when individual #1 was home.</p> <p>DCS C stated individual #1 and individual #5 did not get along. Staff stated individual #5 came out of her bedroom when individual #1 was gone and individual #5 was in her bedroom when individual #1 was home.</p> <p>When asked during an interview conducted on 9/23/14 from 4:02 - 4:25 p.m., what intervention strategies had been implemented in response to individual #1 and individual #5's interactions, the Program Supervisor stated the following:</p> <ul style="list-style-type: none"> - During the morning routine, staff tried offering individual #5 time in the office (separate from the residential area of the facility) to use the computer until individual #1 left for school so individual #5 did not have to hear her voice. That intervention was successful and still utilized. - Individual #5 was provided with headphones for her electronic tablet to block the sound of individual #1's voice. - The dining room seating was altered for individual #5 and individual #1 to sit on the same side of the table, at opposite ends, to avoid them seeing each other. However, the intervention failed due to individual #5 still being able to hear 	W 289		

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(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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289	<p>Continued From page 47 Individual #1.</p> <ul style="list-style-type: none"> - Staff tried serving Individual #5's meals at a table up against the wall in the dining area with her visibility of Individual #1 blocked with a mat, but that also failed. Individual #5 had since chosen to eat outside. - Individual #5's bedroom assignment was changed so that she no longer shared a Jack-and-Jill bathroom with Individual #1. - Staff encouraged Individual #5 to leave her bedroom as much as possible when Individual #1 was not home per the Program Supervisor's training at a 7/23/14 staff meeting. - Staff attempted to utilize a mat to block Individual #1 from Individual #5's line of sight. Staff have since taught Individual #5 to cover her eyes when she needs to leave her bedroom, such as for medication administration, to avoid seeing Individual #1. <p>During the same interview, the Program Supervisor stated she was not sure when each intervention had been implemented or for how long, but stated the information should be present in Individual #5's plans.</p> <p>However, no documentation related to the implemented interventions could be located in Individual #5's plans.</p> <p>During an interview on 9/24/14 from 12:18 - 12:25 p.m., the QIDP stated she was not sure how Individual #5's plan incorporated the interventions implemented related to her interactions with Individual #1. The QIDP stated the AQIDP was in</p>	W 289		
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289	Continued From page 48 the facility each day and knew more about individual #5's behaviors. In an interview on 9/25/14 from 2:19 - 2:24 p.m., the AQIDP stated updated information related to Individual #5's interactions with Individual #1 and the subsequent interventions had not been included in Individual #5's record. The AQIDP stated Individual #5 had engaged in the same maladaptive behaviors prior to her placement at the facility and the effect Individual #1 had on Individual #5 behaviors was a factor that had been missed. The facility failed to ensure Individual #5's BMPs provided sufficient direction to staff to consistently address her maladaptive behaviors.	W 289		
303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a record of restraint was maintained for 1 of 4 individuals (Individual #5) whose PCLPs were reviewed. Failure to keep a comprehensive record of restraint usage impeded the ability of the IDT, the facility's HRC and an individual's guardians to make informed decisions and/or recommendations regarding the use of restraint. The findings include: 1. Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose diagnoses included mild	W 303		

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303	<p>Continued From page 49 intellectual disability.</p> <p>Individual #5's record contained a BMP, revised 9/20/14, which stated she engaged in physical aggression which was defined as hitting, kicking or throwing objects at others. The BMP documented "For the safety of others in (Individual #5's) environment she may need to be escorted back to her room. Staff will assist (Individual #5) in walking by holding her hands/arm ..."</p> <p>Individual #5's behavior logs from 4/15/14 to 9/7/14 were reviewed. The data did not document a clear understanding of the events before, during and after the use of restraints, as follows:</p> <ul style="list-style-type: none"> - 5/22/14 at 7:00 p.m.: Individual #5 saw Individual #1 dancing in the living room, screamed and threw her plate on the floor. Staff escorted Individual #5 to her bedroom while another staff helped block Individual #5's view of Individual #1. <p>No additional information related to the events before, during and after the use of the escort could be found.</p> <ul style="list-style-type: none"> - 5/28/14 at 5:00 p.m.: Individual #5 was asked to come to the dinner table, which she did. Individual #1 and Individual #5 were staring at each other across the table and Individual #5 began "crying, grabbing, getting upset." Individual #5 broke her glasses, threw them across the table, and was walked to her bedroom by three staff. One staff remained in the bedroom with individual #5 until she calmed down. Individual #5 and the staff then returned to 	W 303		
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303	<p>Continued From page 50</p> <p>the dinner table and Individual #5 again began crying, hitting staff and attempting to throw things. "[Individual #5] was again assisted back to her room." The ABC Behavior Log also documented Individual #5 had been placed in a "1 person standing arm control" restraint from 5:05 - 5:08 p.m.</p> <p>Clear information related to the staff involved in the restraints or events before, during and after the use of the escort and arm control restraint was not evident.</p> <p>- 6/28/14 at 8:06 p.m.: Individual #5 wanted to eat a snack outside and was told she could not. She heard Individual #1's voice and attempted to throw her cup at Individual #1. Individual #5 began yelling and pinching, scratching, biting and grabbing at staff. The other individuals were "taken from the room by staff." Individual #5 moved her chair across the floor to the back door so she could see Individual #1 through the window. Individual #5 was "screaming 'I am going to kill you, kill your mother, stab her with a knife, she is a whore, she is ugly and fat. I am going to kill your whole family. Give me a knife so I can kill her.'" Individual #5 was physically restrained by staff until she calmed. Staff documented "I believe [Individual #5] would have seriously hurt [Individual #1] if she was not kept still." The ABC Behavior Log also documented staff tried "Deflect and Redirect" 30 times and Individual #5 had been placed in an unknown restraint from 8:10 - 8:25 p.m., a "1 person standing body control" restraint from 8:25 - 8:35 p.m., and a 1 person sitting arm control from 8:35 - 8:45 p.m.</p> <p>Clear information related to the staff involved in</p>	W 303		
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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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303	Continued From page 51 each of the restraints or events before, during and after the use of the restraints was not evident. - 7/16/14 at 10:00 a.m.: Individual #5 saw Individual #1 and "tried to charge [Individual #1]..." The ABC Behavior Log documented "she was no longer being safe & implemented 1 arm restraint." The Type of Restraint Utilized section included the use of a 1 person standing arm control restraint from 10:10 - 10:13 a.m. Clear information related to the staff involved in each of the restraints or events before, during and after the use of the restraints was not evident. When asked during a follow-up interview on 10/16/14 from 10:04 - 10:10 a.m., the AQIDP stated information related to restraints was kept in two different binders and the information had not been compared for accuracy. The facility failed to ensure an accurate record of restraint was maintained for Individual #5.	W 303		
407	483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were housed to promote their growth,	W 407		

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

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83666
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4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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407	<p>Continued From page 52</p> <p>independence and development for 2 of 5 individuals (Individuals #1 and #5) residing at the facility. This resulted in individuals residing together despite continued conflict. The findings include:</p> <p>1. Individual #5's 6/9/14 Annual Nursing Summary documented she was a 21 year old female whose diagnoses included mild intellectual disability.</p> <p>Individual #1's PCLP, dated 3/19/14, documented a 12 year old female whose diagnoses included mild intellectual disability.</p> <p>During interviews conducted across shifts on 9/23/14 from 10:20 a.m. - 3:10 p.m., staff were asked about Individual #1 and Individual #5's interactions. Staff stated the following:</p> <p>DCS A stated Individual #5 could be aggressive to Individual #1. The staff stated Individual #5 would pick days to be mean or she would just hide in her room to avoid Individual #1. Staff stated it was "out of control" and that Individual #5 would just hear Individual #1's voice and she (Individual #5) would threaten her (Individual #1).</p> <p>DCS B stated Individual #5 could be aggressive towards Individual #1, including throwing things at her. Staff stated Individual #5 would threaten Individual #1 and her family. DCS B stated Individual #5 previously chose to eat at the kitchen counter to avoid Individual #1 and she now ate outside on the back patio. Staff stated Individual #5 went to her bedroom when Individual #1 was home.</p> <p>DCS C stated Individual #1 and Individual #5 did</p>	W 407		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET		STREET ADDRESS, CITY, STATE, ZIP CODE 7891 BIRCH LANE NAMPA, ID 83686	

4) 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
1407	<p>Continued From page 53</p> <p>not get along. Staff stated Individual #5 came out of her bedroom when Individual #1 was gone and Individual #5 was in her bedroom when Individual #1 was home.</p> <p>Staff encouraged Individual #5 to leave her bedroom as much as possible when Individual #1 was not home. However, the Program Supervisor stated Individual #5 would not come out of her room if she did not believe staff when they said Individual #1 was gone. Monday through Friday while Individual #1 was in school, Individual #5 was out of her bedroom interacting with other individuals in the facility. However, Individual #5 watched the clock and 15 minutes before Individual #1 arrived home from school, Individual #5 returned to her bedroom.</p> <p>Further, the Program Supervisor stated she requested the assistance of the Positive Behavior Support Specialist. He had completed observations at the facility at the end of August 2014. At that time, it was discussed that Individual #5 may not be an appropriate fit for the facility. However, a report with recommendations had not yet been received from the Positive Behavior Support Specialist.</p> <p>Additionally, the Program Supervisor provided an email, dated 8/18/14, which she had written to Individual #5's contact in another state. The email documented Individual #5's behaviors were "affecting the entire house. At this point she is bullying and attempting to hurt a child and that is not ok and is a huge risk for our company. She is not happy here and continues to act out and be verbally and physically aggressive to an individual that is much younger than [sic] her. It has got [sic] to the point that we can't even let this other</p>	W 407		

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NUMBER OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2014
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NAME OF PROVIDER OR SUPPLIER TRANSFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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IC DEFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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407 Continued From page 54

Individuals [sic] mother in the house because [Individual #5] attempts to assault her and threatens to kill her which in turn makes the other resident very upset. It is time that [Individual #5] [sic] parents start looking for other placement for her because [name of company] is no longer able to serve her in a way that benefits her. We will do what ever we need to do to help with this process and we understand that it will not happen tomorrow but we would like her parents to start actively looking..."

On 9/24/14 at approximately 9:00 a.m., the Program Supervisor provided a "Positive Behavior Support Observation Report," dated 9/23/14. The report documented the Positive Behavior Support Specialist had conducted observations at the facility on 8/7/14 and 9/2/14. Under the "Recommendation(s)" section, the report stated "Additional discussion should be had related to [Individual #5's] potential transition to a lower level of care; this may include placements within Idaho or other states. In addition, it appears that [Individual #5] feels strongly about her younger roommate; the team should explore alternative options for [Individual #5's] placement to separate the two individuals."

During an interview on 9/24/14 from 11:35 - 11:45 a.m., the Program Manager stated he was aware that Individual #5 targeted Individual #1. He stated the Program Supervisor had put measures in place to avoid physical assaults. The Program Manager stated he was aware that Individual #5 spent a lot of time in her bedroom and discharging Individual #5 had been discussed.

The City Director stated, during an interview on 9/24/14 from 11:48 - 11:55 a.m., there had been

W 407

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(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 - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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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
407	<p>Continued From page 55</p> <p>struggles between individual #1 and individual #5 in the past. She stated the team had discussed if individual #1 and individual #5 were appropriate to live together. The City Director stated they had discussed discharging individual #5, but notice was never given.</p> <p>The facility failed to ensure housing was arranged to promote the growth of all those residing together.</p>	W 407		

ureau of Facility Standards

STATEMENT OF DEFICIENCIES (1) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/29/2014
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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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4) 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 Henscheld, QIDP, Team Lead Jim Troutfetter, QIDP	M 000		
IM126	16.03.11.050.03(b) Changes in Mental or Physical Conditions Change in Resident Status. Any change in the status of a resident will be regulated as follows: As changes occur in their physical or mental conditions, necessitating services or care not regularly provided by the facility, residents must be transferred to a facility which provides the appropriate services. This Rule is not met as evidenced by: Refer to W407.	MM126		
AM169	16.03.11.075.07(b)(i) Grievances The facility must have a written procedure for registering and resolving grievances and recommendations by residents or any individual or group designated by the resident as his representative. The procedure must ensure protection of the resident from any form of reprisal or intimidation. The written procedure must include: That the administrator or his designee must handle grievances and recommendations; and This Rule is not met as evidenced by: Refer to W153.	MM169		

ureau of Facility Standards
 RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Tom M...

Program Manager 10/30/14

ureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/29/2014
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NAME OF PROVIDER OR SUPPLIER REFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE 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
MM177	<p>16.03.11.075.09 Protection from Abuse and Restraint</p> <p>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).</p> <p>This Rule is not met as evidenced by: Refer to W122 and W149.</p>	MM177		
MM197	<p>16.03.11.075.10(d) Written Plans</p> <p>Is described in written plans that are kept on file in the facility; and</p> <p>This Rule is not met as evidenced by: Refer to W289.</p>	MM197		
MM212	<p>16.03.11.075.17(a) Maximize Developmental Potential</p> <p>The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and</p> <p>This Rule is not met as evidenced by: Refer to W266.</p>	MM212		
MM513	<p>16.03.11.200.01 Governing Body</p> <p>Each facility will be organized and administered</p>	MM513		

ureau of Facility Standards

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/29/2014
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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7591 BIRCH LANE NAMPA, ID 83686
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4) 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
MM513	Continued From page 2 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 W102 and W104.	MM513		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159 and W260.	MM725		
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data	MM730		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2014
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NAME OF PROVIDER OR SUPPLIER DEFERRED COMMUNITY HOMES - SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 7691 BIRCH LANE NAMPA, ID 83686
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(4) 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
M730	Continued From page 3 Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		



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 21, 2014

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

RE: Preferred Community Homes - Sunset, Provider #13G052

Dear Ms. Thomas:

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

Complaint #ID00006625

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, facility policies and procedures, Incident and Accident reports and resident records were reviewed. Observations and staff interviews were also completed.

The governing body did not ensure policies were implemented and monitored, as follows:

The facility's Governing Body policy, dated 1/9/13, documented the facility governing body was comprised of the following staff: the Program Manager, Program Supervisor, Program Director, Director of Nursing, QIDP, AQIDP, LPN or any other staff designated by the City Director. The policy documented the corporate governing body included the City Director, Regional Director, Idaho State Director, Chief Financial Officer, Senior Vice President, Chief Operating Officer and Chief Executive Officer.

The facility also employed a Positive Behavior Support Specialist. When asked, the City Director stated on 9/24/14 at 11:55 a.m., the Positive Behavior Support Specialist's direct supervisor was the Idaho State Director. The Idaho State Director failed to provide monitoring and oversight of the Positive Behavior Support Specialist, necessary to ensure an individual's interdisciplinary team received written reports in a timely fashion, as follows:

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October 21, 2014
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During an interview conducted on 9/23/14 at 4:02 p.m., the Program Supervisor stated that in response to a pattern of negative interactions between two individuals in the facility, the assistance of the Positive Behavior Support Specialist was requested. She stated the Positive Behavior Support Specialist completed observations in the facility at the end of August 2014. However, a report with recommendations had not yet been received from the Positive Behavior Support Specialist.

On 9/24/14 at approximately 9:00 a.m., the Program Supervisor provided a "Positive Behavior Support Observation Report," dated 9/23/14. The report documented the Positive Behavior Support Specialist had conducted observations at the facility on 8/7/14 and 9/2/14. The report did not include information explaining the delay between observations or the delay in generating the written report.

During an interview on 9/24/14 from 11:58 a.m. - 12:00 p.m. the Idaho State Director stated he met with the Positive Behavior Support Specialist "on a fairly consistent basis." The Idaho State Director stated he was made aware of observations conducted by the Positive Behavior Support Specialist regardless of the completion of the report.

The facility's governing body failed to provide sufficient monitoring and oversight of the Positive Behavior Support Specialist.

The facility's Behavior Support Hierarchy & Definitions policy, revised 8/14/14, stated open-handed physical blocking was to be utilized for up to 3 minutes, per Mandt guidelines and physical release methods included in the Mandt system included bite release, hair pull release, clothing release and finger hold release as well as head stabilization principles.

However, the supportive restraints section of the plan stated Therapeutic Options supportive restraints were to be used.

Additionally, the facility's Incident and Accident Reporting policy, revised 7/15/12, stated staff required to complete an Incident/Accident Report for various incidents including "Supportive Resstraint Injury: Any injury that is the result of a supportive restraint (MANDT restraint) The facility's policies were not consistent in which restraint system (Mandt or Therapeutic Options) was to be used.

The facility's governing body failed to ensure policies provided consistent direction to staff.

The governing body failed to ensure policies were sufficiently implemented and monitored. Therefore, the allegation was substantiated and deficient practice was cited at W102 (42 CFR 483.410), W104 (42 CFR 483.410(a)(1)) and M513 (IDAPA 16.03.11.200.10).

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 was conducted from 9/22/14 - 9/29/14. During that time, facility policies and procedures, Incident and Accident reports and resident records were reviewed. Observations and staff interviews were also completed.

During observations on 9/22/14 from 2:10 - 3:00 p.m. and 4:52 - 5:30 p.m. and on 9/23/14 from 1:45 - 2:25 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. Two of the individuals attended school from 8:30 a.m. - 3:30 p.m. and the other sample individual worked at an animal shelter three times a week from approximately 12:00 - 3:00 p.m.

The outing records from 9/2/14 - 9/24/14 were reviewed for each of the individuals. The records documented various activities including trips to the movies, animal shelter, to go shopping and a 42-minute van ride for one individual.

When asked about van rides, during interviews on 9/23/14 between 10:20 a.m. and 3:10 p.m., five direct care staff stated outings occurred on a regular basis. Three of the staff stated van rides were utilized for certain individuals in the facility as a calming technique. The staff estimated the van rides occurred 0 - 2 times per week. Each of the staff described how individuals residing in the facility were regularly kept engaged. For example, each staff reported outside activities took place weekly and 4 of the 5 staff described the weekly schedule for those events.

Therefore, based on a lack of sufficient evidence, 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, facility policies and procedures, Incident and Accident reports and resident records were reviewed. Observations and staff interviews were also completed. During an interview on 9/22/14 at approximately 10:00 a.m., the Administrator stated seven 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.

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Facility As Worked Schedules, dated 5/1/14 - 9/20/14, were reviewed and documented sufficient staff on all shifts.

Observations were conducted on 9/22/14 from 2:10 - 3:00 p.m. and 4:52 - 5:30 p.m. and on 9/23/14 from 1:45 - 2:25 p.m. During that time, no concerns with staffing ratios were observed.

Interviews were conducted with five facility staff on 9/22/14 and 9/23/14. One staff stated shifts were occasionally run with 4 staff and she preferred to have 5 staff on each shift. The other 4 staff stated each shift had a sufficient number of staff to meet individuals' needs.

It could not be determined that the facility had insufficient staff to meet client needs. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

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

Findings #4: An unannounced, on-site complaint investigation was conducted from 9/22/14 - 9/29/14. During that time, facility policies and procedures, Incident and Accident reports and resident records were reviewed. Observations and staff interviews were also completed.

Four individuals were selected for review. Three individuals had assessed behavioral needs related to physical aggression. Three individuals also had assessed needs for verbal aggression. The individual's records contained plans with instructions to staff related to their maladaptive behaviors. One individual's plans did not include comprehensive information related to current interventions and deficient practice was cited at W289 (42 CFR 483.450(b)(4)) and M197 (IDAPA 16.03.11.075.10(d)).

Observations were conducted on 9/22/14 from 2:10 - 3:00 p.m. and 4:52 - 5:30 p.m. and on 9/23/14 from 1:45 - 2:25 p.m. During that time, no individual-to-individual assaults were observed.

Interviews were conducted with eight facility staff from 9/22/14 to 9/25/14. Each of the staff stated individual-to-individual assaults had been worse in the past, but were currently not an issue.

Facility Incident/Accident Reports and investigations, dated 4/12/14 - 9/22/14, were reviewed. Incident/Accident Reports documented multiple incidents of individual-to-individual verbal assault. However, for each of the incidents, staff documented those present at the time, as well as interventions utilized and no concerns were identified.

Megan Thomas, Administrator

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Facility behavior data, dated 4/15/14 - 9/7/14, was reviewed. The behavior data also documented multiple incidents of individual-to-individual verbal assault. For each of the incidents, staff documented those present at the time, as well as interventions utilized.

Review of Incident/Accident Reports and behavior data revealed a pattern of verbal, and attempted physical, altercations between two individuals in the facility. Though staff implemented plans as written during each incident, the facility failed to identify and correct the pattern of on-going abuse. Therefore, the allegation was substantiated and the facility was cited at W122 (42 CFR 483.420), W149 (42CFR 483.420(d)(1) and M177 (IDAPA 16.03.11.075.09).

Conclusion #4: Substantiated. Federal and State deficiencies related to the allegation are cited.

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