



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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December 26, 2013

Wanda Huber, Administrator
Preferred Community Homes - Bedford
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Bedford, Provider #13G039

Dear Ms. Huber:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Bedford, which was conducted on December 20, 2013.

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

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

Wanda Huber, Administrator
December 26, 2013
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being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **January 7, 2014**, and keep a copy for your records.

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

www.icfmr.dhw.idaho.gov

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

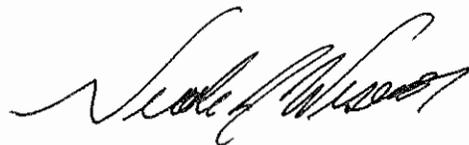
This request must be received by January 6, 2014. If a request for informal dispute resolution is received after January 6, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pt
Enclosures

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

PRINTED: 12/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2013
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - BEDFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 398 EDGAR COURT MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 12/16/13 - 12/20/13. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN Common abbreviations used in this report are: CDC - Centers for Disease Control IDT - Interdisciplinary Team IPP - Individualized Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record NOS - Not Otherwise Specified QIDP - Qualified Intellectual Disability Professional WIC - Written Informed Consent	W 000	See attached plan. Pen + ink change per Program Manager. - M. Case, LSW, QIDP 1.13.14	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 1 of 3 individuals (Individual #1)	W 124	RECEIVED JAN - 7 2014 FACILITY STANDARDS	

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

Tom M...

TITLE

Program Manager

(X6) DATE

1/7/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	<p>Continued From page 1</p> <p>whose written informed consents were reviewed. This resulted in a lack of accurate information being provided to an individual's guardian regarding drugs used for behavioral control. The findings include:</p> <p>1. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder. His Physician's Orders, dated 9/24/13, stated he received Sertraline (an antidepressant drug) 25 mg daily.</p> <p>Individual #1's record contained a WIC for Sertraline, dated 11/18/13. However, the WIC did not include accurate information, as follows:</p> <p>a. Under the "Description Of and Justification for Medication" section, the WIC stated Sertraline was used to "manage depressive type symptoms related to his diagnosis of Depression. These symptoms included; crying without precursors, very loud vocalizations, and increased agitation."</p> <p>Individual #1's Behavioral Assessment, revised 11/25/13, stated he had a diagnosis of depression NOS exhibited by loud vocalizations, excessive rocking, lack of interest in activities, increased or decreased appetite, increased sleepiness, and crying for no apparent reason.</p> <p>Individual #1's assessed signs and symptoms of depression did not include agitation.</p> <p>b. Under the "Description Of and Justification for Medication" section, the WIC stated Individual #1 underwent a medication reduction in October 2013."</p>	W 124		

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W 124	Continued From page 2 However, Individual #1's MAR documented Individual #1's medication reduction for Sertraline did not start until 11/1/13. c. Under the "Description Of and Justification for Medication" section, the WIC stated "It has been recorded that he has been demonstrating an increase in the following behaviors over the course of four weeks; forcibly pulling and pushing staff to the point of falling 6x, hitting staff in the face 1x, attempted to choke staff 1x, and attempted an assault to a peer 1x." However, during the four weeks prior to the 11/18/13 WIC, Individual #1's record only documented one maladaptive behavior, dated 11/3/13, two days after the start of his medication reduction. The documentation stated Individual #1 was "ramming" into staff and other individuals and laughing. During an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP stated she had been trying to link the use of Sertraline to aggression for Individual #1. The QIDP stated the information in the WIC was not accurate and needed to be revised.	W 124			
W 159	The facility failed to ensure Individual #1's WIC for Sertraline contained accurate information. 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.	W 159			

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W 159	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 3 of 3 individuals (Individuals #1 - #3), and had the potential to impact all individuals residing at the facility (Individuals #1 - #5). This failure resulted in a lack of sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of assessments, programing, monitoring and protection of rights. The findings include:</p> <p>1. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder. His Physician's Orders, dated 9/24/13, stated he received Sertraline (Zoloft - an antidepressant drug) 25 mg daily.</p> <p>Individual #1's use of Zoloft was not adequately monitored and assessed, as follows:</p> <p>a. Individual #1's record documented Zoloft was originally prescribed 4/15/10 due to concerns of depression, and used to decrease isolation and withdrawal symptoms and increase engagement with peers and staff in therapeutic activities.</p> <p>Individual #1's Behavior Assessment, revised 11/25/13, defined depressive type symptoms as loud vocalizations, excessive rocking, lack of interest in activities, increased or decreased appetite, increased sleepiness, and crying for no apparent reason.</p> <p>However, Individual #1's record did not include</p>	W 159		

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W 159	<p>Continued From page 4</p> <p>summary information related to depressive type symptoms until November 2013. It was not clear how Individual #1's depressive type symptoms were being monitored and tracked.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP stated there was no summary data related to Individual #1's depressive type symptoms prior to November 2013. The QIDP stated all information reported to the psychiatric provider had been based on anecdotal data from staff rather than documented incidents.</p> <p>b. Individual #1's MAR documented his Zoloft was reduced from 25 mg to 12.5 mg on 11/1/13 and discontinued on 11/14/13 (last dose received that day). A Nursing Progress Notes, dated 10/18/13, stated Individual #1 was evaluated in the psychiatric clinic and Zoloft was to be decreased and discontinued, but no information related to the reason for the reduction was given. Additionally, no psychiatric progress notes for the 10/18/13 appointment were present in the record.</p> <p>A decision was made to decrease Individual #1's Zoloft with no clear rationale.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP was unable to explain why Individual #1's Zoloft had been decreased and discontinued.</p> <p>c. Individual #1's MAR documented Zoloft was restarted on 11/19/13 (4 days after it was discontinued) at 12.5 mg and returned to 25 mg on 11/26/13.</p> <p>A Nursing Progress Notes, dated 11/14/13, stated</p>	W 159			

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W 159	<p>Continued From page 5</p> <p>Individual #1 "was evaluated in Psych Clinic by [name of practitioner] - since [discontinuation] of Sertraline he has had increase in agitation impulsiveness [and] anxiety - today order received to resume Sertraline [sic] 25 mg - 1/2 [tablet orally daily for one week] then 1 [tablet orally daily]."</p> <p>A corresponding Psychiatric Update, dated 11/14/13, stated Sertraline was being resumed due to increased anxiety, irritability, and agitation since the drug had been discontinued.</p> <p>However, a review of Individual #1's data documented one episode of maladaptive behavior, dated 11/3/13, where he was "ramming" into staff and other individuals and then laughing.</p> <p>Individual #1's record did not include documentation that supported he had experienced an increase in maladaptive behavior.</p> <p>Additionally, Individual #1's record included documentation that he had all his lower teeth extracted during two appointments, on 8/26/13 and 10/7/13. Further, a neurology report, dated 10/14/13, stated Individual #1's Lamictal (an anticonvulsant drug) was being decreased due to ataxia (being unsteady on his feet).</p> <p>However, Individual #1's record did not include information that his teeth extraction and decrease in Lamictal had been taken into consideration in relation to a reduction in Zoloft. Additionally, Individual #1's record did not include evidence supportive measures (increased reinforcement, environmental changes, increase or implementation of calming activities, etc.) had been implemented to assist Individual #1 during</p>	W 159		

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W 159	<p>Continued From page 6 the reduction of Zoloft.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP stated information related to Individual #1's dental extractions and changes in seizure medications had not been taken into consideration when Zoloft was reduced. The QIDP stated no additional efforts to support Individual #1 through the reduction process had been implemented.</p> <p>The facility failed to ensure the QIDP ensured appropriate monitoring and assessment was in place related to Individual #1's use of Zoloft.</p> <p>2. Refer to W124 as it relates to the facility's failure to ensure the QIDP ensured an individual's WIC included accurate information.</p> <p>3. Refer to W207 as it relates to the facility's failure to ensure the QIDP ensured appropriate members of the IDT were present for IPP meetings.</p> <p>4. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured an individual's behavior assessment included accurate information.</p> <p>5. Refer to W312 as it relates to the facility's failure to ensure the QIDP ensured drugs to control maladaptive behaviors were appropriately incorporated into an individual's plan.</p> <p>6. Refer to W313 as it relates to the facility's failure to ensure the QIDP ensured the risk of an individual's maladaptive behavior outweighed the potential side effects of a drug used to control that behavior.</p>	W 159		

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W 207	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN</p> <p>Appropriate facility staff must participate in interdisciplinary team meetings.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure appropriate facility staff participated in the IPP meetings for 2 of 3 individuals (Individuals #2 and #3) whose IPPs were reviewed. This resulted in the potential for a lack of comprehensive information being provided in the development of the IPP and a lack of opportunities for the IDT members to consult with one another and to exchange information. The findings include:</p> <p>1. Individual #2 and #3's IPPs were reviewed and showed the following:</p> <p>a. Individual #2's 1/24/13 IPP stated he was a 52 year old male whose diagnoses included profound intellectual disability, spastic quadriplegia, seizure disorder, congenital blindness and a hearing disorder.</p> <p>There was no signature sheet attached to his IPP documenting which members of the IDT attended the IPP meeting on 1/24/13.</p> <p>b. Individual #3's 1/24/13 IPP stated she was a 61 year old female whose diagnoses included mild intellectual disability, cerebral palsy, spastic quadriplegia, and osteoporosis.</p> <p>There was no signature sheet attached to her IPP documenting which members of the IDT attended the IPP meeting on 1/24/13.</p>	W 207		

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W 207	Continued From page 8 During an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP stated there was no signature sheet for attendance at the meeting. She confirmed it was not possible to determine who had been at the meeting.	W 207		
W 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 behavioral assessments contained comprehensive information for 1 of 3 individuals (Individual #1) whose assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder. Individual #1's Behavioral Assessment, dated 11/25/13, stated he engaged in physical aggression, the definition of which included pushing or pulling others. Under the "Weaknesses" section, the Assessment stated Individual #1 "doesn't communicate dislikes appropriately (pushes)..."	W 214		

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W 214	Continued From page 9 Individual #1's Speech and Language Annual Report, dated 6/23/13, stated he was a non verbal communicator and demonstrated limited understanding of spoken language. The Report stated "he will physically lead a communication partner to a desired area or activity in the home setting." However, Individual #1's Behavioral Assessment did not indicate how staff were to differentiate between pushing (communicating dislikes) and pulling (communicating desired area or activity) as forms of communication verses maladaptive behavior. During an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP stated information related to differentiating between Individual #1's communication and maladaptive behavior was not present in the assessment. The facility failed to ensure Individual #1's Behavior Assessment contained comprehensive information.	W 214		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure	W 312		

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W 312	<p>Continued From page 10</p> <p>behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drug was employed for 1 of 1 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving behavior a modifying drug without plans that identified the drugs usage and how it may change in relation to progress or regression. The findings include:</p> <p>1. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder. His Physician's Orders, dated 9/24/13, stated he received Sertraline (an antidepressant drug) 25 mg daily.</p> <p>Individual #1's Psychiatric Update, dated 11/14/13, stated Zoloft was being prescribed due to increased anxiety, irritability, and agitation.</p> <p>However, Individual #1's Medication Reduction Plan, dated 12/16/13, stated Zoloft was being used for depression, defined in his 11/25/13 Behavior Assessment as loud vocalizations, excessive rocking, lack of interest in activities, increased or decreased appetite, increased sleepiness, and crying for no apparent reason.</p> <p>When asked about the discrepancy in use, during an interview on 12/19/13 from 10:40 - 11:55 a.m., the QIDP and Program Manager both stated Individual #1 had been on Zoloft for depression and the current use needed to be clarified.</p> <p>The facility failed to ensure Individual #1's Zoloft</p>	W 312		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - BEDFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 398 EDGAR COURT MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312 W 313	<p>Continued From page 11 was appropriately incorporated into a plan.</p> <p>483.450(e)(3) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.</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 behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs for 1 of 1 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without the necessary justification. The findings include:</p> <p>1. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder. His December MAR documented he received Zoloft (an antidepressant drug) 25 mg daily.</p> <p>Individual #1's record contained a Psychiatric Update, dated 11/14/13, that stated Zoloft was being resumed due to increased anxiety, irritability, and agitation since the drug had been discontinued.</p> <p>However, a review of Individual #1's data documented one episode of maladaptive behavior, dated 11/3/13, where he was "ramming" into staff and other individuals and then laughing.</p>	W 312 W 313		

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W 313	Continued From page 12 The documentation did not indicate any injury to the staff or other individuals. The Nursing 2013 Drug Handbook stated the potential side effects of Zoloft included, but were not limited to, fatigue, headache, tremor, dizziness, insomnia, somnolence (drowsiness), suicidal behavior, paresthesia (pain or burning sensation in the skin), hypesthesia (diminished sensation in the skin), nervousness, anxiety, agitation, hypertonia (muscular rigidity), chest pain, dry mouth, nausea, diarrhea, vomiting, and constipation. Individual #1's record did not document that the risk of his anxiety, irritability, and agitation outweighed the potential side effects of Zoloft. During an interview on 12/19/13 from 10:40 - 11:55 a.m., the Program Manager and QIDP both stated there was no documentation to support Individual #1's maladaptive behavior outweighed the potential side effects of Zoloft. The facility failed to ensure Individual #1's Zoloft was not used until the severity of the behavior was shown to outweigh the associated risks of the drug.	W 313			
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure	W 322			

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W 322	<p>Continued From page 13</p> <p>individuals were provided with general and preventative medical care for 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in individuals not receiving bone density scans as recommended. The findings include:</p> <p>1. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder.</p> <p>Individual #1's record included a bone density scan, dated 7/9/12, which stated "Fracture risk is high. A follow up DXA [sic] [bone density] test is recommended in one year to monitor response to therapy."</p> <p>However, Individual #1's record did not include additionally testing.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the LPN stated she was not sure if a repeat bone density test had been completed and referred to the staff that scheduled medical appointments. The staff who scheduled medical appointments, who joined the interview, stated a repeat bone density scan had not been scheduled because the 7/9/12 test stated a follow up would be to "monitor response to therapy." However, no therapy had been initiated as Individual #1 was already on calcium.</p> <p>The facility failed to ensure Individual #1's low bone density was monitored.</p> <p>2. Individual #2's 1/24/13 IPP stated he was a 52 year old male whose diagnoses included profound intellectual disability, spastic</p>	W 322			

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W 322	<p>Continued From page 14</p> <p>quadriplegia, seizure disorder, congenital blindness and a hearing disorder.</p> <p>Individual #2's record included a bone density scan, dated 8/13/12, that stated it should be repeated in one year. However, no additional testing could be located.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the LPN stated the testing had not yet been completed.</p> <p>The facility failed to ensure Individual #2's follow up bone density screening had been completed.</p> <p>3. Individual #3's 1/24/13 IPP stated she was a 61 year old female whose diagnoses included mild intellectual disability, cerebral palsy, spastic quadriplegia, and osteoporosis.</p> <p>Individual #3's record included a bone density test, dated 11/9/12, which stated it was to be repeated in one year. Additionally, Individual #3 was to be treated with Fosamax (an antiosteoporotic drug) 70 mg.</p> <p>However, Individual #3's Fosamax was discontinued 11/21/13 and there was no additional bone density screening in her record.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the LPN stated the follow up had not been completed at the year mark due to a delay in scheduling the appointment. An appointment had been scheduled for the first part of December 2013 for follow up, but had to be canceled. The LPN stated follow up would be completed in January 2014.</p>	W 322		
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W 322	Continued From page 15 The facility failed to ensure Individual #3's bone density screening had been completed as recommended.	W 322			
W 324	483.460(a)(3)(ii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 3 individuals (Individual #3) whose medical records were reviewed. This resulted in the potential for preventable illness to occur. The findings include: The CDC stated Shingles is a painful localized skin rash often with blisters that is caused by the varicella zoster virus (VZV), the same virus that causes chickenpox. Shingles most commonly occurs in people 50 years old and older, people who have medical conditions that keep the immune system from working properly, or people who receive immunosuppressive drugs. The CDC stated a Shingles (Zoster) vaccine is recommended by the Advisory Committee on Immunization Practices to reduce the risk and its associated pain in people 60 years old and older. The CDC recommended all persons aged 60 and	W 324			

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W 324	Continued From page 16 above who have no contraindications, including persons who report a previous episode of zoster or who have chronic medical conditions, receive the vaccination. Individual #3's 1/24/13 IPP stated she was a 61 year old female whose diagnoses included mild intellectual disability, cerebral palsy, spastic quadriplegia, and osteoporosis. Individual #3's record did not include documentation she had received a Zoster vaccination, or that a discussion related to the need for the vaccination had been conducted with her physician. During an interview on 12/19/13 from 10:40 - 11:55 a.m., the LPN stated a Zoster vaccination had not been obtained for Individual #3 due to an oversight.	W 324			
W 336	The facility failed to ensure Individual #3's record reflected she had received immunizations as recommended by the Public Health Service Advisory Committee. 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure nursing reviews had been completed on a	W 336			

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W 336	<p>Continued From page 17</p> <p>quarterly basis for 2 of 3 individuals (Individuals #1 and #2) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include:</p> <p>1. Individual #1 and #2's records were reviewed and documented the following:</p> <p>a. Individual #1's 7/9/13 IPP stated he was a 49 year old male whose diagnoses included severe intellectual disability, mood disorder NOS, depression NOS, and seizure disorder.</p> <p>Individual #1's record documented quarterly nursing reviews were completed on 10/24/13, 5/1/13, and 2/1/13. However, the review dated 8/22/13 was incomplete and referenced an History and Physical dated 5/22/13. There was no completed assessment for the third quarter (July, August, September) of 2013.</p> <p>b. Individual #2's 1/24/13 IPP stated he was a 52 year old male whose diagnoses included profound intellectual disability, spastic quadriplegia, seizure disorder, congenital blindness and a hearing disorder.</p> <p>Individual #2's record documented quarterly nursing reviews were completed 10/24/13, 5/1/13, and 2/1/13. However, the review for the third quarter referenced a History and Physical dated 6/14/13. There was no completed assessment for the third quarter of 2013.</p> <p>During an interview on 12/19/13 from 10:40 - 11:55 a.m., the LPN stated she was not sure how the facility was defining quarters, which caused the missed reviews. The Program Manager, who</p>	W 336		

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W 336	Continued From page 18 was present during the interview, stated the quarters were to be defined by the calendar year of January-March, April-June, July-September, and October-December. The facility failed to ensure nursing reviews had been completed on a quarterly basis.	W 336			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 12/16/13 - 12/20/13. The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN	M 000	<p style="text-align: center;">RECEIVED JAN - 7 2014 FACILITY STANDARDS</p> <p>See attached plan. Pen-ink change Per Program Manager. - M. Case, LSW, QIDP 1.13.14</p>	
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197		
MM548	16.03.11.210.02(g) Immunization Record of immunizations; and This Rule is not met as evidenced by:	MM548		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	T. Case	TITLE Program Manager	(X6) DATE 1/7/14
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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

PREFERRED COMMUNITY HOMES - BEDFORD **398 EDGAR COURT**
MERIDIAN, ID 83642

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MM548	Continued From page 1 Refer to W324.	MM548		
MM724	16.03.11.270.01(a) Assessments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to M207.	MM724		
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		
MM735	16.03.11.270.02 Health Services	MM735		

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MM735	Continued From page 2 The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W336.	MM760		



January 7, 2014

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

RE: Bedford, Provider #13G039

Dear Mr. Case:

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

W124 – Protection of Clients Rights

The Bedford team has scheduled a team meeting for 1/15/14 to discuss individual #1's need for the medication Sertraline. At the meeting the team will review individual #1's raw data and make revisions to individual #1's behavior assessment. The team will also discuss if the risk of the medication outweighs the need for the medication based on individual #1's actual displayed behavior and his behavior assessment. If the team makes the decision that individual #1 should require the medication Sertraline, the QIDP will revise individual #1's written informed consent to adequately inform individual #1's guardian of why he would require the medication. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has first conducted a behavior assessment including review of the actual documented raw data, tracking behavior related to the medications and incorporating them into the Individual Program Plan for any individual that utilizes a behavior modifying medication. Aspire Human Services has revised the Peer Review form to include a section for verifying that behavior assessments are accurate and that WIC's are accurate. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate plans.

Person Responsible: Tom Moss, Program Manager
Completion Date: 1/31/14

W159 – Qualified Mental retardation Professional

The Bedford team has scheduled a team meeting for 1/15/14 to discuss individual #1's need for the medication Sertraline. At the meeting the team will review individual #1's raw data and make revisions to individual #1's behavior assessment. The team will also discuss if the risk of the medication outweighs the need for the medication based on individual #1's actual displayed behavior and his behavior assessment. If the team makes the decision that individual #1 should require the medication Sertraline,

the QIDP will revise individual#1's written informed consent to adequately inform individual#1's guardian of why he would require the medication. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has first conducted a behavior assessment including review of the actual documented raw data, tracking behavior related to the medications and incorporating them into the Individual Program Plan for any individual that utilizes a behavior modifying medication. Aspire Human Services has revised the Peer Review form to include a section for verifying that behavior assessments are accurate and that WIC's are accurate. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate corrective plans.

Person Responsible: Tom Moss, Program Manager
Completion Date: 1/31/14

Please refer to the responses given for tags W124, W207, W214, W312 and W313.

W207 – Individual Program Plans – Appropriate Staff Must Participate In Interdisciplinary Meetings

The Individual Program Plans for individuals #2 and #3 are being revised to include information of which individuals were in attendance at the IPP meetings. A chart review is being conducted for all individuals to verify that documentation is on file for who actually attended each individual's program plan meeting. If a signature sheet is missing from an IPP, the QIDP will create an addendum to document who participated in the meeting. For future IPP's the QIDP will not only include the sign in sheet for each meeting but will document on the actual IPP who attended each meeting. Aspire Human Services has revised the Peer Review form to include a section for verifying that each IPP contains information of who attended each IPP meeting. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate corrective plans.

Person Responsible: Tom Moss, Program Manager
Completion Date: 1/31/14

W214 – Individual Program Plan – CFA

Individual #1's behavior assessment is being revised to include comprehensive information in regards to how his communication and behavior relate to each other. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for providing comprehensive assessments. The training will include but will not be limited to assuring that the team has first conducted a behavior assessment including review of the actual documented raw data, how communication relates to behavior and tracking behavior related to the medications and incorporating them into the Individual Program Plan for any individual that utilizes a behavior modifying medication. Aspire Human Services has revised the Peer Review form to include a section for verifying that behavior assessments are accurate and that they summarize how an individual's communication is related to their behavior. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate corrective plans.

Person Responsible: Tom Moss, Program Manager
Completion Date: 1/31/14

312 – Drug Usage

The Bedford team has scheduled a team meeting for 1/15/14 to discuss individual #1's need for the medication Sertraline. At the meeting the team will review individual #1's raw data and make revisions to individual #1's behavior assessment. The team will also discuss if the risk of the medication outweighs the need for the medication based on individual #1's actual displayed behavior and his behavior assessment. If the team makes the decision that individual #1 should require the medication Sertraline, the QIDP will revise individual#1's written informed consent to adequately inform individual#1's guardian of why he would require the medication. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has first conducted a behavior assessment including review of the actual documented raw data, tracking behavior related to the medications and incorporating them into the Individual Program Plan for any individual that utilizes a behavior modifying medication. Aspire Human Services has revised the Peer Review form to include a section for verifying that behavior assessments are accurate and that WIC's are accurate. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate plans.

Person Responsible: Tom Moss, Program Manager

Completion Date: 1/31/14

313- Drug Usage

The Bedford team has scheduled a team meeting for 1/15/14 to discuss individual #1's need for the medication Sertraline. At the meeting the team will review individual #1's raw data and make revisions to individual #1's behavior assessment. The team will also discuss if the risk of the medication outweighs the need for the medication based on individual #1's actual displayed behavior and his behavior assessment. If the team makes the decision that individual #1 should require the medication Sertraline, the QIDP will revise individual#1's written informed consent to adequately inform individual#1's guardian of why he would require the medication. The Program Manager has scheduled training for all QIDP's, LPN's and Program Supervisors (Administrators) to discuss the policies and processes outlined for initiating or revising any behavior modifying medication. The training will include but will not be limited to assuring that the team has first conducted a behavior assessment including review of the actual documented raw data, tracking behavior related to the medications and incorporating them into the Individual Program Plan for any individual that utilizes a behavior modifying medication. Aspire Human Services has revised the Peer Review form to include a section for verifying that behavior assessments are accurate and that WIC's are accurate. The peer reviews will be performed quarterly and monitored by the Program Manager. In the event that it is identified that a deficient practice is identified, the team will schedule a meeting at the earliest possible time and develop the appropriate plans.

Person Responsible: Tom Moss, Program Manager

Completion Date: 1/31/14

322 – Physician Services

Bone density scans are being scheduled for all individuals affected by the deficient practice. Aspire Human Services – Preferred Community Homes is currently in the process of auditing all individuals' files to verify bone density scans have been completed as recommended. Any individual that needs a bone density scan will have one scheduled at the earliest possible times. The nursing department has scheduled quarterly nursing peer reviews. Bone density scans are one part of the peer reviews. To assure that corrective actions are monitored, a copy of each peer review is being sent to the nursing supervisor for review.

Person Responsible: LPN
Date Completed: 1/31/14

324 – Physician Services

Individual #3 received her (Zoster) vaccination on 1/6/14. Aspire Human Services – Preferred Community Homes is currently in the process of auditing all individuals' files to verify that (Zoster) vaccinations have been discussed with physicians for any all individuals 60 and over. Any individual that needs a (Zoster) vaccination have one scheduled at the earliest possible time. The nursing department has scheduled quarterly nursing peer reviews. Vaccinations scans are one part of the peer reviews. To assure that corrective actions are monitored, a copy of each peer review is being sent to the nursing supervisor for review.

Person Responsible: LPN
Date Completed: 1/31/14

336 – Nursing Services

The LPN has performed a current quarterly evaluation for individuals #1 and #2. Aspire Human Services – Preferred Community Homes is currently in the process of auditing all individuals' files to verify that quarterly assessments are current. In addition, the nursing policy is being revised to include a definition quarters defined by the calendar year. Any individual that needs a quarterly nursing evaluation will have one completed by the facility LPN at the earliest possible time. The nursing department has scheduled quarterly nursing peer reviews. Quarterly assessments are one part of the peer reviews. To assure that corrective actions are monitored, a copy of each peer review is being sent to the nursing supervisor for review.

*Person Responsible: LPN
Date Completed: 1.31.14*

pen + ink change per Program Manager

M. Cass, LSW QIDP on 1.13.14

MM164

Please refer to the responses given under W124 as it relates to the Development of Plan of Care.

MM197

Please refer to the responses given under W312 as it relates to Written Plans.

MM548

Please refer to the responses given under W324 as it relates to Immunizations.

MM724

Please refer to the responses given under W207 as it relates to Assessments.

MM725

Please refer to the responses given under W159 as it relates to the QMRP.

MM730

Please refer to the responses given under W214 as it relates to Diagnostic and Prognostic Data.

MM735

Please refer to the responses given under W322 as it relates to Health Services.

MM760

Please refer to the responses given under W336 as it relates to Nursing Services.

Tom Moss

Tom Moss
Program Manager
Licensed Social Worker

Wanda Huber
Program Supervisor
Administrator