



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

RECEIVED
JAN 07 2014

IDAHO DEPARTMENT OF MEDICAID
HEALTH & WELFARE

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

December 26, 2013

Kristin Sonnenberg, Administrator
Preferred Community Homes - Cougar Creek
7091 West Emerald Street
Boise, ID 83704

RECEIVED
JAN - 7 2014
FACILITY STANDARDS

RE: Preferred Community Homes - Cougar Creek, Provider #13G037

Dear Ms. Sonnenberg:

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

Kristin Sonnenberg, Administrator
December 26, 2013
Page 2 of 2

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

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

After you have completed your Plan of Correction, return the original to this office by **January 9, 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 8, 2014. If a request for informal dispute resolution is received after January 8, 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/pmt
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: 13G037 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/20/2013 |
|--|--|--|--|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - COUGAR CREEK | STREET ADDRESS, CITY, STATE, ZIP CODE 1230 EAST COUGAR CREEK 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 |
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|-------|--|-------|--|--|
| W 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 12/16/13 - 12/20/13.</p> <p>The survey was conducted by: Michael Case, LSW, QIDP, Team Leader Trish O'Hara, RN</p> <p>Common abbreviations used in this report are:</p> <p>CDC - Centers for Disease Control IPP - Individualized Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disability Professional</p> | W 000 | <p>See attached plan.</p> <p>Pen + Ink charge per Program Manager - M. Case, LSW, QIDP 1.13.14</p> | |
| W 159 | <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</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 2 of 3 individuals (Individuals #1 and #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. The findings include:</p> <p>1. Individual #1's 3/29/13 IPP documented a 26</p> | W 159 | <p>RECEIVED JAN - 7 2014 FACILITY STANDARDS</p> | |

| | | |
|---|------------------------------|-------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tom Wells</i> | 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 159 | <p>Continued From page 1</p> <p>year old male whose diagnoses included mild intellectual disability and bipolar disorder.</p> <p>Individual #1's Physician's Orders, dated 9/19/13, documented his prescribed medications included Melatonin (a supplemental drug) 3 mg daily.</p> <p>Individual #1's medication reduction plan, revised 12/17/13, documented Individual #1's Melatonin was discontinued after 4/18/13 and was re-prescribed on 7/18/13. The plan documented the Melatonin was linked to insomnia in relation to Individual #1's bipolar disorder.</p> <p>Further, the plan documented Individual #1 "currently is assisted with a sleep hygiene routine" and the "team will discuss a reduction in [Individual #1's] Melatonin after he averages 8 hours of sleep per night for 12 [consecutive months]."</p> | W 159 | | |
| | <p>However, Individual #1's IPP included a note which indicated his sleep hygiene guidelines were discontinued on 7/10/13 because "Sleep hygiene is not an issue."</p> <p>Additionally, Individual #1's record did not include documentation that hours of sleep were being tracked and monitored.</p> <p>During an interview on 12/19/13 from 12:07 - 12:45 p.m., the QIDP and Program Supervisor stated hours of sleep were being tracked, but the information was not being reviewed, summarized or monitored. The Program Manager, who was present during the interview, stated the decision to discontinue Individual #1's sleep hygiene program and sleep monitoring was made by a previous QIDP and needed to be corrected.</p> | | | |

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| W 159 | Continued From page 2 The facility failed to ensure the QIDP ensured individual #1's sleep and medication use was being appropriately monitored and tracked. | W 159 | | | |
| W 225 | 2. Refer to W225 as it relates to the facility's failure to ensure the QIDP ensured individuals' vocational assessments contained comprehensive information. 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was completed for 2 of 3 individuals (Individuals #1 and #3) who were of age to be involved in vocational training. Without a comprehensive assessment, the facility would be unable to assist individuals with vocational training needs through the development of objectives designed to optimize the individuals' abilities. The findings include: 1. The facility utilized a Vocational Assessment tool that included 29 probes related to vocational tasks (e.g., "When shown or instructed, participant can learn a new job or task involving one-step," etc.). The Vocational Assessments did not contain sufficient information, as follows: a. Individual #1's 3/29/13 IPP documented a 26 year old male whose diagnoses included mild intellectual disability. He attended a home based | W 225 | | | |

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| W 225 | <p>Continued From page 3 vocational program Monday through Friday.</p> <p>The probes section of Individual #1's Vocational Assessment, reviewed 3/20/13, included the cue level required for Individual #1 to participate in a task on a scale from 1 to 7 (e.g. Individual #1 required cue level 1 [independent] to initiate contact with the supervisor or trainer when he finished a job or task). No additional information was included.</p> <p>Individual #1's Vocational Assessment also included narrative sections for additional information which included sections for past, present, and future employment, work interests, work-related behaviors, vocational strengths, vocational needs, limitations, and adaptive equipment.</p> <p>The narrative section of Individual #1's Vocational Assessment documented Individual #1</p> | W 225 | | |
| | <p>"participates in the Lawn Crew program" and "volunteers for the Meals on Wheels program" in the Present Employment section. No additional information was included. Additionally, the sections for past employment, future employment, work interests, and work-attitudes were all blank.</p> <p>b. Individual #3's 12/11/13 IPP documented a 60 year old male whose diagnoses included moderate intellectual disability. He attended a home based vocational program Monday through Friday.</p> <p>The probes of Individual #3's Vocational Assessment, dated 11/29/13, included the cue level required for Individual #3 to participate in a task on a scale from 1 to 7 (e.g. Individual #3</p> | | | |

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| W 225 | Continued From page 4 required cue level 1 [independent] to accept new tasks). No additional information for Individual #3, such as past, present, and future employment, work interests, work-related behaviors, vocational strengths or vocational needs, was included in his Vocational Assessment. During an interview on 12/19/13 from 12:07 - 12:45 p.m., the QIDP stated she had noticed inconsistencies in the assessment tools but had not had time to correct them. The QIDP and the Program Manger, who was present during the interview, both stated the assessments needed to be revised The facility failed to ensure Individual #1 and Individual #3's Vocational Assessments contained complete and comprehensive information regarding their vocational needs. | W 225 | | | |
| W 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) | W 324 | | | |

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| W 324 | Continued From page 5 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 above who have no contraindications, including persons who report a previous episode of zoster or who have chronic medical conditions, receive the vaccination. | W 324 | | | |
| | Individual #3's 12/11/13 IPP documented a 60 year old male whose diagnoses included moderate intellectual disability, seizure disorder, hypothyroidism, and intermittent skin rash. Individual #3's record did not include documentation he had received a Zoster vaccination, or that a discussion related to the need for the vaccination had been conducted with his physician. During an interview on 12/19/13 from 12:07 - 12:45 p.m., the LPN stated a Zoster vaccination had not been obtained for Individual #3 due to an oversight. | | | | |

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| W 324 | Continued From page 6 The facility failed to ensure Individual #3 received immunizations as recommended by the Public Health Service Advisory Committee. | W 324 | | | |
| W 336 | 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 that nursing reviews had been completed on a quarterly basis for 2 of 3 individuals (Individuals #1 and #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: | W 336 | | | |
| | 1. Individual #1 and #3's records were reviewed and documented the following: a. Individual #1's 3/29/13 IPP documented a 26 year old male whose diagnoses included mild intellectual disability. Individual #1's record documented quarterly nursing reviews were completed 10/22/13, 6/19/13, and 3/12/13. There was no completed assessment for the third quarter (July, August, September) of 2013. b. Individual #3's 12/11/13 IPP documented a 60 year old male whose diagnoses included moderate intellectual disability. | | | | |

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| W 336 | Continued From page 7 Individual #3's record documented quarterly nursing reviews were completed 10/22/13, 6/25/13, and 3/7/13. There was no completed assessment for the third quarter (July, August, September) of 2013. During an interview on 12/19/13 from 12:07 - 12:45 p.m., the LPN stated the reviews had been missed due to an oversight. The facility failed to ensure nursing reviews had been completed on a quarterly basis. | W 336 | | | |
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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 | See attached plan. Pen + ink change per Program Manager. - M. Case, LSW, QIDP 1.13.14 | |
| MM548 | 16.03.11.210.02(g) Immunization Record of immunizations; and This Rule is not met as evidenced by: Refer to W324. | MM548 | RECEIVED JAN - 7 2014 FACILITY STANDARDS | |
| 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 W225. | 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: | MM725 | | |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tom Malt

TITLE

Program Manager

(X6) DATE

1/7/14

Bureau of Facility Standards

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| MM725 | Continued From page 1 Refer to W159. | MM725 | | |
| MM766 | 16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336. | MM766 | | |



January 9, 2014

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

RE: Cougar Creek, Provider #13G037

Dear Mr. Case:

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

W159 - Qualified Mental Retardation Professional

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 a behavior modifying medications. The training will include but will not be limited to assuring the team identifies replacement objectives, tracking behavior related to the medications and incorporating them into the Individual Program Plan for any individual that utilizes a behavior modifying medication such as a medication to help an individual achieve sleep. Aspire Human Services has revised the Peer Review form to include a section for verifying that a training objective is in place for any restrictive medication such as a medication for sleep. 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 and a restrictive medication is being utilized without appropriate replacement behaviors or sufficient monitoring and tracking, 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

1. Please refer to the response given for W225 as it relates to the facility's failure to ensure the QIDP ensured individuals' vocational assessments contained comprehensive information.

W225 – Individual Program Plan – The comprehensive functional assessment must include, as applicable, vocational skills.

Aspire Human Services is in the process of revising the Certified Functional Assessment include more areas in regards to the vocations skills and needs of each individual. After the assessment is revised it will include information such as future employment, work interest, vocational skills and vocational needs. Each individual served within Aspire Human Services – Preferred Community Homes will have these areas assessed during their next scheduled IPP meeting. Before the annual meeting the QIDP will be

creating an addendum which will be attached to the CFA so each individual being served will have an appropriate vocational assessment on file. Aspire Human Services has revised the Peer Review form to include a section for verifying that a vocational assessment is in each persons file. 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 and an individual does not have a thorough vocational assessment in place, 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

W324 – 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

pen + ink change per Program Manager

W336 – Nursing Services

The LPN is performed a current quarterly evaluation for individuals #1 and #3 on 1/10/14. 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. Case, LSW, QIDP on 1.13.14

m. Case, LSW, QIDP on 1.13.14

MM548

Please refer to the response given under W324 as it relates to immunizations.

MM724 – Assessments

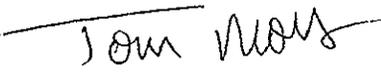
Please refer to the response given under W225 as it relates to assessments.

MM725 – QMRP

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

MM766 – Periodic Reevaluation

Please refer to the response given under W336 as it relates to Periodic Reevaluation.


Tom Moss
Program Manager
Licensed Social Worker


Kristin Buchanan
Program Supervisor
Administrator