



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
Boise, Idaho 83720-0009
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January 29, 2015

Jonathon Daltow, Administrator
Preferred Community Homes - Fieldstone
12553 West Explorer Drive Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Fieldstone, Provider #13G030

Dear Mr. Daltow:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Preferred Community Homes - Fieldstone, on January 22, 2015.

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

Jonathon Daltow, Administrator
January 29, 2015
Page 2 of 2

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

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

After you have completed your Plan of Correction, return the original to this office by **February 11, 2015**, 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 February 11, 2015. If a request for informal dispute resolution is received after February 11, 2015, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,



MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/lj

Enclosure

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2015
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - FIELDST	STREET ADDRESS, CITY, STATE, ZIP CODE 2774 NORTH OLDSTONE WAY MERIDIAN, ID 83642
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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) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V(000) structure. The building is protected by a NFPA 13 D fire sprinkler system with quick response sprinkler heads. There is a complete fire alarm/smoke detection system. The facility was built in April of 1996. Currently it is licensed for 8 ICF/ID beds.</p> <p>The following deficiency was cited at the above facility during the annual Fire/Life Safety survey conducted on January 21, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, and in accordance with 42 CFR, 483.470.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K0012	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>IMPRACTICAL Buildings are of any construction type in accordance with 8.2.1 other than Type II (000), Type III (200), or Type V (000) construction. 33.2.1.3.3.</p> <p>Exception: Buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5 are permitted to be of any type of construction.</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to assure that all smoke partitions would provide protection against passage of smoke between compartments. This deficient practice affected six clients, two staff members, and visitors on the</p>	K0012	<p>RECEIVED FEB 12 2015 FACILITY STAFF</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>B. Buchanan</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>2-11-15</i>
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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.

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

**FORM APPROVED
OMB NO. 0938-0391**

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K0012	<p>Continued From page 1 day of the survey. The facility is licensed for 8 ICF beds.</p> <p>Findings include:</p> <p>During the facility tour on January 21, 2015 at approximately 2:00 pm, it was observed that the wall in the hallway bathroom had a large hole approximately 4"x12" that would allow the free passage of smoke in the event of a fire. Interview with the administrator revealed the facility was unaware of the hole in the wall.</p> <p>Actual NFPA Standards: NFPA 101, 8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception*: Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum.</p>	K0012		

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M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story, Type V(000) , residential building. The building is protected throughout except in the garage and attic by a NFPA 13 D fire sprinkler system with quick response sprinkler heads. There is a complete fire alarm/smoke detection system. The facility was built in January of 1996. Currently it is licensed for 8 ICF/ID beds.</p> <p>The following deficiency was cited at the above facility during the annual Fire/Life Safety survey conducted on January 21, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, and in accordance with IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000		
MM309	<p>16.03.11.110 Fire and Life Safety Standards</p> <p>Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities.</p> <p>This RULE: Is not met as evidenced by: Refer to the following federal "K" tags on CMS - 2567</p> <p>K012 - Building Construction</p>	MM309		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Richardson</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>2-11-15</i>
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MM345	Continued From Page 1	MM345		
MM345	<p>16.03.11.110.06(f) Portable Fire Extinguishers</p> <p>Portable fire extinguishers must be serviced in accordance with the applicable NFPA Standard 10 (1978 edition), "Portable Fire Extinguishers." This RULE: is not met as evidenced by: Based on record review it was determined that the facility failed to inspect the portable fire extinguishers in accordance with NFPA 10. Monthly inspections of portable fire extinguishers helps to ensure that they are located at their designated location and their reliability in the event they may be needed. The facility had a census of seven clients on the day of the survey. This deficiency affected all clients, staff and visitors present on the day of the survey.</p> <p>Findings include:</p> <p>During a tour of the facility on January 21, 2015 at approximately 2:00 pm, observation of the portable fire extinguisher inspector tag affixed to the extinguisher indicated that no monthly inspections were conducted since the annual inspection had been documented. When questioned about the monthly inspections the administrator was unaware of the missing monthly inspections.</p> <p>Actual NFPA Standard:</p> <p>NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.</p>	MM345		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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12553 W. Explorer Drive, Suite 190, Boise, ID 83713 * Office (208) 972-5252 * Fax (208) 780-1969

February 11, 2015

Mark Grimes
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83709
Boise, Idaho 83720-0009

Dear Mr. Grimes,

Thank you for your considerateness during the recent Fire Light Safety Survey at the Milliken Heights homes. Please see our responses below for each citation and please give us a call if you have any questions.

K0012:

The wall in the hallway bathroom will be patched denying the free passage of smoke in the event of a real fire effecting all six individuals. Aspire Human Services currently has a monthly checklist which is completed by the home supervisor or lead worker. The monthly checklist includes cabinets, doors, and walls are in good condition. Each month after the home supervisor or lead worker has completed their monthly check list the documentation will be turned into the program manager for verification that the inspection has occurred.

Personal Responsible: Kristin Buchanan
Completion Date: 2.13.2015

MM309:

Aspire Human Services currently has a monthly checklist which is completed by the home supervisor or lead worker. The monthly checklist includes cabinets, doors, and walls are in good condition. Each month after the home supervisor or lead worker has completed their monthly check list the documentation will be turned into the Program Manager for verification that the inspection has occurred.

Personal Responsible: Kristin Buchanan
Completion Date: 2.13.2015



12553 W. Explorer Drive, Suite 190, Boise, ID 83713 * Office (208) 972-5252 * Fax (208) 780-1969

MM345:

Aspire Human Services currently has a monthly checklist which is completed by the home supervisor or lead worker. The monthly checklist indicates the date on the extinguisher will be documented. Each month after the home supervisor or lead worker has completed their monthly check list the documentation will be turned into the Program Manager for verification that the inspection has occurred.

Personal Responsible: Kristin Buchanan

Completion Date: 2.16.2015

MM380:

Aspire Human Services currently has a monthly checklist which is completed by the home supervisor or lead worker. The monthly checklist has been revised to include the outside appearance of the home; including window screens. Each month after the home supervisor or lead worker has completed their monthly checklist the documentation will be turned into the Program Manager for verification that the inspection has occurred.

Personal Responsible: Kristin Buchanan

Completion Date: 2.16.2015

Kristin Buchanan
Program Manager