



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

January 29, 2015

Shantelle Kates, Administrator  
Preferred Community Homes - Mallard  
12553 West Explorer Drive Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Mallard, Provider # 13G032

Dear Ms. Kates:

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

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction 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,

Shantelle Kates, Administrator  
January 29, 2015  
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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 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:

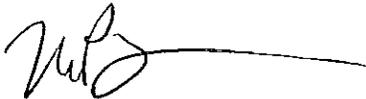
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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  
Facility Fire Safety and Construction Program

MPG/lj

Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - MALLAR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER MERIDIAN, ID 83642</b>
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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><b>INITIAL COMMENTS</b></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 facility was found to be in substantial compliance 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>	K 000		
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RECEIVED  
FEB 12 2015  
PROPERTY DEPARTMENT

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G032	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  01/22/2015
NAME OF PROVIDER OR SUPPLIER  PREFERRED COMMUNITY HOMES - MALLARD		STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER 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) COMPLETE DATE
M 000	16.03.11 Initial Comments  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.  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.  The Survey was conducted by:  Nathan Elkins Health Facility Surveyor Facility Fire Safety and Construction	M 000		
MM345	16.03.11.110.06(f) Portable Fire Extinguishers  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	MM345		

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

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

TITLE

(X6) DATE

*K. Buchanan*

*Program Manager*

2-11-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - MALLARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER MERIDIAN, ID 83642</b>		
(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
MM345	Continued From Page 1  deficiency affected all clients, staff and visitors present on the day of the survey.  Findings include:  During a tour of the facility on January 21, 2015 at approximately 12:00 pm, observation of the portable fire extinguisher inspection tags affixed to the extinguisher indicated that the monthly inspections from October 2014-December 2014 were missing. When questioned about the monthly inspections the administrator was unaware of the missing monthly inspections.  Actual NFPA Standard:  NFPA 10 Standard for Portable Fire Extinguishers 1998 Edltion 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.	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 Elk Run homes. Please see our responses below for each citation and please give us a call if you have any questions.

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

A handwritten signature in cursive script that reads 'Kristin Buchanan'.

Kristin Buchanan  
Program Manager