



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

IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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January 29, 2015

Cathy Morales, Administrator  
Preferred Community Homes - Milliken  
12553 West Explorer Drive Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Milliken, Provider #13G053

Dear Ms. Morales:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Preferred Community Homes - Milliken, 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

Cathy Morales, 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](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  
Fire Life Safety & Construction Program

MPG/lj

Enclosure

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>13G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - MILLIKI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7904 ARLINGTON DRIVE NAMPA, ID 83686</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) COMPLETION DATE
K 000	<b>INITIAL COMMENTS</b>  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 April 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 42 CFR, 483.470.  The Survey was conducted by:  Nathan Elkins Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K0012	<b>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</b>  <b>IMPRACTICAL</b> 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.  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.  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	K0012		

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

TITLE

(X6) DATE

*Nathan Elkins*

*Program Manager*

*2-11-15*

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

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K0012	<p>Continued From page 1</p> <p>compartments. This deficient practice affected six clients, two staff members, and visitors on the 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 3:00 pm, it was observed that the wall in the hallway bathroom had a 3" x 4" hole 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><b>16.03.11 Initial Comments</b></p> <p>The facility is a single story, Type V(000) , residential building. The building is protected throughout except in the gerage 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 April of 1996. Currently it is licensed for 8 ICF/ID beds.</p> <p>The following deficiencies were 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><b>16.03.11.110 Fire and Life Safety Standards</b></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

TITLE

(X6) DATE

*Buchanan*

*Program Manager*

*2-11-16*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2015</b>
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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 observation 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 3:15 pm, observation of the portable fire extinguisher inspection tag affixed to the extinguisher indicated that no monthly inspections since the annual inspection had been documented. When questioned 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		
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such</p>	MM380		

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	<p>character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This RULE: is not met as evidenced by: Based on observation, the facility failed to provide exterior window screens. This deficient practice allows flies and other insects into the facility, affecting the six clients residing there on the day of the survey. The facility is licensed for eight beds with a census of six on day of survey</p> <p>Findings include</p> <p>During the survey tour on January 21, 2015 at approximately 3:30 pm, observation revealed the facility failed to provide exterior bedroom window screens. The building administrator acknowledged the finding during the exit conference.</p> <p>Actual reference:</p> <p>IDAPA 16.02.11 - Rules Governing Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)</p> <p>120.03. a General Building Requirements. All buildings to be used for ICF/ID facilities must be be of such character suitable for such usage. These buildings will be subject to approval by the Department. Other requirements are as follows (a) The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p>			

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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



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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*

Kristin Buchanan  
Program Manager