



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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February 11, 2015

Bridger Fly, Administrator
Communicare, Inc #5 Kuna
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #5 Kuna, Provider # 13G021

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey of Communicare, Inc #5 Kuna, which was concluded on February 2, 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,

Bridger Fly, Administrator
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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 24, 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 23, 2015. If a request for informal dispute resolution is received after February 23, 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

Printed: 02/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA	STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634
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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 single story Type V(000) unprotected construction. The building has a complete automatic sprinkler system with coverage throughout including closets and bathrooms. There is an automatic fire alarm system with smoke detection throughout and manual pull stations are located at each of the two exits to grade. The fire alarm system is interconnected with the sprinkler system. The facility is currently licensed for 8 ICF/MR beds.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety code survey conducted on February 2, 2015. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 32 New Residential Board and Care Occupancies, Impractical Evacuation Capabilities, adopted March 11, 2003 in accordance with 42 CFR 483.470.</p> <p>The annual life safety code survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety and Construction Program</p>	K 000		
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FEB 23 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>02/23/2015</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: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(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	<p>16.03.11 Initial Comments</p> <p>The facility is single story Type V (000) unprotected construction. The building has a complete automatic sprinkler system with coverage throughout including closets and bathrooms. There is an automatic fire alarm system with smoke detection throughout and manual pull stations are located at each of the two exits to grade. The fire alarm system is interconnected with the sprinkler system. The facility is currently licensed for 8 ICF/MR beds.</p> <p>The following deficiencies were cited during the annual fire/life safety code survey conducted on February 2, 2015. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 32 New Residential Board and Care Occupancies, Impractical Evacuation Capabilities, and in accordance with IDAPA 16.03.11. Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities</p> <p>The annual life safety code survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety and Construction Program</p>	M 000		
MM327	<p>16.03.11.110.02(h) Emergency Electrical Service</p> <p>Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system.</p> <p>This RULE: is not met as evidenced by: Based on observation and functional testing, it was determined that the facility had not ensured that the emergency electrical lighting was maintained in working order. The facility is</p>	MM327	<p><u>MM327</u></p> <p>Corrective Actions: The facility has repaired the malfunctioning emergency electrical lighting. It should be noted that the lighting had been inspected as part of a routine preventative maintenance checklist inspection and had been in proper working order the month prior according to the house manager.</p>	04/12/15

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
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MM327	Continued From Page 1 licensed for eight ICF beds. The findings include: Observation on February 2, 2015 at 4:00PM, revealed that two of five emergency lighting units in the facility were not functioning upon pressing of the test button. Findings were witnessed by the facility Staff. This deficiency affected two staff members and eight clients on the day of survey.	MM327	Identifying Others Potentially Affected: All individuals living at this location were potentially affected by this issue. System Changes: No system changes are needed as corrective actions will bring the facility into compliance. Monitoring: House supervisor will be monitoring the facility emergency lighting is part of the preventative maintenance checklist already in place at this location.	

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