



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

March 25, 2015

Bridger Fly, Administrator
Communicare, Inc #6 Weiser
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #6 Weiser, Provider #13G027

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #6 Weiser, which was conducted on March 12, 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Bridger Fly, Administrator
March 25, 2015
Page 2 of 2

6. Include dates when corrective action(s) 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 **April 6, 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:

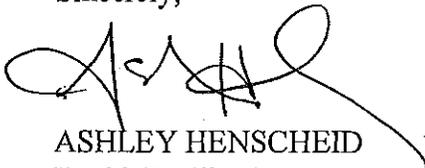
www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

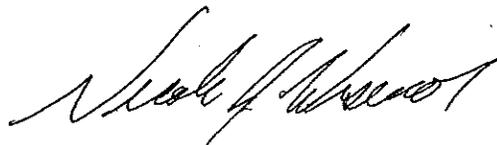
This request must be received by April 6, 2015. If a request for informal dispute resolution is received after April 6, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey conducted from 3/9/15 to 3/12/15.</p> <p>The survey was conducted by:</p> <p>Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>AQIDP - Assistant Qualified Intellectual Disabilities Professional DCS - Direct Care Staff LPN - Licensed Practical Nurse PRN - As needed RN - Registered Nurse</p>	W 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">APR 06 2015</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate nursing services were provided for 3 of 4 individuals (Individuals #1, #2 and #4) whose medical records were reviewed. This resulted in a lack of clear physician orders being available to staff. The findings include:</p> <p>1. The facility's "Assistance With Oral Medication Training Instructor (Active Treatment Staff) Module #5," dated 1/14, stated "PRN (As Needed) Medications are given only as needed for conditions such as headache, elevated</p>	W 331	<p><u>W331</u></p> <p>Corrective Actions: This issue has been further evaluated by our RN Supervisor and discussed with the LPN at this location. The observations by the survey team were accurate and we have determined that further instruction and inservice training is needed related to this issue. An additional section will be added to our RN Oversight & Nursing Services Manual titled "Consistency of Records" (Attachment A). This document outlines expectations of nursing staff related to the issue of both making sure Physician's Orders are accurate resulting in accurate MARs and Nursing Summaries and clarification of how PRN orders are to</p>	05/12/15

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

TITLE

(X6) DATE

Administrator

4/3/15

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 331	<p>Continued From page 1</p> <p>temperature or cough. PRN medications are not to be given more frequently than the prescriber's order indicates." The policy stated if a PRN medication was "...listed on the medication sheet, nurse DOES NOT NEED TO BE CALLED FOR AUTHORIZATION PRIOR TO USE."</p> <p>However, the individuals' "Physician's Order Sheet and Progress Note" forms included PRN medications which were duplicative and did not consistently include specific individualized orders, as follows:</p> <p>a. The PRN section of Individual #2's "Physician's Order Sheet and Progress Note" form, dated 2/26/15, stated he was to receive Promethazine with Codeine cough syrup 5-10 cc every 4-6 hours as needed for cough. The order did not include specific information regarding how much of the medication he was to receive or how often he was to receive it.</p> <p>b. The PRN section of Individual #1's "Physician's Order Sheet and Progress Note" form, dated 2/26/15, stated she was to receive Robitussin DM 1-2 tsp every 4-6 hours as needed for coughing. The order did not include specific information regarding how much of the medication she was to receive or how often she was to receive it.</p> <p>Additionally, the PRN orders also included Robitussin CF 2 tsp every 4 hours as needed for cold symptoms. The PRN orders did not include information regarding which medication she was to receive for cold symptoms which included coughing (Robitussin DM, Robitussin CF or both).</p> <p>c. Individual #4's "Physician's Order Sheet and Progress Note" forms, dated 11/18/14 and</p>	W 331	<p>be written. The RN Supervisor will inservice the LPN on these expectations and together they will review all current Physician's Orders then request that the physician clarify orders related to the dosages of PRN medications.</p> <p>PLEASE NOTE: Although the RN initially stated that the nurse should be contacted prior to administering cold medications, she corrected herself during the course of the conversation and surveyors were given a copy of an excerpt from our "Assistance with Oral Medications" training module that states "IF a PRN medication (excluding those for behavior management) is listed on the medication sheet, a nurse DOES NOT NEED TO BE CALLED FOR AUTHORIZATION PRIOR TO USE." For instance when a person complains of a headache check the medication sheet to see if there is a PRN order for medication for a headache. The medication sheet will also indicate how often the medication can be given. If the order reads "Tylenol 2 tabs, every 4 hours for complaints of headache, check the medication sheet and Medical Observation Log to determine if the person has had Tylenol within the last 4 hours. If he/she has not received Tylenol within the last 4 hours, the Tylenol may be given. The results of the use of the PRN must be documented in the Medication Observation Log."</p>	

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 331	Continued From page 2 2/26/15, stated he was to receive Robitussin DM 1-2 tsp every 4-6 hours as needed for coughing and Robitussin AC (Cheratussin AC) 1-2 tsp every 4-6 hours as needed for coughing. The orders did not include specific information regarding how much of the medication he was to receive or how often he was to receive it, and the PRN orders did not include information regarding which medication he was to receive when coughing (Robitussin DM, Cheratussin AC or both). Additionally, a physician's prescription, dated 8/26/13, stated Individual #4 was to receive Tussin CF 10 ml every 4 hours as needed. Further, Individual #4's "Medical Observation Log" documented on 2/20/15 he received both Cheratussin AC and Tussin CF at 9:00 p.m. His corresponding 2/2015 medication administration record did not include the amount (1 or 2 teaspoons) of Cheratussin AC he received. However, the Cheratussin AC's control sheet documented he had received 10 milliliters (2 teaspoons). When asked about the medications, during an interview on 3/12/15 from 8:40 - 9:50 a.m., the RN stated the individuals should not be getting both medications and the nurse should be contacted prior to administering cold medications. The RN further stated the individuals' physicians orders should not include ranges and that the dose should be specified. The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were clarified.	W 331	Identifying Others Potentially Affected: All other individuals living at this location are potentially affected by this issue. System Changes: A copy of the addition to the RN Oversight & Nursing Services Manual titled "Consistency of Records" is attached. Monitoring: The RN Supervisor will insure that all orders for PRN medications are clarified as to dosage range and time span. She will check "Physician's Orders" during regular Nursing Summary Reviews. The nurse at this location is very experienced and conscientious. Since she has been made aware of this issue we are sure this will not be repeated.	
W 426	483.470(d)(3) CLIENT BATHROOMS	W 426	<u>W426</u>	05/12/15

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 426	<p>Continued From page 3</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 3 of 3 individuals (Individuals #6, #11 and #12) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include:</p> <p>1. An environmental review was conducted on 3/10/15 from 10:00 - 11:00 a.m. During that time, water temperatures on the 180 side of the facility were as follows:</p> <p>Back left bathroom - 116.9 degrees Fahrenheit Back right bathroom - 115.2 degrees Fahrenheit</p> <p>The AQIDP, who was present during the environmental review, stated not all individuals who used the bathrooms could self-regulate water temperatures. The AQIDP was notified of the high water temperatures.</p> <p>During an interview on 3/12/15 from 8:40 - 9:50 a.m., the AQIDP stated the back bathrooms on the 180 side of the facility were generally only used by Individuals #1, #2, #4, #5, #6, #11 and #12. Of those individuals, Individuals #6, #11, and #12 were not able to self-regulate water temperatures.</p>	W 426	<p>Corrective Actions: Water temperatures were checked by the AQIDP shortly before surveyors did their check. There was a discrepancy between her results and the results of the surveyors which we feel we identified during the exiting process as different procedures for taking water temperatures. The procedures for checking water temperatures used by surveyors has now been explained to us.</p> <p>Identifying Others Potentially Affected: All individuals who cannot self-regulate water temperatures are potentially affected.</p> <p>System Changes: The AQIDP (House Manager) at this location will now use water checking procedures as demonstrated by surveyors.</p> <p>Monitoring: Water temperatures are checked on an ongoing basis and recorded on the "Preventative Maintenance Checklist." This is completed by the AQIDP and reviewed by the Administrator every month. If temperatures do not fall within the limits in the future more actions will be discussed.</p>	

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 426	Continued From page 4 The facility failed to ensure water temperatures were maintained at 110 degrees Fahrenheit or below for Individuals #6, #11 and #12. Note: Water temperatures were re-checked on 3/11/15 at 1:05 p.m. and found to be within an acceptable range.	W 426		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 9 of 13 individuals (Individuals #3, #5 - #10, #12 and #13) residing at the facility and had the potential to impact all individuals (Individuals #1 - #13) residing at the facility. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. Observations were conducted at the facility on 3/9/15 from 3:20 - 4:55 p.m. and 5:45 - 7:05 p.m. and on 3/10/15 from 7:25 - 8:55 a.m. During those times, DCS were not observed to appropriately utilize gloves for infection control. Examples included, but were not limited to, the following: a. On 3/9/15 at 2:30 p.m., DCS B was in the	W 455	<u>W455</u> Corrective Actions: We believe there was group "performance anxiety" related to the issue of glove use during surveyor's mealtime observation as our management staff at this location who do regular mealtime evaluations had not previously seen the issues the surveyors identified. However, we do acknowledge that there were issues related to gloves during both mealtimes and medication administration times. The RN Supervisor has prepared a "Glove use in the kitchen" handout (Attachment B) which will be inserviced and then added to Menu Binders at this location. Additionally, she will prepare a similar "Glove use when during Medication Administration" which will be inserviced with Medication Assistants and which will be added to Medication Binders. We have also added proper use of gloves during both medication pass (Attachment C) and mealtime observations (Attachment D).	05/12/15

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 455	<p>Continued From page 5</p> <p>kitchen preparing meat patties. DCS A entered the kitchen to obtain a pen. DCS A's hair was not restrained as required by IDAPA 16.02.19 (Idaho Food Code). DCS A leaned over to bowl of ground meat DCS B was using to prepare the meal, allowing her long hair to drag over the lip of the bowl as she obtained a pen.</p> <p>b. On 3/9/15 from 6:15 - 6:28 p.m., Individual #5 was observed to participate in a medication administration routine. During that time, DCS C donned gloves and set up Individual #5's glucometer. DCS C assisted Individual #5 to complete a finger-stick with a lancet device and squeezed Individual #5's finger to encourage blood flow. DCS C placed the lancet device in a sharps container, then removed and disposed of his gloves. DCS C donned a new pair of gloves. However, no hand washing or hand sanitizing was completed.</p> <p>DCS C assisted Individual #5 to apply blood to the glucometer strip and read the results of the test. DCS C removed his gloves and disposed of them, then donned a new pair of gloves. No hand washing or hand sanitizing was completed.</p> <p>When asked during the observation about the glove use, DCS C stated "better safe than sorry." The LPN, who was present during the observation, stated glove use was not a replacement for hand washing, and hand washing or hand sanitization should occur between glove changes.</p> <p>c. Dinner set-up and service was observed on 3/9/15 from 6:30 - 7:05 p.m. During that time, the three direct care staff working with individuals on the 160 side of the facility were observed to</p>	W 455	<p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: See corrective actions.</p> <p>Monitoring: The proper use of gloves during medication passes and mealtime activities will become part of the observations for both of these types of activities. Observations are done monthly and reviewed by the QIDP, AQIDP, and RN Supervisor. Noted issues will result in further staff training.</p>	

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER	STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672
---	---

(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
--------------------	--	---------------	---	----------------------

W 455	<p>Continued From page 6</p> <p>change gloves without completing appropriate hand hygiene no less than 10 times each. For example:</p> <ul style="list-style-type: none"> - DCS D donned gloves, then donned a hairnet and used her gloved hands to tuck her hair up into the hairnet. Once her hair was in the hairnet, DCS D removed her gloves and disposed of them. DCS D donned a new pair of gloves and proceeded to set the table for Individuals #6 and #13. Hand hygiene was not completed. - DCS D donned a glove to her left hand. DCS D then placed the gloved hand under her right arm (near her armpit) and pulled her hand free of the glove. DCS D applied hand sanitizer to her hands, reapplied the glove that was under her right arm and proceeded to set food and dishes on the tables. - DCS E donned gloves and wrapped a plate of meat patties in plastic wrap. He placed the meat patties in the microwave, then removed and disposed of the gloves. DCS E then donned a new pair of gloves. Hand hygiene was not completed. DCS E then removed the meat patties from the microwave, checked the temperature, and placed the meat patties on the table for Individuals #7, #9 and #10. - DCS F donned a pair of gloves and utilized a serving utensil to place meat patties on the plates of Individuals #3, #8 and #12. DCS F removed and disposed of the gloves. She then donned a new pair of gloves as she entered the kitchen. Hand hygiene was not completed. While in the kitchen, DCS F's phone alarm sounded. She reached into her back pants pocket with her gloved hand and silenced the alarm. DCS F then 	W 455		
-------	--	-------	--	--

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

PRINTED: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672		
(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	
W 455	<p>Continued From page 7</p> <p>took baked potatoes to the table and used her gloved hand to place the potatoes on individuals' plates.</p> <p>d. On 3/10/15 at 7:55 a.m., DCS A was observed to enter the kitchen on the 180 side of the facility. DCS A donned a hair net and tucked her hair into the net. DCS A then donned gloves. Hand hygiene was not completed. DCS A then obtained a box of shredded wheat, removed the food item with her gloved hands and wrapped it in foil. DCS A informed DCS B, who was present during the observation, that the shredded wheat was for Individual #13.</p> <p>During an interview on 3/12/15 from 8:40 - 9:50 a.m., the RN stated gloves should not be used as a replacement for hand washing and that hand hygiene should be completed before gloves were donned and after they were removed.</p> <p>The facility failed to ensure staff were appropriately using gloves and completing appropriate hand hygiene.</p>	W 455			

Bureau of Facility Standards

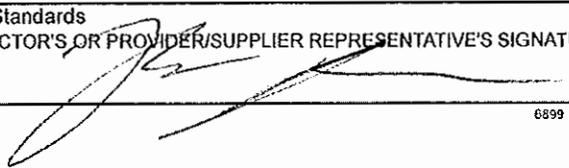
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER	STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672
--	---

(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 following deficiencies were cited during the licensing survey conducted from 3/9/15 to 3/12/15. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP	M 000	RECEIVED APR 06 2015 FACILITY STANDARDS	
MM412	16.03.11.120.04(m) Furniture and Equipment All furniture and equipment must be maintained in a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents. This Rule is not met as evidenced by: Based on observation, it was determined facility failed to ensure all furniture was kept in good repair for 1 of 13 individuals (Individual #13) residing in the facility. This resulted in Individual #13's chest of drawers being kept in ill-repair and in a manner that did not permit ease of use. The findings include: 1. An environmental review was conducted on 3/10/15 from 10:00 - 10:52 a.m. During that time, it was noted 8 of Individual #13's dresser drawers did not have back stops to prevent the drawer from falling forward when opened. Additionally, the drawer pulls were loose, making the drawers difficult to open. The facility failed to ensure repairs were maintained for Individual #13's chest of drawers.	MM412	<u>MM412</u> Corrective Actions: The chest of drawers being kept will be replaced with a new set by the AQIDP. Identifying Others Potentially Affected: The individual identified during the survey process was the only one effected by this issue. System Changes: No changes are needed upon replacement of the furniture item. Monitoring: Furniture items are checked on an ongoing basis and recorded on the "Preventative Maintenance Checklist." This is completed by the AQIDP and reviewed by the Administrator every month. The Administrator has reviewed this process with all AQIDP's to improve monitoring of these types of issues.	05/12/15
MM762	16.03.11.270.03(b) Route of Contact Providing a route of contact with a resident's	MM762	<u>MM762</u> Please refer to W331	05/12/15

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



TITLE

Administrator

(X6) DATE

4/3/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/12/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER	STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672
--	---

(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
MM762	Continued From page 1 responsible physician to licensed personnel in the event of an unanticipated health related condition and to coordinate follow-up of care. This Rule is not met as evidenced by: Refer to W331.	MM762		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	<u>MM769</u> Please refer to W455	05/12/15