



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
Bolsa, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 26, 2015

Bridger Fly, Administrator
Communicare, Inc #4 Leland
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #4 Leland, Provider #13G012

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #4 Leland, which was conducted on May 15, 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
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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 **June 8, 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:

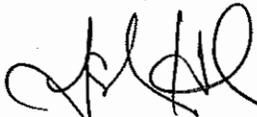
www.icfmr.dhw.idaho.gov

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 June 8, 2015. If a request for informal dispute resolution is received after June 8, 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 HENSCHER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

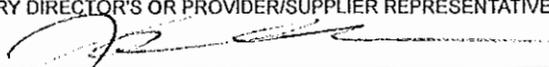
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2015
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #4 LELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 4150 LELAND WAY BOISE, ID 83709	
(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	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey conducted from 5/11/15 to 5/15/15. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disabilities Professional IDT - Interdisciplinary Team IPP - Individualized Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 199	483.440(b)(2) ADMISSIONS, TRANSFERS, DISCHARGE Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure admission decisions were based on a preliminary evaluation of an individual that was conducted or updated by the facility for 1 of 1 individuals (Individual #2) admitted within the past year. This failure resulted in the potential for an individual to be admitted without indications the facility could	W 199	W199 Corrective Actions: This was an oversight. As stated in the survey results "preliminary information was missed as Individual #2 came from a sister facility and was considered a transferred individual." This individual stated that he wanted to move, his mother/guardian visited this location and wanted him to move, we were in a transitional period between QIDPs and the QIDP Supervisor did make this judgement. We do have a system for pre-admission staffings but as stated, considered this a transfer rather than a new admission. Our thinking about this issue has now	07/15/15

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TITLE

Administrator

(X6) DATE

5/29/15

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.

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W 199	<p>Continued From page 1 meet his needs. The findings include:</p> <p>1. Individual #2's IPP, dated 2/12/15, documented a 22 year old male whose diagnoses included unspecified mental retardation and pervasive developmental disorder. He had been residing in a sister facility within the company until he was admitted to the facility on 11/6/14.</p> <p>The history section of Individual #2's IPP stated his parents had wanted him to live in a facility which was closer to their home. The IPP stated a vacancy became available and after discussion with Individual #2 and his guardian, the move was facilitated.</p> <p>However, Individual #2's record did not include documentation that preliminary evaluation information had been garnered and reviewed by the IDT to ensure Individual #2's needs could be met by the admitting facility.</p> <p>During an interview on 5/15/15 from 12:00 to 12:30 p.m., the QIDP Supervisor stated the preliminary evaluation information was missed as Individual #2 came from a sister facility and was considered a transferred individual.</p> <p>The facility failed to ensure a preliminary evaluation was conducted prior to Individual #2's admission to the facility.</p>	W 199	<p>been clarified. A pre-admission overview will be constructed and labeled as a "late entry". Please note that a post-admission staffing was conducted.</p> <p>Identifying Others Potentially Affected: No one else at this location is potentially affected.</p> <p>System Changes: We feel this was an implementation not a systems error. See "Corrective Actions"</p> <p>Monitoring: Our update to Operational Policies and procedures will clearly state that any move from one physical location to another must be considered as a new admission and the Administrator will be responsible for questioning QIDP's about the processing of pre-admission information should such a transfer again occur.</p>	
W 312	483.450(e)(2) DRUG USAGE	W 312	<p><u>W312</u></p> <p>We have clarified this process in our current QIDP Oversight Manual and have included the page of instructions as Attachment A. The QIDP at this</p>	07/15/15

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W 312 | Continued From page 2
are employed.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure a behavior modifying drug was used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction and eventual elimination of the behaviors for which the drug was employed for 1 of 4 individuals (Individual #3) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without a plan that identified how the drug may change in relation to progress or regression. The findings include:

1. Individual #3's 2/19/15 IPP stated he was a 52 year old male whose diagnoses included major depression, Prader Willi syndrome, and mild mental retardation.

Individual #3's record was reviewed and contained the following:

- A 4/22/15 order for Effexor (an antidepressant drug) 37.5 mg every day for two weeks then discontinue.
- An undated physician's order for Clonazepam (an anticonvulsant drug) 0.5 mg one-half tablet every 12 hours twice daily.
- A May 2015 MAR documented beginning 5/7/15 he received Clonazepam as ordered and the Effexor was discontinued on 5/14/15.
- In addition, an April 2015 Nursing Summary

W 312 | location was hired 11/14 and still is learning the very complex job of a QIDP. The QIDP Supervisor generally prepares the medication reduction plan. The QIDP Supervisor did not sufficiently train the she QIDP as to this issue.

- 1) The QIDP Supervisor will review the attached document with the QIDP.
- 2) The QIDP Supervisor and QIDP will update this individual's medication reduction plan.

Identifying Others Potentially Affected:
No others at this location were affected.

System Changes: Please refer to corrective actions.

Monitoring: The QIDP and QIDP Supervisor will monitor each other's work related to the preparation of consents and consistency with other documents mentioned above.

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W 434	<p>Continued From page 4</p> <p>1. The AQIDP accompanied the surveyor during an environmental review on 5/13/15 from 1:00 - 2:15 p.m. During that time, the following concerns were noted:</p> <p>a. In the living room it appeared the carpet had unraveled exposing a nine foot long by one-half inch wide area.</p> <p>b. In the kitchen and dining room area, there were in excess of 100 gouges in the vinyl flooring. The size of the gouges ranged from one and one-half inches long by one-fourth inches wide to seven inches long by one-fourth inch wide.</p> <p>The AQIDP acknowledged the carpet had unraveled in the living room and the kitchen and dining room vinyl flooring was gouged.</p> <p>The facility failed to ensure the carpeting and vinyl flooring was maintained in a clean and sanitary manner.</p>	W 434	<p>Identifying Others Potentially Affected: All individuals living at this location are affected.</p> <p>System Changes: Please refer to corrective actions.</p> <p>Monitoring: The AQIDP completes a monthly Preventative Maintenance Checklist where issues with flooring and other maintenance issues in the house are noted and processed.</p>	

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 5/11/15 to 5/15/15. The surveyors conducting your survey were: Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000		
MM112	16.03.11.050.01(d) Residential Facility The residential facility is to admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. This Rule is not met as evidenced by: Refer to W199.	MM112	<u>MM112</u> Please refer to W199	07/15/15
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	<u>MM197</u> Please refer to W312	07/15/15
MM298	16.03.11.100.06(e) Storage Areas, Attics, Basements Storage areas, attics, basements, and grounds must be kept free from refuse, litter, weeds, or other items detrimental to the health, safety, or welfare of the residents. This Rule is not met as evidenced by: Refer to W434.	MM298	<u>MM298</u> Please refer to W434	07/15/15

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