



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

June 3, 2015

Bridger Fly, Administrator  
Communicare, Inc #1 Gem  
40 West Franklin Road, Suite F  
Meridian, ID 83642

RE: Communicare, Inc #1 Gem, Provider #13G008

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #1 Gem, which was conducted on May 29, 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  
June 3, 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 **June 16, 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:

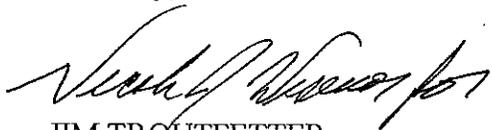
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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 June 16, 2015. If a request for informal dispute resolution is received after June 16, 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,



JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

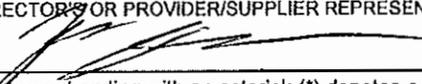
PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/29/2015
NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #1 GEM			STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651	
(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 5/26/15 to 5/29/15.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>AQIDP - Assistant Qualified Intellectual Disabilities Professional CDC - Centers for Disease Control HPV - Human Papilloma Virus IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse NSAID - Non Steroidal Anti-inflammatory Drug PRN - As Needed QIDP - Qualified Intellectual Disabilities Professional RD - Registered Dietitian</p>	W 000	<p>RECEIVED</p> <p>JUN 11 2015</p> <p>FACILITY STANDARDS</p>	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</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 general and preventative medical care was provided for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in the potential for Individual #1 to not</p>	W 322	<p>W322</p> <p>Corrective Actions: We will do further inservice training with our nursing staff related to these issues. The Administrator and QIDP Supervisor will jointly re-inservice the RN Supervisor related to the system which has been designed to check for such records. After this is done, the RN Supervisor and QIDP Supervisor will jointly will inservice the LPN related to the issues of documentation and record keeping.</p>	07/29/15

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

TITLE

(X6) DATE



Administrator

6/11/15

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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	
W 322	<p>Continued From page 1</p> <p>receive adequate medical care. The findings include:</p> <p>1. Individual #1's 5/1/14 IPP documented she was a 26 year old female whose diagnoses included profound mental retardation.</p> <p>The CDC recommends screening for cervical cancer in women 21 to 65 years with cytology (Pap smear) and the decision to perform a complete pelvic examination should be a shared decision after a discussion between the patient and the health care provider.</p> <p>Individual #1's record was reviewed and did not include documentation that a pelvic examination or a Pap smear had been completed. In addition, the record did not include documentation of a discussion with the physician related to a Pap smear and pelvic examination.</p> <p>Individual #1's Medical Observation Log was reviewed. The Log contained a 5/21/14 hand-written entry that documented she was seen by a physician and a pap and pelvic examination was not required due to her age and lack of sexual activity. However, the physician's 5/21/14 progress note was not located in Individual #1's medical record.</p> <p>During record review on 5/28/15 from 12:55 - 3:20 p.m., the LPN was interviewed and stated she contacted the physician on 5/28/15 to obtain a copy of the physician's progress note.</p> <p>On 5/29/15 at 1:48 p.m., the facility faxed a copy of the physician's 5/21/14 progress note. The progress note did not document that a pap and pelvic was not required due to Individual #1's age</p>	W 322	<p>Identifying Others Potentially Affected: The issue of accurate record keeping can affect anyone living at this location.</p> <p>Monitoring: As previously stated the Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p>		

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/29/2015
NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #1 GEM			STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651		
(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 322	Continued From page 2 and lack of sexual activity.  The facility failed to ensure Individual #1's Pap smear and pelvic examination were completed as recommended.  2. Individual #1's 5/1/14 IPP documented she was a 26 year old female whose diagnoses included profound mental retardation.  Individual #1's medical record and Medical Observation Log were reviewed. The Medical Observation Log contained a 5/21/14 hand-written entry that documented she was seen by a physician and a P&P (pap and pelvic examination) was not required due to her age and lack of sexual activity.  However, Individual #1's medical record did not contain the physician's 5/21/14 progress note.  During record review on 5/28/15 from 12:55 - 3:20 p.m., the LPN was interviewed and stated she contacted the physician on 5/28/15 to obtain a copy of the physician's progress note from 5/21/14.  The facility failed to ensure Individual #1's medical record contained current and accurate information.	W 322			
W 324	483.460(a)(3)(ii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious	W 324	<u>W324</u>  Corrective Actions: A memo was sent out 7/13 to all LPN's about Zoster and HPV vaccinations. The LPN who was responsible for this home did not document her actions related to this	07/29/15	

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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	
W 324	<p>Continued From page 3</p> <p>Diseases of the American Academy of Pediatrics.</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 immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in the potential for preventable illness to occur. The findings include:</p> <p>1. Individual #1's 5/1/14 IPP documented she was a 26 year old female whose diagnoses included profound mental retardation.</p> <p>The CDC Pink Book, which contains the recommendations for vaccination needs and schedules, stated HPV can cause genital warts, laryngeal papillomas (tumors that form on the larynx or other parts of the respiratory tract, and cancer of the cervix, vulva, vagina, penis, and anus). The Pink Book stated "HPV is transmitted by direct contact, usually sexual, with an infected person. Transmission occurs most frequently with sexual intercourse but can occur following nonpenetrative sexual activity."</p> <p>The CDC recommends all females between age 9 and 26, and all males between 9 and 21, should receive the HPV vaccination series, and males between 22 and 26 may receive the series unless contraindications exist.</p> <p>Individual #1's record was reviewed and did not include documentation she had received the HPV vaccination or that a discussion related to the need for the vaccination had been conducted with</p>	W 324	<p>issue. The RN Supervisor, hired 10/21/13, is still learning the intricacies of her job. Monitoring expectations were reviewed with her initially but this will be done again jointly by the Administrator who is her immediate supervisor and the QIDP Supervisor who helped to develop various monitoring systems.</p> <p>The need for this immunization will be discussed with this individual's guardian and if he chooses to decline its use, a medical declination will be processed by the QIDP with input from the LPN.</p> <p>Identifying Others Potentially Affected: This is the only person in this age range living at this location.</p> <p>Monitoring: As previously stated the Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p>		

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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
W 324	Continued From page 4 her physician.  During record review on 5/28/15 from 12:55 to 3:20 p.m., the LPN was interviewed and stated Individual #1 had not received the HPV vaccination and the vaccination was not discussed with the physician.	W 324		
W 331	The facility failed to ensure Individual #1 received the HPV vaccination as recommended by the Public Health Service Advisory Committee. <b>483.460(c) NURSING SERVICES</b>  The facility must provide clients with nursing services in accordance with their needs.  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 #2 - #4) whose medical records were reviewed. This resulted in a lack of clear physician orders being available to staff. The findings include:  1. Individual #1 - #4's physician's orders were reviewed. The Physician's Order Sheet and Progress Note forms included PRN medications which were duplicative and did not consistently include specific individualized orders, as follows:  a. The PRN section of Individual #2's 5/1/15 Physician's Order Sheet and Progress Note stated she was to receive Acetaminophen (an analgesic drug) 325 mg for "pain, temp >101 [temperature greater than 101]." The section stated Individual #2 could also receive Ibuprofen	W 331 <u>W331</u>	<b>07/29/15</b>	
			Corrective Actions: This issue has been further evaluated by our RN Supervisor. 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 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.	

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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	
W 331	<p>Continued From page 5 (an NSAID) 600 mg for "pain or discomfort." The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>b. The PRN section of Individual #3's 5/1/15 Physician's Order Sheet and Progress Note stated she was to receive Acetaminophen 650 mg every 4 hours for "mild pain or elevated temp &gt;101." The section stated Individual #2 could also receive Ibuprofen 600 mg for "pain or discomfort." The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>c. The PRN section of Individual #4's 5/1/15 Physician's Order Sheet and Progress Note stated she was to receive Acetaminophen 650 mg every 4 hours for "mild pain, temp &gt;101." The section stated Individual #4 could also receive Ibuprofen 400 mg every 8 hours for "pain or discomfort." The orders did not include specific information regarding how to determine which medication to use and when.</p> <p>During an interview on 5/28/15 from 9:45 to 9:50 a.m., the facility LPN acknowledged the orders did not include specific information to determine which medication to use and when.</p> <p>Additionally, Individuals #2 and #4 Physician's Order Sheet and Progress Notes documented they were to receive Artificial Tears 1-2 drops in each eye twice a day. However, the orders did not specify if Individuals #2 and #4 were to receive 1 eye drop or 2 eye drops.</p> <p>During an interview on 5/27/15 at 10:45 a.m., the facility LPN stated the orders needed to be</p>	W 331	<p>Identifying Others Potentially Affected: All other individuals living at this location are potentially affected by this issue.</p> <p>System Changes: A copy of the addition to the RN Oversight &amp; Nursing Services Manual titled "Consistency of Records" is attached.</p> <p>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.</p> <p>Additionally the Administrator and the QIDP Supervisor will again inservice the RN Supervisor on monitoring systems and the Administrator, who is her immediate supervisor, will do a sampling of the implementation of these monitoring systems on a quarterly basis.</p>		

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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
W 331	Continued From page 6 clarified.	W 331		
W 440	<p>The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were clarified.</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</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 evacuation drills were conducted quarterly for each shift of personnel for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas in the event of an emergency. The findings include:</p> <p>1. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the day shift (6:00 a.m. - 2:00 p.m.) during the fourth quarter (October - December) of 2014.</p> <p>During an interview on 5/27/15 at 11:00 a.m., the AQIDP stated the evacuation drill for the day shift had not been completed due to an oversight.</p> <p>The facility failed to ensure an evacuation drill was completed for the a.m. shift during the fourth quarter.</p>	W 440	<p><u>W440</u></p> <p>Corrective Actions: Monthly evacuation drills are scheduled on CCI's Annual Calendar related to shift and time. The secretary checks monthly to insure that scheduled evacuation drills in all CCI locations are completed. The failure to complete this one evacuation drill appears to be an implementation error which occurred during the current House Managers vacation and was not identified until it was too late to take corrective action for that month. The House Manager understands this regulation and her responsibility to schedule fire drills according to time segments identified on our annual calendar and will receive a formal written counseling related to this issue. If further scheduling errors occur related to evacuation drills occur, disciplinary action will be implemented.</p> <p>Identifying Others Potentially Affected: All individuals living at this location are potentially affected.</p>	07/29/15
W 463	483.480(a)(4) FOOD AND NUTRITION SERVICES	W 463	System Changes: We feel this was an implementation not a systems error. See "Corrective Actions"	

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/29/2015
NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #1 GEM			STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651	
(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 463	<p>Continued From page 7</p> <p>The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure modified diets were adequately reviewed and prescribed to meet the individualized needs of 1 of 4 individuals (Individual #4) whose nutritional records were reviewed. This resulted in a lack of clear direction to staff regarding an individual's food texture. The findings include:</p> <p>1. Individual #4's 5/27/14 IPP stated she was a 31 year old female whose diagnoses included legal deafness and blindness, obsessive compulsive disorder, autism, and profound mental retardation.</p> <p>The facility's Spring/Summer menu was reviewed and stated Individual #4 was to receive a pureed diet. Her menu for the breakfast meal on Wednesday, 5/27/15, included 1/2 bagel pureed with cream cheese.</p> <p>However, during a breakfast observation on 5/27/15 from 6:53 to 8:20 a.m., Individual #4 was eating breakfast and a direct care staff served her 1/2 of a bagel that was cut into bite sized pieces.</p> <p>Individual #4's record included a 4/9/14 Speech, Language and Swallow Evaluation signed by a Speech Language Pathologist (SLP) which stated, "...Continue pureed diet with thin liquids for meals, but present soft foods in 1 inch bites for snacks during the day..." The evaluation did</p>	W 463	<p>Monitoring: The secretary will continue to monitor that evacuation drills have occurred and will inform the Administrator of any drills that do not occur by the third week of the month so that corrective actions can be taken.</p> <p><u>W463</u></p> <p>PLEASE NOTE: We appreciate the identification and assessment of this issue by the survey team. Seldom do we have situations when food textures are changed to firmer rather than softer. However, we would like to take credit at this location for challenging a diet order of "gluten free" for this individual and for assessing and making changes to this dietary modification.</p> <p>Corrective Actions: The QIDP will arrange a meeting with the dietician, the speech therapist and other IDT members to further discuss this issue and to determine what dietary texture changes can be made. A plan will be developed based on this input and then will be implemented.</p> <p>Identifying Others Potentially Affected: No other individuals living at this location are potentially affected by this issue.</p> <p>System Changes: We do not feel that systems changes are indicated.</p>	07/29/15

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

PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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
W 463	<p>Continued From page 8 not include a list of soft foods.</p> <p>Individual #4's Ancillary Log included documentation that soft pureed foods had been presented to Individual #4, per the SLP recommendations. The log documented she had consumed non-pureed foods, which included but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- 8/7/14 diced peaches; 8/8/14 &amp; 8/11/14 cottage cheese with pineapple; 8/14/14 mandarin oranges; 8/17/14 fruit cup; 8/18/14 cottage cheese; 8/21/14 melon; 8/23/14 rice cakes; 8/29/14 pear cup; 9/17/14 cottage cheese; 9/22/14 and 9/29/14 fruit cup; and 10/4/14 1/2 half cheese sandwich cut into bite-sized pieces.</li> </ul> <p>Further, Individual #4's quarterly nutrition assessments were reviewed and included the following documentation:</p> <ul style="list-style-type: none"> <li>- 11/6/14 Diet pureed trialing different food texture as appropriate.</li> <li>- 5/15/15 Diet remains puree Dysphagia Level I, per staff trialing mechanical soft options as approved previously by SLP.</li> </ul> <p>However, Individual #4's 5/1/15 Physician's Order Sheet and Progress Note stated she was to receive a pureed diet. Individual #4's record did not include clarification of the physician's pureed diet order, the soft foods she could eat, a recommendation from the RD to clarify the diet order, menu adjustments based on the soft food trials, or a recommendation to re-evaluate Individual #4's chewing ability.</p> <p>When asked during record review on 5/28/15</p>	W 463	<p>Monitoring: After implementation of whatever plan is recommended, observations related to mealtime activities will be conducted by management staff on a monthly basis for at least three months. Additionally, the dietician will review this individual's status on a quarterly basis as documented in Ancillary Log notes.</p>	

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

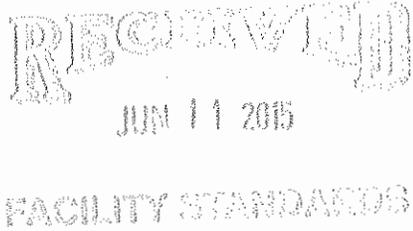
PRINTED: 06/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/29/2015
NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #1 GEM		STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651		
(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 463	<p>Continued From page 9</p> <p>from 12:55 - 3:20 p.m., the AQIDP stated the facility had previously contacted the RD and was told Individual #4 could eat bagels. The AQIDP also said Individual #4 had not been re-evaluated to determine the necessity of the pureed diet.</p> <p>During an interview on 5/28/15 from 9:30 - 9:45 a.m., the QIDP stated the facility needed to readdress Individual #4's chewing and eating ability and diet texture to ensure the least restrictive diet was in place for Individual #4.</p> <p>The facility failed to ensure Individual #4's diet texture was appropriately prescribed by the IDT including the RD and the physician.</p>	W 463		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/29/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #1 GEM	STREET ADDRESS, CITY, STATE, ZIP CODE 32 N GEM STREET NAMPA, ID 83651
---	---

(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 annual licensure survey conducted from 5/26/15 to 5/29/15.  The surveyors conducting your survey were:  Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD  Common abbreviations used in this report are:	M 000		
MM337	16.03.11.110.04(c) Fire Drills  A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337		07/29/15
MM548	16.03.11.210.02(g) Immunization  Record of immunizations; and This Rule is not met as evidenced by: Refer to W324.	MM548		07/29/15
MM679	16.03.11.250.08(c)(i) Pureed or Ground Meat  Food must be cut, ground, or pureed only for those who require it. Pureed or ground food must be the same foods as the menu for that meal; leftovers are not to be used for this purpose; This Rule is not met as evidenced by: Refer to W463.	MM679		07/29/15
MM735	16.03.11.270.02 Health Services	MM735		07/29/15

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

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #1 GEM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>32 N GEM STREET NAMPA, ID 83651</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
MM735	Continued From page 1  The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM762	16.03.11.270.03(b) Route of Contact  Providing a route of contact with a resident's 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	<u>MM762</u>  Please refer to W331	07/29/15