



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 2, 2015

Bridger Fly, Administrator  
Communicare, Inc #2 Boone  
40 West Franklin Road, Suite F  
Meridian, ID 83642

RE: Communicare, Inc #2 Boone, Provider #13G009

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #2 Boone, 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  
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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 15, 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 15, 2015. If a request for informal dispute resolution is received after June 15, 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 TROUTVETTER  
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: 06/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/29/2015
NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #2 BOONE			STREET ADDRESS, CITY, STATE, ZIP CODE 1210 W BOONE ST 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	INITIAL COMMENTS  The following deficiency was cited during the annual recertification survey conducted from 5/26/15 to 5/29/15.  The survey was conducted by:  Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD  Common abbreviations used in this report are:  LPN - Licensed Practical Nurse NSAID - Non Steroidal Anti-inflammatory Drug PRN - As Needed	W 000		
W 331	483.460(c) NURSING SERVICES  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 #1, #2, and #4) whose physician's orders 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 #1's 5/1/15 Physician's Order Sheet and Progress Note	W 331	W331  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	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.

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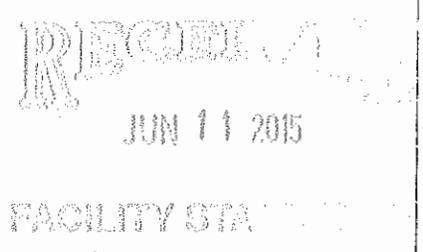
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #2 BOONE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1210 W BOONE ST 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 1</p> <p>stated she was to receive Acetaminophen (an analgesic drug) 325 mg for "pain, temp &gt;101 [temperature greater than 101]." The section stated Individual #1 could also receive Ibuprofen (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 #2'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 he was to receive Acetaminophen 650 mg every 4 hours for "mild pain, temp &gt;101." The section stated Individual #4 could also receive Ibuprofen 600 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>The facility failed to provide sufficient nursing oversight necessary to ensure individuals' medication orders were clarified.</p>	W 331	<p>then request that the physician clarify orders related to the dosages of PRN medications.</p> <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>	

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments  The following deficiency was 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	M 000		
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	<p><u>MM762</u></p> <p>Please refer to W331</p>	07/29/15

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

TITLE

(X6) DATE