



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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June 10, 2015

Bridger Fly, Administrator
Communicare, Inc #9 Main
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #9 Main, Provider #13G059

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Communicare, Inc #9 Main, on June 1, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states

Bridger Fly, Administrator
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Page 2 of 2

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 23, 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:

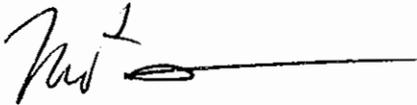
www.icfmr.dhw.idaho.gov

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 22, 2015. If a request for informal dispute resolution is received after June 22, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/lj

Enclosure

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

Printed: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

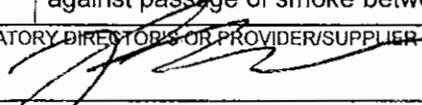
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #9 MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 876 EAST MAIN JEROME, ID 83338
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 0001	INITIAL COMMENTS The facility is a single story Type V (000) duplex sprinklered throughout by a modified 13-D extinguishment system. It is protected by a complete fire alarm/smoke detection system. It was built in 1996 and completed in January of 1998. It is currently licensed for 9 ICF/ID beds. The following deficiencies were found during the annual Life Safety Code survey conducted on June 1, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j), and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities. The survey was conducted by: Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	K 000		
K0012	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD IMPRACTICAL Buildings are of any construction type in accordance with 8.2.1 other than Type II (000), Type III (200), or Type V (000) construction. 33.2.1.3.3. Exception: Buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5 are permitted to be of any type of construction. This Standard is not met as evidenced by: Based on observation, the facility failed to assure that all smoke partitions would provide protection against passage of smoke between	K0012	<u>K0012</u> Corrective Actions: The facility uses a Preventative Maintenance Checklist (PMC) (See Attachment A) to inspect various issues on a routine basis. This hole was not listed on the checklist and had most likely occurred recently. This facility is a home to individuals with fairly significant maladaptive behaviors. Every effort is made to keep the home in good repair but keeping up with these repairs can be a challenge. The hole will be repaired by the maintenance man and would have been placed on the PMC for repair when that form was	08/07/15

RECEIVED
JUN 26 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>6/23/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Printed: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

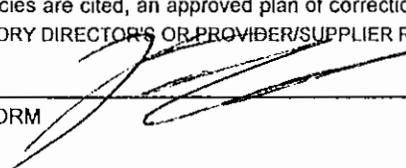
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K0012	<p>Continued From page 1</p> <p>compartments. This deficient practice affected six clients, two staff members, and visitors on the day of the survey. The facility is licensed for 9 ICF beds with a census of 8 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on January 21, 2015 at approximately 12:15 PM, observation of the living room wall near the back door revealed a hole approximately 6" x 4". When asked, the house manager and the maintenance supervisor stated they were unaware of the hole.</p> <p>Actual NFPA reference: NFPA 101, 8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception*: Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum.</p>	K0012	<p>completed by the house supervisor.</p> <p>Identifying Others Potentially Affected: All clients could potentially have been affected.</p> <p>System Changes: Please refer to Corrective Actions.</p> <p>Monitoring: House supervisor will be monitoring the facility for these types of issues that are not in compliance as part of the preventative maintenance checklist already in place at this location.</p>	

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M 000	16.03.11 Initial Comments The facility is a single story Type V (000) duplex sprinklered throughout by a modified 13-D extinguishment system. It is protected by a complete fire alarm/smoke detection system. It was built in 1996 and completed in January of 1998. It is currently licensed for 9 ICF/ID beds. The following deficiencies were found during the annual Fire/Life Safety survey conducted on June 1, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j). The survey was conducted by: Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This RULE: is not met as evidenced by: Refer to the following federal "K" tags on CMS - 2567 K012 - Building Construction	MM309	<u>MM309</u> Please Refer to K0012	08/07/15
MM311	16.03.11.110.01(a) Structurally Sound The facility must be structurally sound and must be maintained and equipped to assure the safety of residents, employees and the public.	MM311	<u>MM311</u> Corrective Actions: It should be noted that all soffit panels and siding had been replaced in the last few months.	08/07/15

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



TITLE

Administrator

(X6) DATE

6/23/15

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MM311	<p>Continued From Page 1</p> <p>This RULE: is not met as evidenced by: Based on observation and interview the facility failed to maintain the structure of the facility. This deficient practice could allow smoke and gases, or insects and vermin to enter the open space of the underside of the exterior roof and spread throughout the facility affecting all clients, staff members, and visitors on the date of survey. The facility is licensed for 9 ICF beds with a census of 8 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on June 1, 2015 at approximately 12:00 PM, observation of building 876 revealed the soffit panels on the roof eave structure located above the garage door were damaged.</p> <p>2.) During the facility tour on June 1, 2015 at approximately 12:00 PM, observation of building 876 revealed the soffit panels on the roof eave structure located above the front door were damaged..</p> <p>3.) During the facility tour on June 1, 2015 at approximately 12:00 PM, observation of building 878 revealed approximately six soffit panels on the roof eave structure located above the front door were missing.</p> <p>4.) During the facility tour on June 1, 2015 at approximately 12:00 PM, observation of building 878 revealed soffit panels on the roof eave structure located above back door were damaged.</p> <p>5.) During the facility tour on June 1, 2015 at approximately 12:15 PM, observation of the glass of the fire extinguisher cabinet in building 878 revealed a crack starting from the latch running horizontally approximately 7-8 inches. When asked, the house manager and the maintenance supervisor were unaware of the cracked glass.</p> <p>6.) During the facility tour on June 1, 2015 at</p>	MM311	<p>This facility is a home to individuals with fairly significant maladaptive behaviors. Shortly after replacement the damage was done again and we are going through the bidding process with contractors to replace the soffits and siding issues.</p> <p>The following issues will be repaired:</p> <ol style="list-style-type: none"> 1) Damaged soffit panels above garage door 2) Damaged soffit panels above front door 3) Missing soffit panels above front door 4) Damaged soffit panels at back door 5) Glass on fire extinguisher cabinet 6) Window crack on building 876 <p>Identifying Others Potentially Affected: All clients could potentially have been affected.</p> <p>System Changes: Please refer to Corrective Actions.</p> <p>Monitoring: House supervisor will be monitoring the facility for these types of issues that are not in compliance as part of the preventative maintenance checklist already in place at this location.</p>	

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MM311	Continued From Page 2 approximately 12:05 PM, observation of a room window of building 876 revealed a horizontal crack running the full length of the window. When asked, the house manager and the maintenance supervisor stated they were unaware of the broken glass on both the fire extinguisher cabinet and the room window but were aware of the damaged and missing panels. Actual Reference: IDAPA 16.03.22.110.01 (a) The facility must be structurally sound and must be maintained and equipped to assure the safety of residents, employees and the public.	MM311		
MM327	16.03.11.110.02(h) Emergency Electrical Service Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system. This RULE: is not met as evidenced by: Based on observation and functional testing, it was determined that the facility had not ensured that the emergency electrical lighting was maintained in working order. The facility is licensed for 9 ICF beds with a census of 8 on the day of survey. The findings include: During the facility tour on June 1, 2015 at approximately 12:15 PM, observation and operational testing of building 876 revealed the emergency lighting located in the hallway across from the laundry room was not functioning upon pressing of the test button. When asked, the house manager and the maintenance supervisor were not aware of the inoperable lights.	MM327	<u>MM327</u> Corrective Actions: The facility has repaired the malfunctioning emergency electrical lighting. It should be noted that the lighting had been inspected as part of a routine preventative maintenance checklist inspection and had been in proper working order the month prior according to the house manager. Identifying Others Potentially Affected: All individuals living at this location were potentially affected by this issue. System Changes: No system changes are needed as corrective actions will bring the facility into compliance.	08/07/15

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MM327	Continued From Page 3 Actual Reference: IDAPA 16.03.22.110.02 (h) Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system.	MM327	Monitoring: House supervisor will be monitoring the facility emergency lighting is part of the preventative maintenance checklist already in place at this location.	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This RULE: is not met as evidenced by: Based on observation, the facility failed to provide exterior window screens. This deficient practice allows flies and other insects into the facility. The facility is licensed for nine ICF beds with a census of eight on day of survey Findings include 1.) During the survey tour on June 1, 2015 between 12:00 PM and 1:00 PM, observation revealed the facility failed to provide exterior bedroom window screens for three rooms in building 878. When questioned, the house manager and the maintenance supervisor were aware of the screens missing. 2.) During the survey tour on June 1, 2015 between 12:00 PM and 1:00 PM, it was observed that the bedroom door across from the hallway bathroom was missing the latch. When questioned, the house manager and the	MM380	<u>MM380</u> Corrective Actions: This facility is a home to individuals with fairly significant maladaptive behaviors. Every effort is made to keep the home in good repair but keeping up with these repairs can be a challenge. The following issues will be repaired: 1) Exterior screens for three rooms will be replaced in building 878 2) The missing latch on the bedroom door will be replaced Identifying Others Potentially Affected: All clients could potentially have been affected. System Changes: Please refer to Corrective Actions. Monitoring: House supervisor will be monitoring the facility for these types of issues that are not in compliance as part of the preventative maintenance checklist already in place at this location.	08/07/15

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MM380	Continued From Page 4 maintenance supervisor were unaware of the missing latch. Actual reference: IDAPA 16.02.11.120.03. a General Building Requirements. All buildings to be used for ICF/ID facilities must be of such character suitable for such usage. These buildings will be subject to approval by the Department. Other requirements are as follows (a) The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.	MM380		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.