



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Eder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

January 13, 2016

Matt Borchardt, Administrator  
Preferred Community Homes-- Cougar Creek  
12553 West Explorer Drive Suite 190  
Boise, ID 83713

RE: Preferred Community Homes - Cougar Creek, Provider #13G037

Dear . Borchardt:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Preferred Community Homes - Cougar Creek, on January 4, 2016.

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,

Matt Borchardt, Administrator

January 13, 2016

Page 2 of 2

5. Include dates when corrective action 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 **January 26, 2016**, 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 January 26, 2016. If a request for informal dispute resolution is received after January 26, 2016, 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: 01/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/04/2016</b>
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NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - COUGAR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 EAST COUGAR CREEK MERIDIAN, ID 83642</b>
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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 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(000), residential building. The building is protected throughout except in the detached garage and attic by a NFPA 13 D fire sprinkler system with quick response sprinkler heads. There is a complete fire alarm/smoke detection system. The facility was built in January of 1996. Currently it is licensed for 8 ICF/ID beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on January 4, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies and in accordance with 42 CFR, 483.470.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K0046	<p><b>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</b></p> <p>Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that safe electrical connections were provided. Multiple outlet, non-grounded extension cords used for electrical installations could result in electrocution by arcing or fires created from overcurrent applications. This deficient practice affected clients, staff and visitors on the date of the survey. The facility is</p>	K0046	<p style="text-align: right;"> <i>Reviewed</i>  <i>JAN 25 2016</i>  <i>FACILITY STANDARDS</i> </p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sam Burbank</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>1.10.2016</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

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NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - COUGAR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 EAST COUGAR CREEK MERIDIAN, ID 83642</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
K0046	<p>Continued From page 1 licensed for 8 ICF/ID beds and had a census of 5 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 4, 2016 from 11:30 AM to 12:30 PM, observation of the northeast bedroom revealed a 3-1 non-grounded extension cord in use. Interview of the Maintenance Supervisor revealed he was not aware of the use of this extension cord.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 Chapter 2 Wiring and Protection</p> <p>200.3 Connection to Grounded System. Premises wiring shall not be electrically connected to a supply system unless the latter contains, for any grounded conductor of the interior system, a corresponding conductor that is grounded. For the purpose of this section, electrically connected shall mean connected so as to be capable of carrying current, as distinguished from connection through electromagnetic induction.</p> <p>Chapter 4 Equipment for General Use</p> <p>400.3 Suitability. Flexible cords and cables and their associated fittings shall be suitable for the conditions of use and location.</p>	K0046		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/04/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - COUGAR CRE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 EAST COUGAR CREEK MERIDIAN, ID 83642</b>		
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M 000	16.03.11 Initial Comments  The facility is a single story, Type V(000) , residential building. The building is protected throughout except in the detached garage and attic by a NFPA 13 D fire sprinkler system with quick response sprinkler heads. There is a complete fire alarm/smoke detection system. The facility was built in January of 1996. Currently it is licensed for 8 ICF/ID beds.  The following deficiencies were cited during the annual Fire/Life Safety survey conducted on January 4, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, in accordance with 42 CFR, 483.470 and IDAPA 16.03.11, Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID).  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	M 000		
MM322	16.03.11740 Fire, Life Safety - Existing Facility  All buildings on the premises of an ICF/ID must meet all the requirements of local, state, and national codes concerning fire and life safety standards that are applicable to ICFs/ID.  This Rule is not met as evidenced by: Please refer to federal form 2567:  K - 046 Utilities	MM322		

RECEIVED  
JAN 23 2016  
FACILITY STANDARDS

Idaho form

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

TITLE

(X6) DATE

*B. Buchanan*

*Program Manager*

*1.20.2016*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/04/2016</b>
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MM333	<p>16.03.11740.05 Portable Space Heating Devices</p> <p>The use of portable comfort space heating devices of any kind is prohibited in an ICF/ID.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe environment by allowing the use of portable space heating devices. Portable space heating devices are historically linked as the cause of residential home fires. This deficient practice affected clients, staff and visitors on the date of the survey. The facility is licensed for 8 ICF/ID beds and had a census of 5 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 4, 2016 from approximately 11:30 AM to 12:30 PM, observation of the office revealed a portable space heater in use. When asked about the heater use in the office, the care giver staff present stated the office was often cold and the heater helped to keep it warm. Interview of the Maintenance Supervisor revealed he was not aware of the heater use.</p> <p>Actual IDAPA rule: 16.03.11.740.05</p> <p>740. FIRE AND LIFE SAFETY STANDARDS -- EXISTING FACILITY.</p> <p>05. Portable Comfort Space Heating Devices Prohibited. The use of portable comfort space heating devices of any kind is prohibited in an ICF/ID.</p>	MM333		



January 20, 2016

Mark Grimes  
Health Facility Surveyor  
Non-Long Term Care  
3232 Elder Street  
P.O. Box 83709  
Boise, Idaho 83720-0009

RECEIVED  
JAN 29 2016  
FACILITY STANDARDS

Dear Mr. Grimes,

Thank you for your attentiveness during the recent Fire Light Safety Survey at the Cougar Creek facility. Please see our responses below for each citation and give us a call if you have any questions.

K0046:

1. Aspire Human Services will remove the extension cord from the facility affecting 5 individuals served, staff, and visitors.
2. The Maintenance Supervisor will complete quarterly home inspections to ensure there are no extension cords in the facility.
3. Aspire Human Services will train direct support professionals and the individuals served on the regulation to ensure extension cords are no longer purchased or brought into the facility
4. The facility will have a visual spot check for extensions cords daily by direct support professionals, while they are working, after receiving training on this regulation.
5. Person Responsible: Program Manager, Maintenance Supervisor, Program Supervisor, Direct Support Professionals  
Completion Date: 1.31.2016

MM322:

See K0046

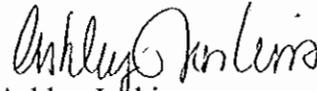
MM333:

1. Aspire Human Services will remove the space heater from the facility affecting the 5 individuals served, staff, and visitors.
2. The Maintenance Supervisor, when completing day to day tasks, will spot check the facility for space heaters.
3. Aspire Human Services will have the heating system inspected at the facilities to ensure it is running as intended, removing the desire for a space heater.

4. The Program Manager and Maintenance Supervisor will complete a walk through on the facility when visiting, ensuring there are no space heaters.
5. Person Responsible: Maintenance Supervisor, Program Supervisor  
Completion Date: 2.15.2016



Kristin Buchanan  
Program Manager



Ashley Jenkins  
Program Supervisor