



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 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 13, 2016

Shantelle Kates, Administrator
Preferred Community Homes-- Mallard
12553 West Explorer Drive Suite 190
Boise, ID 83713

RE: Preferred Community Homes-- Mallard, Provider #13G032

Dear Ms. Kates:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Preferred Community Homes - Mallard, 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,

Shantelle Kates, 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

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: 13G032	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2016
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MALLAR	STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642
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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>INITIAL COMMENTS</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 deficiency was 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 (j).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K0046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</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 safe electrical installations were provided which limited the potential of fires created by overcurrent usage or arcing. The use of multiple plug adapters has historically been linked to fires in health care facilities. This deficient practice affected clients, staff and visitors on the date of the survey. The facility is</p>	K0046	<p>RECEIVED JAN 25 2016 FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K Buchanan</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>1.20.2016</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 PREFERRED COMMUNITY HOMES - MALLAR		STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642		
(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 6 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on January 4, 2016 from approximately 2:30 PM to 3:30 PM, observation of the dining/living area revealed a 6 to 2 multiple plug adapter installed. Interview of the Maintenance Supervisor indicated he was not aware of the installation.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 ARTICLE 110 Requirements for Electrical Installations</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p>	K0046		

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K0046	Continued From page 2 (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K0046		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G032	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2016
NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MALLARD		STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642		
(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	<p>16.03.11 Initial Comments</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 deficiency was cited at the above facility 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 (j) and IDAPA 16.03.11, Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000		
MM322	<p>16.03.11740 Fire, Life Safety - Existing Facility</p> <p>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.</p> <p>This Rule is not met as evidenced by: Please refer to federal form 2567:</p> <p>K - 046 Utilities</p>	MM322		

RECEIVED
JAN 26 2016
FACILITY STANDARDS

Idaho form

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

TITLE

(X6) DATE

S. Burbank

program manager

1.20.2016



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 23 2016
FACILITY STANDARDS

Dear Mr. Grimes,

Thank you for your attentiveness during the recent Fire Light Safety Survey at the Mallard Landing 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 multiple plug adapter from the facility affecting 6 individuals served, staff, and visitors.
2. The Maintenance Supervisor will complete quarterly home inspections to ensure there is safe electrical installations. In addition, when completing day to day tasks, the Maintenance Supervisor will spot check the facility.
3. Aspire Human Services currently has a monthly home inspection checklist. The checklist will be reviewed to ensure safe electrical installations is inspected. Aspire Human Services will remove the multiple plug adapter from the facility.
4. The monthly home inspection checklist is reviewed by the Program Supervisor, Program Manager, and Maintenance Supervisor to ensure the deficient practice does not occur again and there is safe electrical installations for the facility.
5. Person Responsible: Program Manager, Maintenance Supervisor, Program Supervisor
Completion Date: 1.31.2016

MM322:
See K0046

A handwritten signature in cursive script that reads 'Kristin Buchanan'.

Kristin Buchanan
Program Manager

Carlos Magana
Program Supervisor

A handwritten signature in cursive script that reads 'Carlos Magana'.