



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

Christina Plasencia, Administrator  
Preferred Community Homes-- Vineyards  
12553 West Explorer Drive Suite 190  
Boise, ID 83713

RE: Preferred Community Homes-- Vineyards, Provider #13G028

Dear Ms. Plasencia:

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

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

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  
Facility Fire Safety and 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:<br><br><b>13G028</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02 - ENTIRE STRUCTURE</b><br><br>B. WING _____                     | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>PREFERRED COMMUNITY HOMES - VINEYAR</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2226 WEST SONOMA DRIVE<br/>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                                |
| 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 1996. Currently it is licensed for 8 ICF/MR beds.</p> <p>The facility was found to be in substantial compliance with applicable fire/life safety requirements 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 &amp; Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank<br/>Health Facility Surveyor<br/>Facility Fire Safety and Construction</p> | K 000   |   |   |

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

TITLE

(X6) DATE

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.

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>13G028</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02 - ENTIRE STRUCTURE</b><br><br>B. WING _____                     | (X3) DATE SURVEY COMPLETED<br><br><b>01/04/2016</b> |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>PREFERRED COMMUNITY HOMES - VINEYARDS</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2226 WEST SONOMA DRIVE<br/>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) 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 1996. Currently it is licensed for 8 ICF/MR beds.</p> <p>The facility was found to be in substantial compliance 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).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank<br/>Health Facility Surveyor<br/>Facility Fire Safety and Construction</p> | M 000   |   |   |

Idaho form

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

TITLE

(X6) DATE