



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

February 10, 2016

Bridger Fly, Administrator
Communicare, Inc. #4 Leland
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #4 Leland, Provider #13G012

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 #4 Leland, on February 1, 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: 02/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #4 LELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 4150 LELAND WAY BOISE, ID 83709
---	---

(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>INITIAL COMMENTS</p> <p>The facility is a single story Type V (000) residential building built in 1980. It is fully sprinklered throughout with a complete fire alarm/smoke detection system. Currently the building is licensed for 8 ICF/ID beds. The survey was conducted under the Life Safety Code 2000 Edition, Existing Board and Care Occupancy, Impractical Evacuation Capability in accordance with 42 CFR 483.470.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on February 1, 2016.</p> <p>The survey was conducted by: Sam Burbank Health Facility Surveyor Fire Safety and Construction Program</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: 13G012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2016
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #4 LELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 4150 LELAND WAY BOISE, ID 83709		
(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 built in 1980. It is fully sprinklered throughout with a complete fire alarm/smoke detection system. Currently the building is licensed for 8 ICF/ID beds. The survey was conducted under the Life Safety Code 2000 Edition, Existing Board and Care Occupancy, Impractical Evacuation Capability 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 facility was found to be in substantial compliance during the annual fire/life safety survey conducted on February 1, 2016.</p> <p>The survey was conducted by: Sam Burbank Health Facility Surveyor Fire Safety and Construction Program</p>	M 000		

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

TITLE

(X6) DATE