



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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January 14, 2014

Bridger Fly, Administrator
Communicare, Inc. #5 Kuna
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #5 Kuna, Provider # 13G021

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey of Communicare, Inc. #5 Kuna, which was concluded on January 7, 2014.

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 Statement of Deficiencies/Plan of Correction form listing State licensure 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,

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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 27, 2014**, 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 27, 2014. If a request for informal dispute resolution is received after January 27, 2014, 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
Facility Fire Safety and Construction Program

MPG/lj

Enclosures

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

Printed: 01/13/2014
FORM APPROVED
OMB NO. 0938-0391

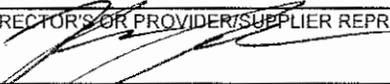
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA	STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634
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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 single story Type V(000) unprotected construction. The building has a complete automatic sprinkler system with coverage throughout including closets and bathrooms. There is an automatic fire alarm system with smoke detection throughout and manual pull stations are located at each of the two exits to grade. The fire alarm system is interconnected with the sprinkler system. The facility is currently licensed for 8 ICF/MR beds.</p> <p>The facility was found to be in substantial compliance during the annual recertification life safety code survey conducted on January 6 - 7, 2014. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 32 New Residential Board and Care Occupancies, Impractical Evacuation Capabilities, adopted March 11, 2003 in accordance with 42 CFR 483.470.</p> <p>The annual life safety code survey was conducted by:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction Program</p>	K 000		
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JAN 27 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/23/2014
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(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	16.03.11 Initial Comments The facility is single story Type V (000) unprotected construction. The building has a complete automatic sprinkler system with coverage throughout including closets and bathrooms. There is an automatic fire alarm system with smoke detection throughout and manual pull stations are located at each of the two exits to grade. The fire alarm system is interconnected with the sprinkler system. The facility is currently licensed for 8 ICF/MR beds. The following deficiencies were cited during the annual licensure life safety code survey conducted on January 24, 2011. The facility was surveyed under the Life Safety Code, 2000 Edition, Chapter 32 New Residential Board and Care Occupancies, Impractical Evacuation Capabilities, and in accordance with IDAPA 16.03.11. Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities The annual life safety code survey was conducted by: Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction Program	M 000		
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 all emergency electrical lighting was maintained in working order. The facility had a	MM327	CCI #5 MM327 Corrective Actions: The facility does provide a system for monitoring emergency lighting units for proper functioning. The system includes a "Preventative Maintenance Checklist" which includes running the emergency lights for 30 seconds a month and	1/27/2014

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

TITLE

(X6) DATE

Administrative

1/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA		STREET ADDRESS, CITY, STATE, ZIP CODE 750 SWAN FALLS ROAD KUNA, ID 83634		
(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
MM327	Continued From Page 1 census of eight clients on the day of the survey. The findings include: Observation on January 6, 2014 at 11:30 AM, disclosed that three of five emergency lighting units in the facility were not functioning upon pressing of the test button. Findings were witnessed and noted by Surveyor and facility Staff. This deficiency affected all staff and clients present on the day of the survey.	MM327	90 minutes once a year (see Attachment A). The AQIDP who is responsible for monitoring this check list was trained on how to use this checklist properly to ensure emergency lighting devices are functioning properly. Identifying others potentially affected: All individuals at this location could be potentially affected by not having properly functioning emergency lighting. This location has been retrained to make sure the lighting is functioning properly and that it is monitored on a monthly basis. System Changes: The system in place is adequate when properly used. The Administrator already signs off that the emergency lighting check has been completed and will continue to do so. Monitoring: The facility will be monitoring the emergency lighting by using the "Preventative Maintenance Checklist" as outlined above in the corrective actions section of this plan of correction (see Attachment A).	

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