



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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RECEIVED
MAR 11 2014
DIV. OF MEDICAID

February 27, 2014

Bridger Fly, Administrator
Communicare, Inc #6 Weiser
40 West Franklin Road, Suite F
Meridian, ID 83642

RECEIVED
MAR 11 2014
FACILITY STANDARDS

RE: Communicare, Inc #6 Weiser, Provider #13G027

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #6 Weiser, which was conducted on February 14, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar 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,
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

Bridger Fly, Administrator
February 27, 2014
Page 2 of 2

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 **March 11, 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:

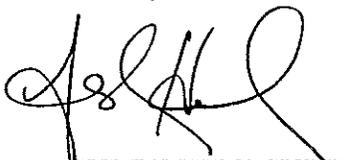
www.icfmr.dhw.idaho.gov

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 March 11, 2014. If a request for informal dispute resolution is received after March 11, 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 us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



ASHLEY HENSCHEN
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672	
(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
W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 2/10/14 to 2/14/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Trish O'Hara, RN Common abbreviations used in this report are: AED - Anti-Epileptic Drug AQIDP - Assistant Qualified Intellectual Disabilities Professional BMP - Behavior Management Plan DCS - Direct Care Staff H&P - History and Physical IDT - Interdisciplinary Team IPP - Individualized Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, record review and staff and guardian interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base	W 124	<u>W124</u> Corrective Actions: Two of Individual #1's guardian's regularly attend this individual's IPP meetings and have regular lunch dates with him when they often talk to management staff. We were surprised to hear that they did not understand the "pants" strategy which, as stated in survey results and as documented in the BMP has been the most successful strategy at helping this individual to understand the cause and effect of his behavior of ripping his clothes. At least one of his guardians attends his annual staffing	04/14/14

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

TITLE

(X6) DATE



Administrator

3/11/2014

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.

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W 124	<p>Continued From page 1</p> <p>consent decisions for 1 of 7 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of information being provided to the individual's guardians regarding behavioral interventions. The findings include:</p> <p>1. Individual #1's IPP, dated 10/10/13, documented a 52 year old male whose diagnoses included moderate mental retardation.</p> <p>During the entrance conference on 2/10/14 at 2:15 p.m., the AQIDP stated Individual #1 attended work on Monday, Tuesday, Thursday and Friday.</p> <p>During observations on 2/11/14, a Tuesday, for a cumulative 2 hours 25 minutes, Individual #1 was observed to stay at the facility. When asked, direct care staff on shift stated Individual #1 did not have wearable pants and was to stay at the facility per his BMP.</p> <p>Individual #1's BMP, dated 10/31/13, included a target behavior related to damaging apparel items. The instructions documented if Individual #1 "does not have a wearable pair of pants when he gets up on Tuesday, Friday, or Saturday, he will have pajama bottoms made available to him and will not be able to go on any outing including work or shopping." The BMP also documented "This 'pants' strategy has proven to be the most effective and [Individual #1] seems to finally be connecting the action of destroying his clothes with not having enough clothes to go on outings which he enjoys."</p> <p>Individual #1's record contained a BMP Authorization and Informed Consent, dated 10/10/13, which documented guardian consent</p>	W 124	<p>when this issue would have been discussed in detail. All three guardians receive copies of his IPPs and the guardians who signed his BMP consent which had a copy of the BMP attached did not mention any concerns. The QIDP will arrange a meeting with the two local guardians to discuss this issue further. If after this meeting the "pants" strategy is to continue, new informed consents will be prepared and will be sent to all three guardians. All future informed consents will be sent to all three guardians.</p> <p>Identifying Others Potentially Affected: No other individuals living at this location are affected by this issue.</p> <p>System Changes: QIDPs will be instructed that if an individual has co-guardians that they are all to consent.</p> <p>Monitoring: We don't feel that supplemental monitoring is needed now that this expectation has been clarified.</p>	

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W 124	<p>Continued From page 2</p> <p>from one of Individual #1's three legal co-guardians. Guardian consent for Individual #1's BMP from the other two guardians could not be found in his record.</p> <p>One of Individual #1's co-guardians, from whom consent was not obtained, was interviewed on 2/14/14, from 8:31 - 8:49 a.m. The guardian stated he thought the facility was keeping Individual #1 at the facility due to privacy concerns and a lack of pants in the facility.</p> <p>However, the BMP stated "When [Individual #1] gets up, if he does not have a wearable pair of pants available, he will receive a replacement pair on the following [days]: Monday, Wednesday, Thursday, and Sunday."</p> <p>During the interview on 2/14/14 from 8:31 - 8:49 a.m., Individual #1's guardian stated he thought work was important for Individual #1. The guardian stated Individual #1 has succeeded in his work environment. He further stated he did not agree with the intervention as he thought losing a privilege was not an effective intervention for Individual #1.</p> <p>The guardian who consented to Individual #1's BMP was interviewed on 2/14/14 from 10:26 - 10:32 a.m. She also stated she was unaware of Individual #1 being kept at the facility for tearing his pants, and she felt work had been beneficial for Individual #1.</p> <p>During an interview on 2/14/14 from 11:45 a.m. - 12:37 p.m., the QIDP stated consent was not obtained from all three guardians. He stated as two of the guardians were in close communication, he typically informed one</p>	W 124			

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W 124	Continued From page 3 guardian of significant events or changes and asked the guardian to communicate the information to the second guardian.	W 124			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility failed to ensure consent was obtained from each of Individual #1's co-guardians. The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure all allegations of abuse were immediately reported to the Administrator. That failure directly impacted 1 of 6 individuals (Individual #2) involved in allegations of abuse, neglect or mistreatment. This resulted in the potential for on-going abuse to occur without appropriate corrective action being taken. The findings include: 1. The facility's Protection from Abuse Policy, dated 2/8/13, stated staff were to immediately report any incident of possible abuse to the Administrator or the Administrator Designee. The policy's definition of abuse included "non-consensual sexual interactions such as sexual harassment, sexual coercion or sexual assault." During an interview on 2/10/14 with the AQIDP	W 153	W153 Corrective Actions: Individual #3 has a well established history of delusional statements and false reporting which is outlined in her BMP. However, it is our intention to do everything we can to make sure individuals in our care are safe and well protected. Individual #3's BMP did outline in the intervention plan that staff should contact the Administrator or Administrator designee when allegations related to having a staff's baby are made. We have taken many actions to improve our reporting of potential abuse and, as discussed in the exit interview, the surveyors identified one "failure to report" since the previous survey. We are taking the following additional actions: 1) we have clarified management review responsibilities (Attachment A) related to reviewing incident reports; 2) we have developed an additional information sheet on abuse reporting and this will be located in "Incident Binders" for easy staff access (Attachment B); 3) we added an "Administrator Notification" reminder to some individual's Active Treatment binders which are the reference	04/14/14	

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W 153	<p>Continued From page 4</p> <p>and QIDP, the QIDP stated the Administrator Designee could include the Administrator, the QIDP Supervisor or the QIDPs. Further, the AQIDP stated if staff reported allegations of abuse to her or the lead staff, she instructed them to call the Administrator.</p> <p>a. The facility's 2/2014 incident reports were reviewed on 2/10/14 at 6:00 p.m. An Incident Report Addendum, dated 2/7/14 and timed 3:30 p.m., included a handwritten note by DCS A, which documented "[Individual #2] starts saying her and another staff, [DCS B] are married and they have a happy loving life together. She said her and [DCS B] have sex every night because they're trying to have more kids together." Individual #2 proceeded to discuss other topics, including concerns her beauty products were being stolen. Individual #2 stated "she wanted to talk to [AQIDP] and get us all fired."</p> <p>At the bottom of the Incident Report Addendum there was a second handwritten note by the AQIDP. The AQIDP documented that she spoke with Individual #2 about the incident. However, the AQIDP only made note of talking with Individual #2 about her concerns with her beauty products and Individual #2's desire to move.</p> <p>There was no evidence the Administrator or Administrator Designee was notified of the above incident per policy.</p> <p>During an interview on 2/11/14 at 11:35 a.m., the AQIDP stated she was unaware of the allegation made by Individual #2 related to DCS B. The AQIDP stated she would report the incident to the Administrator.</p>	W 153	<p>binders staff are to use on a daily basis (Attachment C, & D).</p> <p>Identifying Others Potentially Affected: We have determined that Individual #5 is potentially affected.</p> <p>System Changes: Please refer to corrective actions.</p> <p>Monitoring: The QIDP will review all Accident/Injury and behavior incident reports. Any overlooked reporting issues not reported to the Administrator/ Designee will be immediately reported and disciplinary action with the staff who failed to report will occur.</p>	

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W 153	Continued From page 5	W 153		
W 155	<p>The facility failed to ensure all allegations of abuse were immediately reported to the Administrator or Administrator Designee.</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure potential abuse, neglect, and mistreatment were prevented while investigations were in process. This failure directly impacted 1 of 6 individuals (Individual #8) involved in allegations of abuse, neglect or mistreatment. This resulted in the potential for individuals being subjected to potential abuse and neglect during the course of investigations. The findings include:</p> <p>1. The facility's Protection from Abuse Policy, dated 2/8/13, documented if an allegation of abuse or neglect was received, the Administrator or Administrator Designee "will take immediate action to prevent further potential abuse/neglect while an investigation is conducted."</p> <p>An Accident/Injury Report, dated 5/9/13, documented at 7:25 a.m. DCS C noticed injuries of unknown origin on Individual #8's head and shoulder. DCS C notified the LPN and Administrator Designee. The investigation documented that the LPN contacted the AQIDP and stated Individual #8 had to have "had a fall as he had an egg sized lump on the back of the head along with a large scrape where the skin</p>	W 155	<p><u>W155</u></p> <p>Corrective Actions: This is a difficult situation to sort out. What initially appeared to be an "unknown injury" became an accident which involved some reporting issues which then became a potentially neglectful situation which we determined to be abusive. The "fall" had been reported according to policy to both the Administrator/Designee and nursing personnel but this reporting had downplayed the severity of the injury. What should have happened is when the LPN and AQIDP started discussing their concerns, they should have contacted the Administrator again at that point and we will be doing staff training with both management level staff and nursing staff to strengthen our reaction when situations in the future have been felt by any management staff to have been under reported. The Administrator and RN Supervisor will do this training.</p> <p>Identifying Others Potentially Affected: All individuals at this location are potentially affected.</p> <p>System Changes: See corrective actions.</p>	04/14/14

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W 155	<p>Continued From page 6</p> <p>had been removed and an even larger scrape on his right shoulder." DCS C also "informed [the LPN] that [Individual #8] could not use his left arm/shoulder..." The LPN told the AQIDP someone had to have found him after sustaining the injuries "as he is unable to pick himself up off the floor" and Individual #8 was in bed when DCS C arrived on shift. The LPN further stated "the wounds were very fresh and had to have been sustained at least within the 2 hours prior to [DCS C] arriving at 7AM. This would mean that the incident would have occurred around 5-7AM." The LPN "stated her concerns that his caregiver [DCS D] had not reported the fall or the injuries."</p> <p>The facility maintained two graveyard staff, one for each half of the facility, as well as a third who "floated" from one half of the facility to the other, assisting as needed. The investigation documented DCS D was the primary staff for the half in which Individual #8 resided, and DCS E was the "floater" staff on the graveyard shift (10:00 p.m. - 7:00 a.m.) 5/8/13.</p> <p>The investigation continued until 5/17/13 when it was concluded DCS D "admitted understanding and not following the 'bed check' routine" and was separated from employment. However, no details related to how individuals were protected from DCS D and DCS E during the investigation were included in the documentation.</p> <p>The facility's 5/2013 as-worked schedule was reviewed and documented DCS D and DCS E worked multiple shifts, separate from each other and primarily on graveyard shift, between 5/9/13 and 5/17/13.</p> <p>During an interview on 2/14/14 from 9:30 - 10:15</p>	W 155	Monitoring: The Administrator will continue to review all investigations for completeness.		

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W 155	Continued From page 7 a.m., the Administrator stated DCS D and DCS E were not suspended or re-assigned, and continued to work graveyard shifts, from 5/9/13 - 5/17/13. The facility failed to ensure Individual #8 was protected after an allegation of neglect was made.	W 155			
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 2 of 7 individuals (Individuals #2 and #3) whose medical records were reviewed. This resulted in individuals not receiving bone density studies, as recommended in accordance with their medication use. The findings include: 1. An article, published by the American Epilepsy Society in March 2009, stated AED therapy (e.g. Depakote) was associated with metabolic bone disease and a high risk for fractures, with a reduction in bone mineral density reported in 20% - 75% of individuals taking AEDs. The article further recommended assessment of bone mineral density 3-5 years after initiation of AED therapy. a. Individual #2's 10/3/13 IPP documented she was a 51 year old female with diagnoses	W 322	<u>W322</u> Corrective Actions: We have added a "Dexa Scan Policy" to our "RN Oversight and Nursing Services Manual" (see Attachment E) and have revised our current CCI Nursing Summary form to include a section to document the need for, frequency of, and completion of dexa scans. As stated in survey results, the LPN at this location has been requesting bone density scan from their primary physician at annual H & P examinations and this will be completed for all individuals at this location. Identifying Others Potentially Affected: All individuals living at this location who have medical conditions as described on the attached "Dexa Scan Policy" are potentially affected. System Changes: Please refer to Corrective Actions. Monitoring: The RN Supervisor has trained LPN's on the "Dexa Scan	04/14/14	

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W 322	<p>Continued From page 8</p> <p>including moderate mental retardation and schizoaffective disorder. Review of her record showed she was receiving Depakote (an AED) 1250 mg each evening to control signs and symptoms of schizoaffective disorder.</p> <p>In an interview on 2/14/14 from 11:45 a.m. - 12:37 p.m., the QIDP stated Individual #2 had been receiving Depakote since she was admitted to the facility in 2008. The LPN, who was present during the interview, stated Individual #2 had not received a bone density study since her admission to the facility and there had been no discussion with the physician concerning the need for a bone density study.</p> <p>The facility failed to ensure a bone density study, as recommended by the American Epilepsy Society, was discussed with the physician based on Individual #2's AED use.</p> <p>b. Individual #3's IPP, dated 8/8/13, documented an 80 year old male whose diagnoses included severe mental retardation and intermittent explosive disorder.</p> <p>Individual #3's Physician's Order Sheet, dated 11/26/13, documented Individual #3 received Depakote (an AED) 800 mg daily. Individual #3's record contained a Psychoactive Medication Reduction Plan, dated 11/23/10, which documented the Depakote was prescribed for Individual #3's intermittent explosive disorder on 10/24/08.</p> <p>However, Individual #3's record did not contain a bone density study.</p> <p>When asked, the LPN stated on 2/13/13 at 12:45</p>	W 322	<p>Policy" and will include a review dexa scan on the monthly nursing summaries during the monthly RN review process.</p>	

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PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #6 WEISER			STREET ADDRESS, CITY, STATE, ZIP CODE 180 EAST PARK ST WEISER, ID 83672		
(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	
W 322	Continued From page 9 p.m. she was requesting bone density scans at individuals' H&P examinations as needed. The LPN stated the focus of Individual #3's last H&P was a vaccination, and the bone density scan was not addressed. The facility failed to ensure a bone density study, as recommended by the American Epilepsy Society, was discussed with the physician based on Individual #3's AED use.	W 322			

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 2/10/14 to 2/14/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Leader Trish O'Hara, RN Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disabilities Professional	M 000	RECEIVED MAR 11 2014 FACILITY STANDARDS	
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	<u>MM164</u> Please refer to W124	04/14/14
MM169	16.03.11.075.07(b)(i) Grievances The facility must have a written procedure for registering and resolving grievances and recommendations by residents or any individual or group designated by the resident as his representative. The procedure must ensure protection of the resident from any form of reprisal or intimidation. The written procedure	MM169	<u>MM169</u> Please refer to W153	04/14/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

3/11/2014

Bureau of Facility Standards

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MM169	Continued From page 1 must include: That the administrator or his designee must handle grievances and recommendations; and This Rule is not met as evidenced by: Refer to W153.	MM169		
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W155.	MM177	<u>MM177</u> Please refer to W155	04/14/14
MM387	16.03.11.120.04(c) Windows No window area in a resident's room can be less than one-eighth (1/8) of the floor area, and one-half (1/2) of the window area must be openable. Suitable window shades or drapes must be provided as a means of controlling light. Windows must be so located as to permit residents a view through the windows from a sitting position. Windows must be of such construction as to prevent any drafts when closed. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure appropriate windows were provided for 2 of 14	MM387	<u>MM387</u> Corrective Actions: Individual #1 has a well established history of taking things apart and destroying cloth material items. The current window was put in place in an effort to provide privacy for individuals #1 and #3. We will replace this window with one that has unobstructed view from inside the room but has diminished or no view into the room from the outside. This will be done by using a tinted or mirror treated window to protect privacy of the individuals in this room. This will	04/14/14

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MM387	Continued From page 2 individuals (Individuals #1 and #3) residing in the facility. This resulted in individuals being unable to view the outside through their bedroom window. The findings include: During an environmental review conducted with the AQIDP on 2/13/14 at 1:20 p.m., the window in the bedroom shared by Individual #1 and Individual #3 was noted to be opaque, preventing a view to the outside. During the environmental review, the AQIDP stated Individual #1 would destroy alternative window coverings, so the facility installed the opaque glass window. The facility failed to ensure Individual #1's and Individual #3's bedroom window provided a view to the outside.	MM387	be done in addition to using curtains or blinds and as a precaution for privacy. Identifying Others Potentially Affected: Only Individuals #1 and #3 were affected. System Changes: Please refer above to corrective actions. Monitoring: We will monitor and keep a record of interventions and strategies used if destruction of privacy items such as curtains and blinds is done by Individual #1 with the option to request a waiver for this particular window in the future should the need arise.	
MM428	16.03.11.120.10(c) Temperature of hot water The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 14 of 14 individuals (Individuals #1 - #14) residing in the facility. This resulted in the potential for insufficiently hot water being available for tasks such as hand washing and bathing. The findings include: During an environmental review conducted with the AQIDP on 2/13/14 at 1:20 p.m., the water	MM428	<u>MM428</u> Corrective Actions: It should be noted that this issue was resolved as noted on the CMS-2567 from by 2/14/2014 at 1:45PM before the end of the survey. A preventative maintenance checklist is already in place for monitoring hot water temperatures. If in the future temperatures fall outside the expected range further action will be discussed at that time. Identifying Others Potentially Affected: All individuals living at this location are potentially affected by this issue.	04/14/14

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MM428	<p>Continued From page 3</p> <p>temperature in the front bathroom was noted to be 96.3 degrees Fahrenheit. The kitchen sink was noted to be 95.2 degrees Fahrenheit.</p> <p>During the environmental review the AQIDP was informed of the low water temperature. The AQIDP stated regulating the water temperature had been an issue due to direct care staff adjusting the water heater.</p> <p>The facility failed to ensure water temperatures were maintained between 105 and 120 degrees Fahrenheit.</p> <p>Note: Water temperatures were re-checked on 2/14/14 at 1:45 p.m. and were found to be within an acceptable range.</p>	MM428	<p>System Changes: See "Corrective Actions."</p> <p>Monitoring: Water temperatures are checked on an ongoing basis and recorded on the "Preventative Maintenance Checklist." This is completed by the AQIDP and reviewed by the Administrator every month. If temperatures do not fall within the limits in the future more actions will be discussed.</p>	
MM735	<p>16.03.11.270.02 Health Services</p> <p>The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.</p>	MM735	<p><u>MM735</u></p> <p>Please refer to W322</p>	04/14/14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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February 27, 2014

Bridger Fly, Administrator
Communicare, Inc #6 Weiser
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #6 Weiser, Provider #13G027

Dear Mr. Fly:

On **February 14, 2014**, a complaint survey was conducted at Communicare, Inc #6 Weiser. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006364

Allegation #1: Individuals reside in an environment with unresolved mold issues, resulting in health complications requiring allergy medications.

Findings #1: An unannounced on-site complaint investigation was conducted from 2/12/14 to 2/14/14. During that time record reviews, interviews with an outside professional and facility staff and an environmental review were completed with the following results:

On 2/13/14 at 11:40 a.m., the Home Manager was interviewed about major repairs to the facility. The Home Manager stated the facility had the kitchens re-modeled. She stated the original plan was to replace the cabinets and the flooring. However, upon removing the old cabinets, water damage was found. The Home Manager stated she requested that the wood in the wall and floor be replaced to ensure the damage was repaired properly.

An environmental review was conducted on 2/13/14 from 1:21 - 3:00 p.m. During the environmental review, kitchens, bathrooms, bedrooms, living rooms and hallways were inspected. All areas of the facility were noted to be in sanitary condition.

On 2/13/14, interviews were conducted with five direct care staff at the facility, whose employment duration ranged from 10 months to 6 years. Each of the five staff stated they never had sanitation concerns, including mold concerns, related to the condition of the facility.

Bridger Fly, Administrator
February 27, 2014
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On 2/14/14 at 8:30 a.m., an interview was conducted with the company that replaced the facility's kitchen cabinets. The employee stated there was a small amount of mold from the water damage under the cabinets and in the wall. He stated they replaced all materials affected.

An interview was conducted with the facility's owner on 2/14/14 at 9:15 a.m. He stated there was a small leak in the kitchen at the time the kitchen renovation was scheduled. The owner stated he called a plumbing company who stated there was mold present and he would not repair the leak until the mold was gone. The owner stated he called a company to cleanup the mold. The owner stated the mold was addressed with a combination of fans, chemicals and new building materials. He further stated they monitored everyone in the facility for cold-like symptoms through the end of 2011.

Invoices for the building repairs were reviewed. An invoice from the cleanup company, dated 10/5/11, documented "mold remediation services" had been completed. An invoice from the cabinet company, dated 2/14/12, documented mildew resistant sheetrock as well as new plywood had been installed.

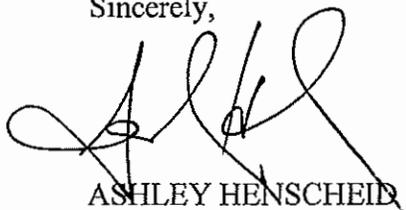
Seven individuals were randomly selected to review. Physician's orders for the seven sample individuals documented 2 of 7 were taking allergy medications. Both individuals began taking the medications over two years before the mold concerns began.

Though mold and water damage did occur, the issue was thoroughly resolved and no remaining mold could be found. Additionally, allergy medications prescribed after the discovery of the water damage and mold could not be found. Therefore, the allegation was unsubstantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt