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MAY 16 2014
DIV. OF MEDICAID



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 9, 2014

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 survey of Communicare, Inc #4 Leland, which was conducted on May 1, 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Bridger Fly, Administrator
May 9, 2014
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6. Include dates when corrective action(s) 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 **May 22, 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:

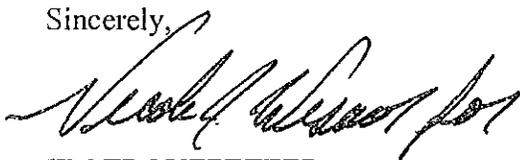
www.icfmr.dhw.idaho.gov

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 May 22, 2014. If a request for informal dispute resolution is received after May 22, 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,



JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures

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

PRINTED: 05/09/2014
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #4 LELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 4150 LELAND WAY BOISE, ID 83709
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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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W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 4/28/14 to 5/1/14. The survey was conducted by: Jim Troutfetter, QIDP Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional	W 000	<p>RECEIVED</p> <p>MAY 16 2014</p> <p>FACILITY STANDARDS</p>	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. The facility's evacuation drill records, dated 1/31/13 through 4/30/14, were reviewed and did not include an evacuation drill for the following quarter on the following shift: The second quarter of 2013 (April, May, and June) for the day shift. When asked, the AQIDP stated during an interview on 4/30/14 at 9:25 a.m., the specified evacuation drill had not been completed.	W 440		W440
			Corrective Actions: Monthly evacuation drills are scheduled on CCI's Annual Calendar related to shift and time. The secretary checks monthly to insure that scheduled evacuation drills in all CCI locations are completed. The failure to complete this one evacuation drill appears to be an implementation error when the previous House Manager at this location did not realize that the scheduled fire drill occurred 15 minutes later than the time specified on the annual calendar until it was too late to take corrective action for that month. House Manager responsibilities changed 11/13 and the new House Manager understands this regulation and her responsibility to schedule fire drills according to time segments identified on our annual calendar. If further scheduling errors occur related to evacuation drills occur, disciplinary action will be implemented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Admission Director (X6) DATE 5/16/14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #4 LELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 4150 LELAND WAY BOISE, ID 83709
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W 440	Continued From page 1 The facility failed to ensure evacuation drills were conducted on a quarterly basis for each shift.	W 440	Identifying Others Potentially Affected: All individuals living at this location are potentially affected. System Changes: We feel this was an implementation not a systems error. See "Corrective Actions" Monitoring: The secretary will continue to monitor that evacuation drills have occurred and will inform the Administrator of any drills that do not occur by the third week of the month so that corrective actions can be taken.	
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Bureau of Facility Standards

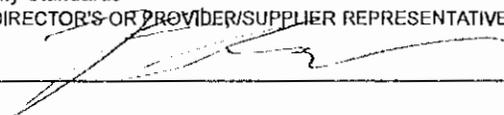
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #4 LELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 4150 LELAND WAY BOISE, ID 83709
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 4/28/14 to 5/1/14. The survey was conducted by: Jim Troutfetter, QIDP	M 000	<p>RECEIVED</p> <p>MAY 16 2014</p> <p>FACILITY STANDARDS</p> <p><u>MM337</u></p> <p>Please refer to W440</p>	
MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337		

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



TITLE

Administrator

(X6) DATE

5/16/14