



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
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July 9, 2014

Bridger Fly, Administrator
Communicare, Inc #2 Boone
40 West Franklin Road, Suite F
Meridian, ID 83642

RECEIVED

JUL 21 2014

FACILITY STANDARDS

RE: Communicare, Inc #2 Boone, Provider #13G009

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #2 Boone, which was conducted on July 2, 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
July 9, 2014
Page 2 of 2

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

JF/pmt
Enclosures

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

PRINTED: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #2 BOONE	STREET ADDRESS, CITY, STATE, ZIP CODE 1210 W BOONE ST NAMPA, ID 83651
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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

W 000

The following deficiencies were cited during the annual recertification survey conducted from 6/30/14 to 7/2/14.

The survey was conducted by:
Jim Troutfetter, QIDP, Team Leader
Ashley Henscheid, QIDP

Common abbreviations used in this report are:
IPP - Individualized Program Plan
LPN - Licensed Practical Nurse
QIDP - Qualified Intellectual Disability Professional

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159 W159

09/02/14

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 1 of 3 individuals (Individual #1), and had the potential to impact all individuals (Individuals #1 - #7) residing at the facility. This failure resulted in a lack of sufficient QIDP monitoring and oversight to ensure the accuracy and appropriateness of assessments, programing, and monitoring. The findings include:

1. Individual #1's IPP, dated 3/13/14, documented a 64 year old female whose diagnoses included profound mental retardation and schizophrenia.

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Corrective Actions: A system for monitoring sleep had previously been in place and its continued implementation had been overlooked. As stated on the surveyor note, the QIDP noted an oversight by the entire Trending & Tracking team and will be corrected as of 08/01/2014. We understand the importance of keeping accurate records related to these types of issues and the QIDP and QIDP Supervisor were counseled by the Administrator regarding this issue 07/21/14.

Identifying Others Potentially Affected:
No other individuals at this location are taking any type of medication to assist with sleep.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/21/2014
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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.

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W 159 Continued From page 1

Her record contained a Physician's Order Sheet and Progress Note, dated 5/2/14, documenting she received Melatonin (an herbal supplement used for sleep) 3 mg each evening.

Her record also contained a medication reduction plan, dated 5/27/14, that documented Melatonin would be challenged if she slept an average of eight hours per night for twelve consecutive months.

However, her record did not contain data related to her average hours of sleep per month.

When asked, the QIDP stated during an interview on 7/1/14 from 1:15 - 1:47 p.m., the sleep data had not been tracked due to an oversight.

The QIDP failed to ensure Individual #1's sleep data was documented in measurable terms.

W 369 483.460(k)(2) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.

This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 3 individuals (Individual #5) observed to take medications. This resulted in an individual not receiving the ordered dose of a medication. The findings include:

1. Individual #5's IPP, dated 3/13/14, documented

W 159

System Changes: We view this as an implementation rather than systems issue and therefore no systems changes are being planned.

Monitoring: The QIDP Supervisor will insure that there is a recoding summary in the Trending & Tracking form by initialing this information on TT forms for the rest of this calendar year and this information will be reviewed at all future TT meetings.

W 369

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 369	Continued From page 2 a 64 year old female whose diagnoses included severe mental retardation. Individual #5's record included a Physician's Order Sheet and Progress Note, dated 5/7/14, which stated Individual #5 was to receive 1 tablespoon of Citrucel (a supplemental laxative drug) each morning. An observation was conducted on 7/1/14 from 6:30 - 8:00 a.m. At 7:51 a.m., Individual #5 was observed to enter the medication administration area where a direct care staff waited to administer her morning medications. The direct care staff measured 2 tablespoons of Citrucel into a dosing cup. The direct care staff mixed the Citrucel in a glass of water, which Individual #5 drank. When asked, at 7:56 a.m., the direct care staff double checked the dosing cup level and the medication administration record for Individual #5. The direct care staff stated she dispensed 2 tablespoons of Citrucel and should have dispensed 1 tablespoon. On 7/1/14 at 8:36 a.m., the medication administration observation was reviewed with the LPN. The LPN stated the direct care staff immediately self-reported the medication administration error. The facility failed to ensure Individual #5's medications were administered without error.	W 369	W369 Corrective Actions: We have a systematic and carefully thought out training system both for staff who assist with medications and for individuals who are involved in training programs to be more independent in this self-administration of medications. In reviewing this citation we have determined that the staff member observed did not follow correct medication preparation procedures as taught in our "Assistance with Oral Medication" training module. She also stated that she was experiencing performance anxiety as this was the first observation by survey team members that she had experienced. We view this as a staff training issue rather than as a system flaw. We will address this issue as follows: 1) The Medication Passer involved in this incident was suspended, is expected to review the Medication Administration Module, and will be observed by the LPN prior to being recertified to assist with medication administration. Identifying Others Potentially Affected: All other individuals living at this location are potentially affected but this was not observed during the medication pass and we do not believe it is a common problem.	09/02/14
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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 6/30/14 to 7/2/14. The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Ashley Henscheid, QIDP	M 000	System Changes: See "Corrective Actions" Monitoring: Starting 08/01/14 for the next two months medication pass observations will be increased from once per month each by the LPN and other management staff to twice per month to insure proper medication pass procedures are followed. This staff member will be observed at least once per month during this process. The management team at this location and RN Supervisor will review these observations and will do additional staff training if indicated.	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation it was determined the facility failed to ensure the facility was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 7/1/14 from 12:40 - 1:10 p.m. During that time, the following was noted: - Bathroom #3 had a leaking hot water valve in the shower. - Bathroom #2 had a leaking bath tub faucet. - The toilet in bathroom #2 was missing the toilet bolt covers.	MM380	<u>MM380</u> We make a concerted effort to maintain this home in an attractive and safe manner. We have a maintenance man and a system to detect and address needed repairs. The items found were either not found on our Preventative Maintenance <ul style="list-style-type: none"> Bathroom #3's leaking hot water valve in the shower Bathroom #2's leaking bath tub faucet Bathroom #2's missing toilet bolt covers The broken stove drawer The small drawer to the left of the stove The missing screen in Individual #6's bedroom 	09/02/14

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

TITLE

(X6) DATE

STATE FORM 659 69UB11 7/21/14
If continuation sheet 1 of 2

Bureau of Facility Standards

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MM380 Continued From page 1

- The drawer on the stove was broken and off its tracks.
- The small drawer to the left of the stove was broken and off its tracks.
- The west window in Individual #6's bedroom was missing the screen.
- The window in Individual #5's bedroom was missing the screen.
- The window in Individual #1's bedroom was missing the screen.

The facility failed to ensure environmental repairs were completed and maintained.

MM380

- The missing screen in Individual #5's bedroom
- The missing screen in Individual #1's bedroom

The above list has been provided to the Maintenance Man for repair. Several of the items have already been repaired. In addition the Administrator will continue to review the Preventative Maintenance Checklist for repairs needed.

MM730 16.03.11.270.01(d)(i) Diagnostic and Prognostic Data

MM730

MM730

09/02/14

Based on complete and relevant diagnostic and prognostic data; and
This Rule is not met as evidenced by:
Refer to W252.

This refers to W252 but we believe this citation was changed to W159. Please refer to W159.

MM757 16.03.11.270.02(f)(iii) Signed Physician's Order

MM757

MM757

09/02/14

No resident can receive any medication unless his record contains a current and signed physician's order for such medication.
This Rule is not met as evidenced by:
Refer to W369.

Please refer to W369.