



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

December 10, 2014

Bridger Fly, Administrator  
Communicare, Inc #8 Lincoln  
40 West Franklin Road, Suite F  
Meridian, ID 83642

RE: Communicare, Inc #8 Lincoln, Provider #13G062

Dear Mr. Fly:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #8 Lincoln, which was conducted on December 4, 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  
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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 **December 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](http://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 December 22, 2014. If a request for informal dispute resolution is received after December 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, option 4.

Sincerely,

  
KAREN MARSHALL  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

KM/pmt  
Enclosures

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

PRINTED: 12/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

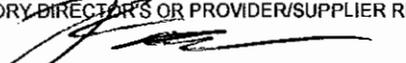
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #8 LINCOLN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1128 N LINCOLN JEROME, ID 83338</b>
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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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey conducted 12/1/14 to 12/4/14.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Lead James Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>IPP - Individualized Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional</p>	W 000		
W 353	<p><b>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE</b></p> <p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed including radiographs when indicated and detection of manifestations of systemic disease.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a periodic comprehensive dental evaluation was completed for 1 of 4 individuals (Individual #3) whose dental records were reviewed. This resulted in the potential for an individual's dental needs to be unidentified and untreated. The findings include:</p> <p>1. Individual #3's 6/25/14 IPP stated she was a 36 year old female whose diagnoses included</p>	W 353	<p><u>W353</u></p> <p><u>Comprehensive Dental Diagnostic Services</u></p> <p>Corrective Action: Nurses don't typically attend dental appointments so the RN Supervisor has developed a "Dental Appointment Checklist" (see attached) for instructional staff giving them specific direction on clarifying the issue of routine x-rays (having these done or documenting why not).</p> <p>Identifying Others Potentially Affected: The LPN assigned to this location and the RN supervisor will do a Quality Assurance Check at this location and any similar issues identified will be responded to as outlined above.</p>	<p>02/04/15 <del>03/02/15</del></p> <p>per telephone call with administrator km 12.23.14 3:20pm</p>

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DEC 22 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>12/19/2014</b>
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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.

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

PRINTED: 12/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNICARE, INC #8 LINCOLN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1128 N LINCOLN JEROME, ID 83338</b>		
(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 353	<p>Continued From page 1 profound mental retardation.</p> <p>Her record included a 9/8/14 dental note which stated the dentist was not able to complete much at the appointment as Individual #3 would not allow anything in her mouth. However, her record did not indicate when the last comprehensive x-rays were completed.</p> <p>During an interview on 12/4/14 from 10:48 - 11:03 a.m., the LPN reviewed Individual #3's record and stated she would contact the dentist.</p> <p>During a follow-up interview on 12/4/14 at 1:16 p.m., the LPN provided a local medical center operative report, dated 6/10/11, that stated radiographs were completed. The LPN stated Individual #3 had not had x-rays completed since 2011.</p> <p>The facility failed to ensure Individual #3 had a yearly comprehensive dental examination.</p>	W 353	<p>System Changes: We will be implementing the system described above.</p> <p>Monitoring: The RN Supervisor will be reviewing medical records, including dental records, for thoroughness and follow-up on a monthly basis. In addition, our organization is instituting a revised QA procedure which involves an annual records review at each CCI location by agency QIDPs and other management staff including nurses. The intent of this review is to identify issues so that corrective action can occur. This review format is available for surveyor review upon request. QA reviews for each CCI location are specified on CCI's annual calendar.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNICARE, INC #8 LINCOLN	STREET ADDRESS, CITY, STATE, ZIP CODE 1128 N LINCOLN JEROME, ID 83338
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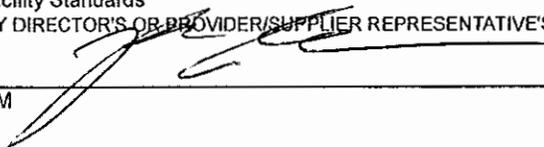
M 000	16.03.11 Initial Comments  The following deficiencies were cited during the annual licensing survey conducted from 12/1/14 to 12/4/14.  The survey was conducted by:  Karen Marshall, MS, RD, LD, Team Lead James Troutfetter, QIDP	M 000		
MM781	16.03.11.270.04(a) Comprehensive Diagnostic Services  There must be comprehensive diagnostic services for all residents which include: This Rule is not met as evidenced by: Refer to W353.	MM781	MM781  Please refer to W353.	Km 02/04/15 <del>03/02/15</del>

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

TITLE

(X6) DATE



Administrator

12/19/14