



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

RECEIVED
DEC 22 2014
FACILITY STANDARDS

December 15, 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 survey of Communicare, Inc #5 Kuna, which was conducted on December 11, 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
December 15, 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 **December 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 December 27, 2014. If a request for informal dispute resolution is received after December 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 us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

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

PRINTED: 12/12/2014
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
--	--	--	--

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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey conducted from 12/9/14 - 12/11/14. The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Trish O'Hara, RN Common abbreviations used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional ILW - Instructional Lead Worker IPP - Individual Program Plan NSAID - Non-Steroidal Anti-Inflammatory Drug	W 000		
W 324	483.460(a)(3)(ii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure immunizations as recommended by the Public Health Service Advisory Committee were provided for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in the potential for preventable illness to occur. The findings include:	W 324	W324 Corrective Actions: Two other nurses were responsible for attempting to resolve this issue under the direction of the previous RN Supervisor, obviously without the desired results. We have determined that we did not provide the current LPN with sufficient training related to this issue. When the expectation was clarified during the survey process, she contacted this individual's primary physician who has now documented his review and recommendations related to this issue. Identifying Others Potentially Affected: We do not believe others living at this location are affected by this issue but the RN Supervisor and LPN will	03/11/15

RECEIVED
DEC 22 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 12/19/2014

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.

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

PRINTED: 12/12/2014
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014	
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) COMPLETION DATE
W 324	<p>Continued From page 1</p> <p>Individual #1's 4/3/14 IPP stated he was a 31 year old male whose diagnoses included profound intellectual disability and seizure disorder.</p> <p>Individual #1's medical record documented he had a received TB (tuberculin) screening on 9/27/12, a tetanus/diphtheria vaccination on 4/12/12, and a flu vaccination on 10/28/14. However, no documentation of any other immunizations could be found. Additionally, no blood titers or documentation from the physician regarding Individual #1's vaccinations could be found.</p> <p>In an interview on 12/11/14 at 1:30 p.m., the nurse said the facility did not have prior immunization records for Individual #1. When asked, she said the need for immunizations or obtaining blood titers for antibody presence had not been discussed with Individual #1's physician.</p> <p>The facility failed to ensure Individual #1's record reflected he had received immunizations as recommended by the Public Health Service Advisory Committee.</p>	W 324	<p>review records to confirm this and will take necessary actions to resolved any identified issues related to immunizations.</p> <p>System Changes: A list of recommended immunizations will be added to our Nursing Services Manual. The RN Supervisor will review immunization expectations with all CCI nursing personnel at the next nurses meeting.</p> <p>Monitoring: The RN Supervisor will review all immunization records after any admission to insure adequate records are in place and will review monthly Nursing Summaries to insure immunizations are current.</p>	
W 382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 8 of</p>	W 382	<p><u>W382</u></p> <p>Corrective Actions: This cabinet is no longer being used to store medications and those listed have now been locked up either in the House Supervisor's Office or in a locked cabinet in the medication area.</p> <p>Identifying Others Potentially Affected: All individuals at this location who could reach this cabinet were potentially affected.</p>	03/11/15

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

PRINTED: 12/12/2014
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2014
NAME OF PROVIDER OR SUPPLIER COMMUNICARE, INC #5 KUNA			STREET ADDRESS, CITY, STATE, ZIP CODE 760 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) COMPLETION DATE	
W 382	<p>Continued From page 2</p> <p>8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:</p> <p>1. An environmental review was conducted at the facility on 12/9/14 from 1:35 - 2:40 p.m. During that time, the following items were found in an unlocked cabinet in the medication administration area:</p> <ul style="list-style-type: none"> - 1 tube of antibiotic ointment - 1 tube of Bacitracin first aid ointment - 1 packet of aspirin (an NSAID drug) containing two 325 mg tablets - 2 packets of Ibuprofen (an NSAID drug) each containing two 200 mg tablets - 2 packets of APAP (an analgesic drug) each containing two 500 mg tablets - 2 packets of Diphen (an antihistamine drug) each containing two 25 mg tablets - 2 packets of triple antibiotic ointment <p>The ILW, who was present during the observation, stated the items in the cabinet were used by staff not individuals residing at the facility. The AQIDP, who was also present during the observation, stated the items should have been locked.</p> <p>The facility failed to ensure all drugs were maintained under locked conditions.</p>	W 382	<p>System Changes: Refer to corrective actions.</p> <p>Monitoring: The RN will reinstitute the monthly "Medication Safety Log" process (see attached) to be completed with the LPNs at each CCI location.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
--	---	---	---

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	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the licensure survey conducted from 12/9/14 - 12/11/14.</p> <p>The survey was conducted by:</p> <p>Michael Case, LSW, QIDP, Team Lead Trish O'Hara, RN</p>	M 000		
MM548	<p>16.03.11.210.02(g) Immunization</p> <p>Record of immunizations; and This Rule is not met as evidenced by: Refer to W324.</p>	MM548	<p><u>MM548</u></p> <p>Please refer to W324</p>	03/11/15
MM753	<p>16.03.11.270.02(f)(i) Locked Area</p> <p>All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.</p>	MM753	<p><u>MM753</u></p> <p>Please refer to W382.</p>	03/11/15

RECEIVED
DEC 22 2014
FACILITY STANDARDS

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

TITLE

(X8) DATE

Administrator

12/19/2014