



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

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T. -- Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

December 30, 2013

Kristin Sonnenberg, Administrator  
Preferred Community Homes-- Cougar Creek  
7091 West Emerald Street  
Boise, ID 83704

RE: Preferred Community Homes-- Cougar Creek, Provider #13G037

Dear Ms. Sonnenberg:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Preferred Community Homes - Cougar Creek, on December 18, 2013.

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

Kristin Sonnenberg, Administrator  
December 30, 2013  
Page 2 of 2

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 **January 13, 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 January 13, 2014. If a request for informal dispute resolution is received after January 13, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,



MARK P. GRIMES  
Supervisor  
Fire Life Safety & Construction Program

MPG/lj

Enclosure

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

Printed: 12/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - COUGAR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 EAST COUGAR CREEK MERIDIAN, ID 83642</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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K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(000) , residential building. The building is protected throughout except in the garage and attic by a NFPA 13 D fire sprinkler system with quick response sprinkler heads. There is a complete fire alarm/smoke detection system. The facility was built in January of 1996. Currently it is licensed for 8 ICF/ID beds.</p> <p>The following deficiency was cited at the above facility during the annual Fire/Life Safety survey conducted on December 17 and 18, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, and in accordance with 42 CFR, 483.470.</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K0152	<p><b>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</b></p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities;</p> <p>(iii) File a report and evaluation on each drill:</p>	K0152	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JAN 15 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tom May</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>1/15/14</i>
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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.

*Please see attached letter for pcc.*

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

Printed: 12/20/2013  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - COUGAR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1230 EAST COUGAR CREEK MERIDIAN, ID 83642</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
K0152	<p>Continued From page 1</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not conduct evacuation drills quarterly for each shift. Conducting evacuation drills helps to ensure that staff members are trained to act appropriately in the event of a fire or other emergency requiring evacuation of the facility. The facility had a census of six clients on the day of the survey. This deficiency affected all clients, staff and visitors.</p> <p>The findings include:</p> <p>During record review of the facility's evacuation drills on December 18, 2013 at 11:25 AM, it was determined that the facility could not produce documented evacuation drills for the second shift during the first quarter and the first shift during the third quarter during the previous twelve month period. When questioned about the missing drills the Program Manager stated that he was unsure why the drills had not been completed and documented.</p>	K0152		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
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M 000	16.03.11 Initial Comments  The facility is a single story, Type V(000) , residential building. The building is protected throughout except in the garage and attic by a NFPA 13 D fire sprinkler system with quick response sprinkler heads. There is a complete fire alarm/smoke detection system. The facility was built in January of 1996. Currently it is licensed for 8 ICF/ID beds.  The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on December 17 and 18, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, and in accordance with IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities.  The Survey was conducted by:  Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	M 000		
MM327	16.03.11.110.02(h) Emergency Electrical Service  Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system.  This Rule is not met as evidenced by: Based on observation of operational testing it was determined that the facility failed to maintain the emergency lighting units in a fully functional status. Emergency lighting units that do not operate can lead to confusion and hazardous conditions in the event of a power outage or other emergency requiring lighting for exit	MM327		

**RECEIVED**  
**JAN 15 2014**  
**FACILITY STANDARDS**

Idaho form

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

TITLE

(X6) DATE

*[Signature]*

*Program Manager*

*1/15/14*

STATE FORM

021199

ZQN121

If continuation sheet 1 of 3

*Please see attached letter for POC*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
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MM327	Continued From Page 1  passageways. The facility had a census of six clients on the day of the survey. This deficiency affected all clients, staff and visitors.  Findings include:  During a tour of the facility on December 17, 2013 at 1:55 PM, observation of operational testing revealed that the emergency light by the laundry room would not illuminate upon pressing of the test button on the unit. This was observed and noted by a facility staff member and Surveyor.	MM327		
MM346	16.03.11.110.06(g) In-House Check  The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems. This Rule is not met as evidenced by: Based on record review and interview it was determined that the facility did not conduct 30 second monthly or one annual 90 minute test of the emergency lighting units. Testing helps to ensure system reliability in the event of a power outage or other emergency where emergency lighting may be needed. The facility had a census of six clients on the day of the survey. This deficiency affected all clients, staff and visitors.  The findings include:  During record review on December 18, 2013 at 11:19 AM, the facility was unable to provide documented emergency light testing records for the previous twelve month period. When questioned about the emergency light testing records the Program Manager stated that he was unable to provide documented emergency lighting testing records.	MM346		

Bureau of Facility Standards

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MM346	Continued From Page 2  Actual NFPA Standard:  7.9 EMERGENCY LIGHTING 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.  Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	MM346		



January 14, 2014

Mark Grimes  
Health Facility Surveyor  
Non-Long Term Care  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009

RE: Cougar Creek, Provider #13G037

Dear Mr. Grimes:

Thank you for your considerateness during the recent annual Fire Life Safety Survey at the Bedford home. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

K0152

Currently the Program Supervisors at Aspire Human Services are scheduling and conducting quarterly evacuation drills for each shift. Aspire Human Services has a monthly checklist which is completed by the homes supervisor. The checklist has been revised to include a tracking system to document when an evacuation drill occurs. In addition the monthly checklist is given to the Program Manager monthly to verify the evacuation drills are current and scheduled appropriately. The Program Manager will also be tracking evacuation drills on a separate spreadsheet to avoid missing scheduled drills.

Person Responsible: Tom Moss  
Completion Date: 1/24/14

MM327:

The emergency light has been repaired in the laundry room at the home. Aspire Human Services currently has a monthly checklist which is completed by the home supervisor. The checklist has been revised to include a monthly documentation that monthly emergency light unit test have occurred. The monthly checklist also includes a tracking system to document when the 90 minute annual emergency light test occurred. Each month after the Program Supervisors complete their monthly check the documentation will be turned into the Program Manager for verification that the inspections occurred. The Program Manager will assure that emergency lights are repaired anytime one is not functioning properly.

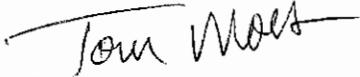
Person Responsible: Tom Moss  
Completion Date: 1/24/14

MM346:

Aspire Human Services currently has a monthly checklist which is completed by the home supervisor. The checklist has been revised to include a monthly documentation that monthly emergency light unit test have occurred. The monthly checklist also includes a tracking system to document when the 90 minute annual emergency light test occurred. Each month after the Program Supervisors complete their monthly check the documentation will be turned into the Program Manager for verification that the inspections occurred.

Person Responsible: Tom Moss

Completion Date: 1/24/14

A handwritten signature in black ink that reads "Tom Moss". The signature is written in a cursive style with a long horizontal stroke extending to the right.

Tom Moss

Program Manager

Licensed Social Worker