



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

December 30, 2013

Wanda Huber, Administrator  
Preferred Community Homes-- Elk Run  
7091 West Emerald Street  
Boise, ID 83704

RE: Preferred Community Homes-- Elk Run, Provider # 13G041

Dear Ms. Huber:

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

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction 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,

Wanda Huber, Administrator  
December 30, 2013  
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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 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  
Facility Fire Safety and Construction Program

MPG/lj

Enclosures

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>13G041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - ELK RUN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2273 SOUTH GULL COVE PLACE 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
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 facility was found to be in substantial compliance with applicable fire/life safety requirements 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 &amp; Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j).</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		

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JAN 15 2014  
FACILITY STANDARDS

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

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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G041</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		
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	MM346		

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Idaho form

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

TITLE

(X6) DATE

*Tow Moss*

*Program Manager*

*1/15/14*

STATE FORM

021199

EZBV21

If continuation sheet 1 of 3

*Please see attached letter for POC*

Bureau of Facility Standards

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MM346	<p>Continued From Page 1</p> <p>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 on December 18, 2013 at 10:45 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.</p> <p>Actual NFPA Standard:</p> <p><b>7.9 EMERGENCY LIGHTING</b> 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.</p> <p>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.</p>	MM346		

Bureau of Facility Standards

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MM380	Continued From Page 2	MM380		
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the building and all equipment was in good repair. The facility had a census of six clients on the day of the survey. This deficiency affected two of six clients and all staff members.</p> <p>Findings include:</p> <p>During a tour of the facility on December 17, 2013 at 2:20 PM observation of room #4 revealed that the window screen was missing. Findings were observed and noted by a facility staff member and Surveyor. When the Program Manager was interviewed on December 18, 2013 at 10:45 AM he stated that he was unaware of the missing window screen.</p>	MM380		



January 14, 2014

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

RE: Elk Run, Provider #13G041

Dear Mr. Grimes:

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

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

MM380

Window Screens have been purchased for the Elk Run Home. Aspire Human Services currently has a monthly checklist which is completed by the home supervisor. The checklist has been revised to include verifying that window screens are present and in good repair. 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. In the event that it is identified that a window screen is missing the Program Manager and Program Supervisor will assure that it is replaced as soon as possible.

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

Tom Moss  
Program Manager  
Licensed Social Worker