



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

Rylee Kaercher, Administrator  
Preferred Community Homes-- Mallard  
7091 West Emerald Street  
Boise, ID 83704

RE: Preferred Community Homes-- Mallard, Provider # 13G032

Dear Ms. Kaercher:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey of Preferred Community Homes - Mallard, 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,

FILE COPY

Rylee Kaercher, 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>13G032</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 - MALLAR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER 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 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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RECEIVED  
JAN 15 2014  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tom Mallar</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.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTRIE STRUCTURE</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>PREFERRED COMMUNITY HOMES - MALLARD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>699 SOUTH OTTER 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) COMPLETE DATE
M 000	<p>16.03.11 Initial Comments</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 IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities.</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p><i>Refer to Attached POC.</i></p> <p><i>6-23-14</i></p> <p><i>MP6</i></p> <p><i>Per phone call 08:50</i></p>	
MM346	<p>16.03.11.110.06(g) In-House Check</p> <p>The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems.</p> <p>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</p>	MM346	<p><b>RECEIVED</b></p> <p><b>JAN 15 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	

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

*[Signature]*

TITLE

*Program Manager*

(X6) DATE

*1/15/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTRIE STRUCTURE</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
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MM346	<p>Continued From Page 1</p> <p>of seven 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 11:15 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>  <b>7.9.3 Periodic Testing of Emergency Lighting Equipment.</b>  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		



January 14, 2014

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

RE: Mallard, Provider #13G032

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.

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 tests 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 and is positioned above the printed name and title.

Tom Moss  
Program Manager  
Licensed Social Worker