



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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March 30, 2015

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

RE: Bitterroot Home, Provider # 13G022

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey of Bitterroot Home, which was concluded on March 17, 2015.

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,

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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 **April 13, 2015**, 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 April 9, 2015. If a request for informal dispute resolution is received after April 9, 2015, 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

Printed: 03/24/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2015
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301	
(X4) ID PREFIX TAG K-000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
<p>The facility is a residential single story, Type V(000) building. It was built in 1992 and is fully sprinklered in living spaces and closets. There is a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICFID 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 March 17, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j).</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction</p>		<div style="text-align: right; font-size: 2em; opacity: 0.5;">RECEIVED</div> <div style="text-align: right; font-size: 1.5em; opacity: 0.5;">APR 15 2015</div> <div style="text-align: right; font-size: 1.5em; opacity: 0.5;">FACILITY STANDARDS</div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Stephens TITLE: Administrator (X8) DATE: 4/15/15

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.

PRINTED: 03/26/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2015
NAME OF PROVIDER OR SUPPLIER BITTERROOT HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301		
(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	16.03.11 Initial Comments The facility is a residential single story, Type V(000) building. It was built in 1992 and is fully sprinklered in living spaces and closets. There is a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/ID beds. The following deficiencies were found during the annual Fire/Life Safety survey conducted on March 17, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j), and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities. The Survey was conducted by: Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	M 000		
MM311	16.03.11.110.01(a) Structurally Sound The facility must be structurally sound and must be maintained and equipped to assure the safety of residents, employees and the public. This RULE: is not met as evidenced by: Based on observation and interview the facility failed to maintain the structure of the facility. This deficient practice could allow smoke and gases, or insects and vermin to enter the open space of the attic and spread throughout the facility affecting six clients, two staff members, and visitors on the date of survey. Findings include:	MM311	The two holes were fixed as of observations on March 30, 2015. No other holes were detected in the structure. All facility personnel are trained to alert maintenance for immediate repair if any holes in the ceilings of the structure occur. Date of correction: 3/30/2015 Responsible: Facility Manager, Administrator	

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APR 15 2015
FACILITY STANDARDS

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

Rene Stephens

Administrator

4/15/15

PRINTED: 03/26/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2015
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MM311	Continued From Page 1 During the facility tour on March 17, 2015 at approximately 3:00 PM, observation revealed two holes in the garage ceiling that measured approximately 2" x 1" and 1" x 1". Interview with the house manager revealed the facility was unaware of the multiple holes in the ceiling. The facility is licensed for 6 ICF beds with a census of 6 on the day of survey. Actual Reference: IDAPA 16.03.22.110.01 (a) The facility must be structurally sound and must be maintained and equipped to assure the safety of residents, employees and the public.	MM311		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.