



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK-- ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

August 12, 2015

Steve Young, Administrator  
Yellowstone Group Home #1 Springfield  
560 West Sunnyside  
Idaho Falls, ID 83402

RE: Yellowstone Group Home #1 Springfield, Provider #13G063

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Yellowstone Group Home #1 Springfield, on August 5, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health 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,

Steve Young, Administrator  
August 12, 2015  
Page 2 of 2

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 **August 25, 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](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 August 25, 2015. If a request for informal dispute resolution is received after August 25, 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  
Fire Life Safety & Construction Program

MPG/lj

Enclosure

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

Printed: 08/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  08/05/2015
NAME OF PROVIDER OR SUPPLIER <b>YELLOWSTONE GROUP HOME #1 SPRINGFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3335 SPRINGFIELD IDAHO FALLS, ID 83404</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	INITIAL COMMENTS  The Facility is single story residential building with a type V (000) construction. It is a fully sprinklered (except for garage and attic) with a 13-R sprinkler system with quick response sprinkler heads. It has a complete fire alarm smoke detection system. This home was built/completed in February of 1998. Currently it is licensed for 6 ICF/MR beds.  The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on August 5, 2015. 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 (j) and IDAPA 16.03.11, Rules Governing Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).  The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K0018	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD  Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4  Doors are self-closing or automatic closing in accordance with 7.2.1.8  Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.	K0018	<p>RECEIVED SEP 15 2015 FACILITY STANDARDS</p> <p>Please see Attached Plan of Correction by:</p> <p>Steve Young Admin / QIDP</p>	

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

TITLE

(X6) DATE

X 

QIDP/PS

8/24/15

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.

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

Printed: 08/11/2015  
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.K0018	Continued From page 1  This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that bedroom doors would close and latch. Failure to ensure doors to sleeping rooms latch could allow smoke and dangerous gases to migrate into rooms exposing clients to harmful by-products of combustion and hindering egress during a fire event. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 6 ICF/ID beds.  Findings include:  During the facility tour conducted on August 5, 2015 from 9:00 AM to 11:00 AM, observation and operational testing of the first and last bedroom doors on the left moving clockwise from the front door revealed both did not latch when closed.  Actual NFPA standard:  33.2.3.6.3 Doors shall be provided with latches or other mechanisms suitable for keeping the doors closed. No doors shall be arranged to prevent the occupant from closing the door.	K0018		
K0150	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD  New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1  This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the flame	K0150		

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K0150	<p>Continued From page 2</p> <p>resistive properties of loosely hanging curtains, drapes and decorations. Failure to provide loosely hanging drapes, curtains and decorations resistive to flame could add to the growth and spread of fire. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 6 ICF/ID beds.</p> <p>Findings include:</p> <p>1) During review of the facility records conducted on August 5, 2015 from 9:00 AM to 11:00 AM, the facility failed to provide documentation of the flame resistive properties of curtains or other loosely hanging decorations. When asked if he was applying any type of flame retardant to the curtains or drapes in the facility, the Maintenance Supervisor stated he was not.</p> <p>2) During the facility tour conducted on August 5, 2015 from 11:00 AM to 3:30 PM, physical inspection of installed curtains did not reveal any labeling or flame resistive treatment having been applied to curtains located in the Kitchen, dining room, bedrooms #1 and #2 moving clockwise from the front door.</p> <p>Actual NFPA standard:</p> <p>33.7.5.1 New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 10.3.1.</p>	K0150			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/05/2015</b>
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M 000	<p>16.03.11 Initial Comments</p> <p>The Facility is single story residential building with a type V (000) construction. It is a fully sprinklered (except for garage and attic) with a 13-R sprinkler system with quick response sprinkler heads. It has a complete fire alarm smoke detection system. This home was built/completed in February of 1998. Currently it is licensed for 6 ICF/MR beds.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on August 5, 2015. 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 (j) and IDAPA 16.03.11, Rules Governing Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).</p> <p>The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p style="text-align: center;">RECEIVED SEP 15 2015 FACILITY STANDARDS</p>	
MM309	<p>16.03.11.110 Fire and Life Safety Standards</p> <p>Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities.</p> <p>This Rule is not met as evidenced by: Refer to Federal "K" tags: K-018 Sleeping room doors K-150 Flame resistive curtains and drapes</p>	MM309	<p style="text-align: center;"><i>Steve Jones City Director.</i></p>	

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*[Signature]*

TITLE  
*QIDP/PS*

(X6) DATE  
*8/24/15*



560 W Sunnyside RD, Idaho Falls, ID 83402 \* Office (208) 523-9839 \* Fax (208) 522-0224

RECEIVED

August 21, 2015

SEP 15 2015

Dear Mark Grimes and Sam Burbank:

FACILITY STANDARDS

For the Fire Life Safety survey conducted at the Springfield home August 5, 2015, we have the following plan of correction for this home's survey:

K0018- As noted, two of the individual's doors would not close and latch as required. This specific item is listed on our monthly fire drill form for doors to be tested. The Program Supervisor and lead Worker for this home will receive training as it is a concern to why it was listed as "not a problem" on the fire drill forms from past fire drills. All staff will also receive training to report any concerns listed on our fire drill form as they perform their daily duties. We also have a comprehensive safety form labeled the universal home checklist that will be performed monthly as a quality assurance measure and turned in to the Program Supervisor of this home for review. The Program Supervisor will note any discrepancies and assure they are addressed through maintenance.

This will be completed by September 11, 2015. Responsible party will be the city director, Steve Young.

K0150- All draperies, curtains and other similar loosely hanging furnishings will be replaced with flame resistant ones in accordance with NFPA 701. All future items purchased will also meet this code and flame resistant. This will be addressed on the universal checklist to ensure compliance and documentation and all such items inspected monthly by the Program Supervisor. This will be completed by September 18, 2015 by the Program Manager, Steve Young.

MM309- Please refer to the previous listed K tag deficiencies.

Program Supervisor signature: \_\_\_\_\_

A handwritten signature in black ink, appearing to read 'Steve Young', is written over a horizontal line.

Date: \_\_\_\_\_

9/14/15