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 #4 Fox Hollow
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #4 Fox Hollow, Provider #13G066

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 #4 Fox Hollow, 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,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	13G066		08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLL	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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 a single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13-R system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility 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). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED AUG 25 2015 FACILITY STANDARDS	
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 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. Findings include:	K0150	Please see attached Plan of Correction Steve Young Admin / ~~QIDP~~	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

x [signature] | QDP/PS | 8/28/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	13G066		08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLL	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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
K0150	Continued From page 1 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. 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 Living room, Kitchen and bedroom #1 moving clockwise from the front door. Actual NFPA standard: 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.	K0150		
K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of	K0152		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	13G066		08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLL	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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	Continued From page 2 clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (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. (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. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted once per shift per quarter. Failure to conduct fire drills quarterly on all shifts could result in staff not being prepared for the event of a 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. Findings include: During review of the facility fire drill records conducted on August 5, 2015 from 9:00 AM to 11:00 AM, the facility was unable to produce fire drill records for the late night shift during the fourth quarter of 2014. Interview of the Maintenance Supervisor found he was not aware of the missing drill. Actual CFR requirement: CFR-42-483.470(i) Evacuation Drills	K0152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	13G066		08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLL	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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	Continued From page 3 (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (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. (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.	K0152		

PRINTED: 08/11/2015
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED
	13G066		08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #4 FOX HOLLOW	370 HOLLOW DRIVE IDAHO FALLS, ID 83402

(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 single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13-R system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility 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 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	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards 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. This Rule is not met as evidenced by: Refer to Federal "K" tags: K150 Flame resistive curtains and drapes K152 Fire drills	MM309	Steve Young Admin / ~~QIDP~~ RECEIVED AUG 25 2015 FACILITY STANDARDS	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X	QIDP/PS	8-26-15

ASPIRE
HUMAN SERVICES, LLC

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

RECEIVED
SEP 15 2015
FACILITY STANDARDS

September 14, 2015

Dear Mark Grimes and Sam Burbank:

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

K0150- All draperies, curtains and other similar loosly 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.

K0152- As noted, the Fox Hollow home was missing a late night fire drill for the fourth quarter of 2014. To ensure this does not occur again, the fire frills will be turned in monthly to the Program Supervisor who will then track the fire drills on a "Fire Drill Schedule". This schedule will be followed according to the drill assigned for that month. A copy of the monthly drills will also be turned in to the city director who will also track the fire drill on a schedule. That way all fire drills will be double tracked to prevent such errors from occurring.
This will be completed by September 1, 2015 by the Program Manager, Steve Young.

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

Program Supervisor signature: _____ Date: 9/14/15