



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

February 17, 2016

Richard Davis, Administrator  
Boise Group Home #3 Holt  
PO Box 4243  
Boise, ID 83711

RE: Boise Group Home #3 Holt, Provider # 13G034

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey of Boise Group Home #3 Holt, which was concluded on February 8, 2016.

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,

Richard Davis, Administrator  
February 17, 2016  
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 **March 1, 2016**, 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 March 1, 2016. If a request for informal dispute resolution is received after March 1, 2016, 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: 03/10/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04, - ENTIRE STRUCTURE  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #3 HOLT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9874 WEST HOLT STREET BOISE, ID 83704</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>INITIAL COMMENTS</p> <p>The facility is a single story, type V (000) wood frame construction with a composite pitched roof and three exits to grade. The facility was converted during the spring of 2008 with plan review in May 2008. It is fully sprinklered with an NFPA 13D system and has a fire alarm/smoke detection system as well as, battery operated emergency lighting. Currently it is licensed for 5 ICF beds.</p> <p>The facility was found to be in substantial compliance with applicable Fire/Life Safety requirements during the annual life safety code survey conducted on February 8, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 32, New Residential Board &amp; Care Occupancies, Impractical Evacuation Capability in accordance with 42 CFR 483.470.</p> <p>The survey was conducted by:</p> <p>Nathan Elkins Health facility Surveyor Facility Fire Safety &amp; Construction</p>	K 000			

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

TITLE

(X6) DATE

02/28/2016

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>13G034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>04 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>BOISE GROUP HOME #3 HOLT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9874 WEST HOLT STREET BOISE, ID 83704</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) wood frame construction with a composite pitched roof and three exits to grade. The facility was converted during the spring of 2008 with plan review in May 2008. It is fully sprinklered with an NFPA 13D system and has a fire alarm/smoke detection system as well as, battery operated emergency lighting. Currently it is licensed for 5 ICF beds.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on February 8, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 32, New 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>Nathan Elkins Health Facility Surveyor Facility Fire Safety &amp; Construction</p>	M 000		
MM334	<p>16.03.11740.06 Emergency Battery Operated Lighting</p> <p>Each ICF/ID must provide emergency battery operated lighting for at least the exit passageway lighting, hall lighting, and the fire alarm system, in accordance with NFPA 101, The Life Safety Code, Section 7.9, as incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Based on observation, operational testing and</p>	MM334		

RECEIVED  
MAR - 9 2016  
FACILITY SURVEILLANCE

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	02/28/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>04 - ENTIRE STRUCTURE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/08/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #3 HOLT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9874 WEST HOLT STREET BOISE, ID 83704</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
MM334	<p>Continued From page 1</p> <p>interview, the facility failed to ensure that battery powered emergency lighting was maintained. Failure to maintain battery powered emergency lighting could inhibit safe evacuation of clients during a power failure or other emergency. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 5 ICF/ID beds.</p> <p>Findings include:</p> <p>During the facility tour conducted on February 8, 2016 at approximately 1:30 PM, observation and operational testing revealed the installed battery backup emergency light located in the hallway was not operational. When asked, the administrator stated he was unaware of the light not working.</p> <p>Actual IDAPA standard:</p> <p>IDAPA 16.03.11.740.06 740. FIRE AND LIFE SAFETY STANDARDS -- EXISTING FACILITY. All buildings on the premises of an ICF/ID must meet all the requirements of local, state, and national codes concerning fire and life safety standards that are applicable to ICFs/ID.</p> <p>06. Emergency Battery Operated Lighting. Each ICF/ID must provide emergency battery-operated lighting for at least the exit passageway lighting, hall lighting, and the fire alarm system, in accordance with NFPA 101, The Life Safety Code, Section 7.9, as incorporated in Section 004 of these rules.</p>	MM334	<p>Corrective Action: The monthly test was done for January. Battery was replaced day after survey,</p> <p>Other Residents Affected: All residents in the house.</p> <p>Systemic Changes: See corrective action. Battery expired between tests.</p> <p>Monitor: Monthly fire checks will continue by the house manager.</p>	Feb 9, 2016