



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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REVISED COPY

April 15, 2016

Valentina Reudter, Administrator
Belmont Care Center
4806 Hawthorne Road
Chubbuck, ID 83202

RE: Belmont Care Center, Provider #13G046

Dear Mr. Reudter:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Belmont Care Center, on March 21, 2016.

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;

Valentina Reudter, Administrator
April 15, 2016
Page 2 of 2

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 **April 25, 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

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 25, 2016. If a request for informal dispute resolution is received after April 25, 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, option 3.

Sincerely,

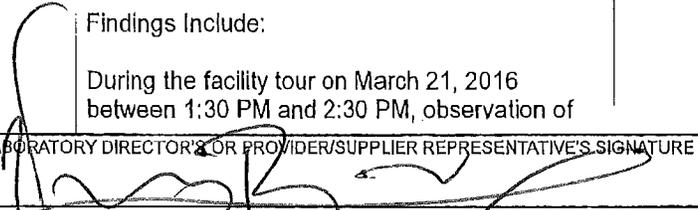


MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2016
NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 VAUGHN AVENUE POCATELLO, ID 83204		
(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 was built in 1991 and is a one story, Type V(III) structure with a daylight basement that contains offices. Clients sleep on the first story (i.e., ground level). The basement has an exit to finished grade level as well as secondary exiting capability via internal stairwell. Emergency lighting is provided. The facility is fully sprinklered and is licensed for 15 ICF/ID beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on March 21, 2016. 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. The Survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	Please see attached letter for POC.  4/22/16	
K 130	NFPA 101 MISCELLANEOUS This Standard is not met as evidenced by: Based on observation and interview, the facility failed to use electrical equipment safely. Failure to use electrical equipment safely could allow for electrical arcing of equipment. This deficient practice affected two clients, staff, and visitors on the day of survey. The facility is licensed for 15 ICF/ID beds with a census of 15 on the date of survey. Findings Include: During the facility tour on March 21, 2016 between 1:30 PM and 2:30 PM, observation of	K 130		

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **Program Manager** (X6) DATE **4/22/16**

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

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K 130	Continued From page 1 "JS" room revealed an inappropriate multi-plug adapter plugged into a power strip. Upon further observation an extension cord was being used as fixed wiring. When asked, the Administrator stated the facility was unaware of the electrical hazards. Actual NFPA standard: NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code Also see UL listings: XBYS Guide information XBZN2 Guide information	K 130		
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,	K0018		

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K0018	<p>Continued From page 2 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>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:</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors with latches or other mechanisms suitable for keeping the doors closed. Failure to maintain doors could allow smoke and dangerous gases to pass freely throughout facility. This deficient practice has the potential to affect all clients, staff, and visitors on the date of survey. The facility is licensed for 15 ICF/ID beds with a census of 15 on the day of survey.</p> <p>Findings Include:</p> <p>1.) During the facility tour on March 21, 2016 at approximately 2:00 PM, observation and operational testing of "GM" room revealed the door would not latch when closed due to the door not having a latching device. When asked, the Administrator stated the door requires to be replaced constantly because of the clients outbursts.</p> <p>2.) During the facility tour on March 21, 2016 at approximately 2:20 PM, observation and operational testing of "PH" & "BB" room revealed the door would not close and latch properly. When asked, the Administrator stated the facility was unaware of the door not operating correctly.</p>	K0018		
K0152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD	K0152		

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K0152	<p>Continued From page 3</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities;</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action; and</p> <p>(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.</p> <p>(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 that fire drills were conducted once per shift per quarter. Failure to adequately train staff could hinder proper response during a fire or emergency event. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 15 ICF/ID beds with a census of 15 on the day of survey.</p> <p>Findings include:</p> <p>During record review on March 21, 2016 at approximately 1:30 PM, review of the facilities</p>	K0152		

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K0152	Continued From page 4 fire drill reports revealed no fire drills were conducted for the 3rd quarter AM shift, and the entire 4th. quarter. When asked, the Administrator stated the she was unaware of the missing drills.	K0152		



4806 Hawthorne Rd, Chubbuck, Idaho, 83202 | Office – 208-238-5950 | Fax 208-238-5860

April 21, 2016

Nate Elkins
Health Facility Surveyor
Fire Life Safety & Construction
3232 Elder Street
P.O Box 83709
Boise, Idaho 83720-0009

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APR 26 2016
FACILITY STANDARDS

Dear Mr. Elkins,

Thank you for your comments during the recent Fire Light Safety Survey at Belmont Care Center. Please see our response for each federal deficiency. Please feel free to reach out to me if you have any additional questions.

K130

- All inappropriate multi-plug adapters were removed from “JS” room.
- Visual inspections of the each bedroom will be completed on a monthly basis to ensure only appropriate power strips are in use.
- Aspire Human Services currently uses a Universal Home Checklist completed by the Program Supervisor or lead worker. The checklist will include verification that no inappropriate multi-plug adapters are in use. If an inappropriate adapter is found it will be removed immediately and replaced with an appropriate power strip. After the checklist is completed by the Program Supervisor or lead worker, it will be turned into the Program Manager to ensure completion.
- Person(s) Responsible – Program Supervisor, Program Manager
- Completion Date – 5/2/16

K0018-

- All doors have been repaired to ensure latching mechanisms are in working order and the doors fully close.
- All doors will be checked at minimum of a monthly basis.

- Aspire Human Services currently uses a Universal Home Checklist completed by the Program Supervisor or lead worker. The checklist will include an inspection of all doors in the facility. If there is a problem noted, the Program Supervisor will coordinate the repair of the door. After the checklist is completed by the Program Supervisor or lead worker, it will be turned into the Program Manager to ensure completion.
- Person(s) responsible – Program Supervisor, Program Manager
- Completion date – 5/2/2016

MM348-

- The drills were found to be completed but the documentation had been lost. Drills were completed to ensure current compliance.
- The drill reports will be maintained in the home by the Program Supervisor.
- Aspire Human Services currently uses a Universal Checklist completed by the Program Supervisor or lead worker of each home. The checklist will include checking the drills completed in the home each month. If missing drills are noted, the Program Supervisor will coordinate the running a drill to ensure compliance. After the checklist is completed, it will be turned into the Program Manager to ensure completion.
- Person(s) responsible – Program Supervisor, Program Manager
- Completion Date – 5/9/16

Sincerely,



Valentina Reudter
Program Manager
Aspire Human Services

444 Hospital Way Suite 701
Pocatello, Idaho 83201

valentinare@aspirehumanservices.com

Office – 208-238-5950

Cell – 208-223-5863

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M 000	16.03.11 Initial Comments The facility was built in 1991 and is a one story, Type V(III) structure with a daylight basement that contains offices. Clients sleep on the first story (i.e., ground level). The basement has an exit to finished grade level as well as secondary exiting capability via internal stairwell. Emergency lighting is provided. The facility is fully sprinklered and is licensed for 15 ICF/ID beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on March 21, 2016. 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., and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities. The Survey was conducted by: Nate Elkins Health Facility Surveyor Fire Life Safety & Construction	M 000	Please see attached letter for POC  4/22/16 RECEIVED APR 26 2016 FACILITY STANDARDS	
MM215	16.03.11711.01 Good Repair Each building used by the ICF/ID and its equipment must be in good repair. This RULE: is not met as evidenced by: Based on observation and interview the facility failed to ensure the building was in good repair. Failure to ensure the building was in good repair could hinder the quality to be suitable for the services and usage of the clients. This deficient practice affects one client, staff, and visitors on the day of survey. The facility is licensed for 15 ICF/ID beds with a census of 15 on the date of	MM215		

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

Program Manager

(X6) DATE

4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2016
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MM215	Continued From Page 1 survey. Findings include: 1.) During the facility tour on March 21, 2016 at approximately 2:00 PM, observation revealed four (4) large holes in the walls of "GM" room. When asked, the Administrator stated this is a reoccurring issue with the client. 2.) During the facility tour on March 21, 2016 at approximately 2:15 PM, observation revealed a 3 inch circular hole behind the door of "SH" room. When asked, the Administrator stated this is a reoccurring issue with the client Actual IDAPA Standard: 711. PHYSICAL FACILITY STANDARDS -- EXISTING CONSTRUCTION. Each ICF/ID must use buildings that are of such character and quality to be suitable for the services and usage provided in its buildings. Other requirements for existing buildings are: 01. Good Repair. Each building used by the ICF/ID and its equipment must be in good repair.	MM215		
MM332	16.03.11740.04 Portable Fire Extinguishers Each ICF/ID must have portable fire extinguishers installed throughout the facility in accordance with applicable provisions of NFPA Standard 10, " Portable Fire Extinguishers. " This RULE: is not met as evidenced by: Based on observation it was determined that the facility failed to inspect the portable fire extinguishers in accordance with NFPA 10. Monthly inspections of portable fire extinguishers helps to ensure that they are located at their	MM332		

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: 13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2016
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MM332	Continued From Page 2 designated location and their reliability to operate in the event they may be needed. This deficiency affected 15 clients, staff and visitors on the day of the survey. The facility is licensed for 15 ICF/ID clients with a census of 15 on the date of survey. Findings include: During a tour of the facility on March 21, 2016 between 1:30 PM and 2:30 PM, observation of the inspection tags affixed to all the ABC fire extinguishers inside the facility indicated that no monthly inspections were conducted. When asked, the Administrator stated the facility was unaware they were required to inspect the extinguishers monthly. Actual NFPA Standard: NFPA 10 Standard for Portable Fire Extinguishers 1998 Edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	MM332		
MM348	16.03,11741.03 Maintanance of Equipment Each ICF/ID must establish routine test, check, and maintenance procedures for alarm systems, extinguishment systems, and all essential electrical systems. Each facility must meet the following requirements: This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to maintain sprinkler escutcheon installations and electrical systems. Failure to	MM348		

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: 13G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2016
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MM348	Continued From Page 3 ensure that sprinkler escutcheons and electrical systems are maintained as required and could allow systems failures resulting in fire spread and/or electrical shock. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 15 ICF/ID beds with a census of 15 on the day of the survey. Findings include: 1.) During the facility tour conducted on March 21, 2016 from 1:30 PM to 2:30 PM, observation of the facility sprinkler pendants found that escutcheons were missing from the TV room, House Managers Office, and the Office in the upstairs area. When asked, the Administrator stated the facility unaware of the missing sprinkler escutcheons. 2.) During the facility tour conducted on March 21 2016 at approximately 1:30 PM, observation of the "GM" room revealed two (2) electrical outlet covers missing. When asked, the Administrator stated the facility was unaware of the missing electrical outlet covers.	MM348		

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



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April 21, 2016

Nate Elkins
Health Facility Surveyor
Fire Life Safety & Construction
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P.O Box 83709
Boise, Idaho 83720-0009

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FACILITY STANDARDS

Dear Mr. Elkins,

Thank you for your comments during the recent Fire Light Safety Survey at Belmont Care Center. Please see our response for each state deficiency. Please feel free to reach out to me if you have any additional questions.

MM215

- The holes in the wall have been repaired in both “GM” and “SH” room.
- Visual inspections of the each bedroom will be completed on a monthly basis to ensure there are no holes in the wall.
- Aspire Human Services currently uses a Universal Home Checklist completed by the Program Supervisor or lead worker. Ensuring there are no holes in the wall will be on the checklist. If a hole is found, the Program Supervisor will coordinate the repair of the hole. If it is found to be a reoccurring problem, further actions will be taken (including but not limited to installing wall mounted door stops). After the checklist is completed by the Program Supervisor or lead worker, it will be turned into the Program Manager to ensure completion.
- Person(s) Responsible – Program Supervisor, Program Manager
- Completion Date – 5/2/16

MM332 –

- All portable fire extinguishers have been inspected and the inspection has been documented.

- Portable fire extinguishers will be inspected as recommended on a monthly basis.
- Aspire Human Services currently uses a Universal Home Checklist completed by the Program Supervisor or lead worker. The checklist will include an inspection of the portable fire extinguishers. After the checklist is completed by the Program Supervisor or lead worker, it will be turned into the Program Manager to ensure completion.
- Person(s) responsible – Program Supervisor, Program Manager
- Completion date – 5/2/2016

MM348-

- All escutcheons and electrical outlet covers have been replaced
- Visual inspections of the sprinkler system and electrical system will be completed on a monthly basis.
- Aspire Human Services currently uses a Universal Checklist completed by the Program Supervisor or lead worker of each home. Inspections of the alarm, extinguishment and electrical systems will be on the checklist. If problems are noted, the Program Supervisor will coordinate the repair of the system. After the checklist is completed, it will be turned into the Program Manager to ensure completion.
- Person(s) responsible – Program Supervisor, Program Manager
- Completion Date – 5/9/16

Sincerely,

A handwritten signature in black ink, appearing to read 'Valentina Reudter', with a long horizontal flourish extending to the right.

Valentina Reudter
Program Manager
Aspire Human Services

444 Hospital Way Suite 701
Pocatello, Idaho 83201

valentinare@aspirehumanservices.com

Office – 208-238-5950

Cell – 208-223-5863