



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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August 5, 2016

Jamie Newton, Administrator  
Southwest Idaho Treatment Center - Kyler  
1660 11th Avenue North  
Nampa, ID 83687-5000

RE: Southwest Idaho Treatment Center - Kyler, Provider #13G081

Dear Ms. Newton:

This is to advise you of the findings of the Medicaid/Licensure survey of Southwest Idaho Treatment Center - Kyler, which was conducted on August 3, 2016.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

  
JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

PRINTED: 08/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHWEST IDAHO TREATMENT CENTER - KYLER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1182 WEST KYLER AVENUE HAYDEN, ID 83835</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	
W 000	<p><b>INITIAL COMMENTS</b></p> <p>Southwest Idaho Treatment Center - Kyler is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for the annual recertification survey conducted from 8/2/16 to 8/3/16.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Autumn Bernal, RN, BSN</p>	W 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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>13G081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/03/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHWEST IDAHO TREATMENT CENTER - K</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1182 WEST KYLER AVENUE HAYDEN, ID 83835</b>
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M 000	<p>16.03.11 Initial Comments</p> <p>Southwest Idaho Treatment Center - Kyler is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID)" for the licensure survey conducted from 8/2/16 to 8/3/16.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Autumn Bernal, RN, BSN</p>	M 000		
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Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_