



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

LESLIE M. CLEMENT – DEPUTY DIRECTOR  
LICENSING AND CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1688

February 23, 2012

Rena Blaser, Administrator  
Emerald House, Llc  
598 North Highway 91  
Firth, ID 83236

License #: RC-935

Dear Ms. Blaser:

On January 13, 2012, a State Licensure survey was conducted at Emerald House. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level:

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Rae Jean McPhillips, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Rae Jean McPhillips  
Team Leader  
Health Facility Surveyor  
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



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January 18, 2012

Rena Blaser, Administrator  
Emerald House, Llc  
490 Emerald Street  
Blackfoot, ID 83221

Dear Ms. Blaser:

**Congratulations** to both you and your staff on your recent State Licensure which was conducted at Emerald House, Llc on 01/13/2012. No core deficiencies were found and you had three or less non-core deficiencies cited during your survey, which qualifies you for a *Silver Excellence in Care Award*.

This award demonstrates that you have worked exceptionally hard to meet the requirements set forth in the Rules for Residential Care or Assisted Living Facilities. Thank you for providing excellent care and ensuring the residents you serve live in a clean, safe and home-like community.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference, on 01/13/2012. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc) are to be submitted to this office within thirty (30) days from the exit date.

Again, congratulations to you and your staff for a job well done.

Sincerely,

**The Residential Assisted Living Facility Survey Team**

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R935</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>EMERALD HOUSE, LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>490 EMERALD STREET BLACKFOOT, ID 83221</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
R 000	<p><b>Initial Comments</b></p> <p>The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core deficiencies were cited during the licensure and follow-up survey conducted January 11, 2012 through January 13, 2012 at your facility. The surveyors conducting the survey were:</p> <p>Rae Jean McPhillips, RN, BSN Team Coordinator Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p>	R 000		

Bureau of Facility Standards

TITLE

(X8) DATE

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

