



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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January 16, 2014

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, which was concluded at Boise Group Home #3 Holt, on January 9, 2014.

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 similar form stating that no State licensure deficiencies were noted at the time of the survey.

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

Enclosure

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

Printed: 01/14/2014  
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 <b>04</b> - ENTIRE STRUCTURE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/09/2014</b>
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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>
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(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
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K 000	<p><b>INITIAL COMMENTS</b></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 in the spring of 2008 with plan review in May 2008. The facility 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/ID 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 January 9, 2014. 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 (j).</p> <p>The annual life safety code survey was conducted by:</p> <p>Tom Mroz CFI-II Health facility Surveyor Facility Fire Safety and Construction</p>	K 000		
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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.

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>01/09/2014</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><b>16.03.11 Initial Comments</b></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 in the spring of 2008 with plan review in May 2008. The facility 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/ID beds.</p> <p>The facility was found to be in substantial compliance with applicable life safety requirements during the annual Life Safety Code survey conducted on January 9, 2014. 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 (j), and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities.</p> <p>The Survey was conducted by:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000		

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

(X6) DATE