



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

March 28, 2014

Richard Davis, Administrator
Boise Group Home #6 Delmar 1
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #6 Delmar 1, Provider #13G058

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #6 Delmar 1, which was conducted on March 26, 2014.

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 our visit. If you have questions, please call this office at (208) 334-6626.

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: 03/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #6 DELMAR 1			STREET ADDRESS, CITY, STATE, ZIP CODE 12477 WEST DELMAR STREET BOISE, ID 83713		
(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>INITIAL COMMENTS</p> <p>Boise Group Home #6 - Delmar 1 is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Intellectual Disability. The annual recertification survey was conducted from 3/24/14 to 3/26/14.</p> <p>The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Michael Case, LSW, QIDP</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: 13G058	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #6 DELMAR 1	STREET ADDRESS, CITY, STATE, ZIP CODE 12477 WEST DELMAR STREET BOISE, ID 83713
---	--

(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>Boise Group Home #6 - Delmar 1 is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)." The annual licensure survey was conducted from 3/24/14 to 3/26/14.</p> <p>The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Michael Case, LSW, QIDP</p>	M 000		
-------	---	-------	--	--

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------