



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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June 23, 2014

Shawn Sayer, Administrator
Belmont Care Center 5th Street
4806 Hawthorne Road
Chubbuck, ID 83202

RE: Belmont Care Center 5th Street, Provider #13G079

Dear Mr. Sayer:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Belmont Care Center 5th Street, on June 18, 2014.

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

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure 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;
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;

Shawn Sayer, Administrator
June 20, 2014
Page 2 of 2

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
6. Include dates when corrective action(s) 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 **July 3, 2014**, 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 July 3, 2014. If a request for informal dispute resolution is received after July 3, 2014, 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 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/pt
Enclosures

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

PRINTED: 06/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2014
NAME OF PROVIDER OR SUPPLIER BELMONT CARE CENTER 5TH STREET			STREET ADDRESS, CITY, STATE, ZIP CODE 6150 SOUTH 5TH STREET 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	
W 000	<p>INITIAL COMMENTS</p> <p>Belmont Care Center - 5th Street is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation for the annual recertification survey conducted from 6/16/14 to 6/18/14.</p> <p>The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Ashley Henscheid, 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: 13G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2014
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NAME OF PROVIDER OR SUPPLIER
BELMONT CARE CENTER 5TH STREET

STREET ADDRESS, CITY, STATE, ZIP CODE
**6150 SOUTH 5TH STREET
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) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 6/16/14 to 6/18/14. The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Ashley Henschel, QIDP Common abbreviations used in this report are:	M 000	POC MM271 16.03.11.100.04(b) Storage of Toxic Chemicals Fifth Street Care Center will ensure all toxic chemicals are properly labeled and stored under lock and key. The Prestone De-Icer windshield wiper fluid was removed from the closet and stored under lock and key.	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic chemicals were properly labeled and stored for 12 of 12 individuals (Individuals #1 - #12) residing in the facility. This resulted in toxic chemicals being unlabeled, unlocked and accessible. The findings include: 1. An environmental review was conducted at the facility on 6/17/14 from 10:00 - 10:45 a.m. During that time, the following was observed: a. An unlocked storage closet was noted to contain a one-gallon bottle of Prestone De-Icer windshield wiper fluid. The label stated "May be fatal or cause blindness if swallowed" and "Cannot be made non poisonous." The Dietary Manager, who was present during the review, stated the chemical should have been locked. When asked if the closet was ever locked, the Dietary Manager stated it was not because the closet contained excess food storage and access was regularly needed.	MM271	The spray bottles in pod four were properly labeled with the contents of the chemical. Person Responsible: Housekeeping Manager, Residential Home Program Supervisor, and City Director. Monitor: Weekly the Housekeeping Manager will ensure all chemicals are properly labeled and under lock and key. Monthly facility inspections be completed by the Home Program Supervisor. Quarterly the City Director will complete facility inspections.	8/18/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
City Director

(X6) DATE
7/3/14

STATE FORM

6899

JDMQ11

If continuation sheet 1 of 3

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/18/2014
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MM271	<p>Continued From page 1</p> <p>The facility failed to ensure all toxic chemicals were maintained under locked conditions.</p> <p>b. A locked cleaning closet in pod four contained two spray bottles. When asked, a direct care staff who was present during the review stated the bottles were used for cleaning supplies.</p> <p>However, the spray bottles did not contain labels indicating the contents.</p> <p>The facility failed to ensure all chemicals were property labeled.</p>	MM271		
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 12 of 12 individuals (Individuals #1 - #12) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 6/17/14 from 10:00 - 10:45 a.m. During that time, the following was noted:</p> <p>- The seam of carpet in the doorway of pod four</p>	MM380		

Bureau of Facility Standards

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MM380	<p>Continued From page 2</p> <p>was separated across the entryway in an approximately six foot strip.</p> <p>- There were various-sized, dark, gray stains on the hallway carpet, ranging from approximately one inch to three inches in diameter.</p> <p>- The seam of carpet in front of the entertainment stand of pod three was separated in an approximately two foot strip.</p> <p>- There were various-sized marks on the carpet of the entryway of pod three, ranging from approximately one inch to ten inches in diameter. The two largest marks were perfect circles. The marks were first noted during an earlier observation on 6/18/14 from 4:15 - 5:00 p.m. At that time, Individual #1 stated the marks were burns from attempts to put out a grease fire that occurred in a pan while cooking.</p> <p>- Individual #7's room had a strong urine-like odor. During the exit conference on 6/18/14 from 10:49 - 11:05 a.m., the Administrator stated attempts to keep Individual #7's room clean had been made, but had not provided a long-term solution.</p> <p>The facility failed to ensure environmental repairs were maintained.</p>	MM380	<p>POC MM380 16.03.11.120.03(a) Building and Equipment</p> <p>Fifth Street Care Center will ensure the building and equipment are in good repair.</p> <ol style="list-style-type: none"> The seam of the carpet in the doorway of pod four will be repaired. The dark grey stains on the hallway carpet will be cleaned or the carpet replaced. The seam of the carpet in front of the entertainment stand in pod three that has separated will be repaired and/or replaced. The carpet in the entry way of pod three will be cleaned and/or replaced. Individual #7's room will be cleaned. The carpet will be cleaned and/or replaced. <p>Person Responsible: Housekeeping Manager, Residential Home Program Supervisor, and City Director.</p> <p>Monitor: Monthly facility inspections be completed by the Home Program Supervisor and Housekeeping. Quarterly the City Director will complete facility inspections.</p>	8/18/14