



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

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 3, 2014

Susan Broetje, Administrator  
Southwest Idaho Treatment Center  
1660 Eleventh Avenue North  
Nampa, ID 83687

RE: Southwest Idaho Treatment Center, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Southwest Idaho Treatment Center, on June 24, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar 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; and,
5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

Susan Broetje, Administrator  
July 3, 2014  
Page 2 of 2

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 16, 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](http://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 15, 2014. If a request for informal dispute resolution is received after July 15, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,



MARK P. GRIMES  
Supervisor  
Fire Life Safety & Construction Program

MPG/lj

Enclosure

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

Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - REDWOOD - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The "Redwood" building was originally constructed in 1967 and is a single story structure with a mechanical room in the basement. The building's original construction classification is protected, non-combustible, Type V(111). The building is now fully sprinklered as of 2010. The building is protected throughout by a complete, supervised fire alarm/smoke detection system with off-site monitoring. There is a total of (2) exits to grade from the central core, plus each of the four "pods" containing resident sleeping has an exit directly to grade and a door leading to the central core. Emergency power is provided by an on-site, fuel fired generator. The facility was recently re-opened for resident use in June 2014.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, CH 19 Existing Health Care Occupancies and in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JUL 16 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*S. Bluetje*

**Administrative Director**

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

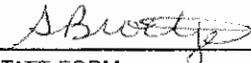
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - REDWOOD - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>The "Redwood" building was originally constructed in 1967 and is a single story structure with a mechanical room in the basement. The building's original construction classification is protected, non-combustible, Type V(111). The building is now fully sprinklered as of 2010. The building is protected throughout by a complete, supervised fire alarm/smoke detection system with off-site monitoring. There is a total of (2) exits to grade from the central core, plus each of the four "pods" containing resident sleeping has an exit directly to grade and a door leading to the central core. Emergency power is provided by an on-site, fuel fired generator. The facility was recently re-opened for resident use in June 2014.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition CH 19 Existing Health Care Occupancies, in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID).</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p><b>RECEIVED</b></p> <p><b>JUL 16 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	
-------	---	-------	---	--

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrative Director</b>	(X6) DATE
---	---	-----------

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

Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - ASPEN</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>The "Aspen" building is a single story structure, with a mechanical loft that was completed/occupied in December of 2002. The building's construction classification Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade; two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier walls. This building has 20 ICF/ID beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, CH 19 Existing Health Care Occupancies and in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JUL 16 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	
K 029	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or</p>	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  <b>Administrative Director</b>	(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>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - ASPEN</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 029	<p>Continued From page 1</p> <p>field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure hazardous area doors inside corridors were smoke resistive and self-closing. Failure to ensure hazardous areas are protected with self-closing doors would allow smoke and dangerous gases to enter corridors and affect egress during a fire event. This deficient practice affected 5 residents, staff and visitors in 1 of 3 smoke compartments on the date of the survey. The facility had a census of 9 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 24, 2014 between 12:30 PM and 1:30 PM observation and operational testing of dedicated storage room doors 131 and 121 revealed that they would not self close. Storage room #131 contained a K style oxygen container and general resident care storage without a self-closing device. Storage room #121 had a self-closing device installed with the main arm missing. This finding was acknowledged by the Maintenance Supervisor.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating</p>	K 029	<p>Aspen K029 and MM309</p> <ol style="list-style-type: none"> <li>1. The door on room 131 will have the self-closing device repaired. Room 121 will have the bins of hazardous materials removed.</li> <li>2. All other storage rooms on all residential buildings have been checked and are free of hazardous materials and/or the self closing devices are operating properly.</li> <li>3. Maintenance personnel will do monthly building inspections to ensure compliance.</li> <li>4. Maintenance and Operations Supervisor will do follow up inspections and review report of the maintenance people.</li> <li>5. The arm for the self-closure on Room 131 was replaced on July 9, 2014. The hazardous materials in room 121 were removed on July 9, 2014.</li> </ol>	

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

Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - ASPEN</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 029	Continued From page 2 or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - ASPEN</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>The "Aspen" building is a single story structure, with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V (111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired; automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There are a total of six exits to grade, two in each of the wings containing resident sleeping rooms, and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/ID beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition CH 19 Existing Health Care Occupancies, in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JUL 16 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p> <p>Refer to K029</p>	
MM309	<p>16.03.11.110 Fire and Life Safety Standards</p> <p>Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities.</p>	MM309		

Idaho form

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

TITLE

(X6) DATE

*Sam Burbank*

**Administrative Director**

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - ASPEN</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
	This Rule is not met as evidenced by: Refer to "K" tag on federal form 2567 1) K 029 - Hazardous area			

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

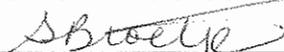
Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>04 - BIRCH</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>The "Birch" building is a single story structure, with a mechanical loft, that was completed/occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and fire/ smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls.</p> <p>Currently the building is unoccupied and under complete renovation until approximately December 2014.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b> <b>JUL 16 2014</b> <b>FACILITY STANDARDS</b></p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrative Director</b>	(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

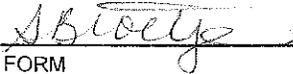
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>04 - BIRCH</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>The "Birch" building is a single story structure, with a mechanical loft, that was completed/occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and fire/smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls.</p> <p>Currently the building is unoccupied and under complete renovation until approximately December 2014.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JUL 16 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	
-------	---	-------	---	--

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	<b>Administrative Director</b>	

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

Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>05 - PINE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The "Pine" building is a single story structure with a mechanical loft. The building was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier walls.</p> <p>The "Pine" building was vacated in 2012 and has been re-opened for residents during the renovation of the "Birch" building. This building has 20 ICF/ID beds.</p> <p>The following deficiency was cited during the annual fire/life safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, CH 19 Existing Health Care Occupancies and in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JUL 16 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	
K 052	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA</p>	K 052		

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

TITLE

(X6) DATE

*S. Burbank*

**Administrative Director**

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>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 05 - PINE  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 052	<p>Continued From page 1</p> <p>72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This Standard is not met as evidenced by: Based on record review observation and interview, the facility failed to ensure that the smoke detection system would properly ensure that the HVAC system dampers would close during a fire event. Failure to properly maintain smoke damper controls per NFPA 72 would allow smoke and dangerous gases to pass freely between smoke compartments and affect egress. This deficient practice affected 10 residents, staff and visitors in 3 of 3 smoke compartments on the date of the survey. The facility had a capacity of 20 ICF beds and a census of 10 on the day of the survey.</p> <p>Findings include:</p> <p>1) During record review of the "Pine" building fire alarm system, it was noted by the inspection company that the in-duct detectors do not shut down the smoke dampers to the system. When asked, the Maintenance Supervisor stated he was not aware that the alarm company had found this deficiency during the annual inspection.</p> <p>2) During the facility tour conducted on June 24, 2014 between 12:00 PM and 3:00 PM, observation of a furnace damper control relay in the south mechanical loft access closet revealed</p>	K 052	<p>Pine K052 and MM309</p> <ol style="list-style-type: none"> <li>The smoke dampers on Pine will be repaired and the damper control relay will be repaired</li> <li>All other buildings were checked for smoke dampers and control relay problems and were all found to be functional.</li> <li>Will require alarm company that does the annual inspection to notify Maintenance and Operations Supervisor of all deficiencies when they are found.</li> <li>Maintenance and Operations Supervisor will meet with alarm company personnel at end of inspection and testing to review findings.</li> <li>The repairs needed on Pine building will be done on or before August 15, 2014.</li> </ol>	

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

Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>05 - PINE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>	
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 052	<p>Continued From page 2</p> <p>that the relay was bypassed with a jumper wire. When asked, the Maintenance Supervisor stated that the relay was currently bad and jumped to keep the damper open until a replacement relay arrived.</p> <p>Actual NFPA standard:</p> <p>NFPA 72 7-4 Maintenance. 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions.</p>	K 052		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>05 - PINE</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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	16.03.11 Initial Comments  The "Pine" building is a single story structure with a mechanical loft. The building was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier walls.  The "Pine" building was vacated in 2012 and has been re-opened for residents during the renovation of the "Birch" building. This building has 20 ICF/ID beds.  The following deficiency was cited during the annual fire/life safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition CH 19 Existing Health Care Occupancies, in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID). The survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	M 000	<b>RECEIVED</b>  <b>JUL 16 2014</b>  <b>FACILITY STANDARDS</b>	
MM309	16.03.11.110 Fire and Life Safety Standards  Buildings on the premises used as facilities must meet all the requirements of local, state and	MM309		Refer to K052

Idaho form

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

TITLE

(X6) DATE



**Administrative Director**  
HG7W21

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>05 - PINE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
	<p>national codes concerning fire and life safety standards that are applicable to ICF/ID facilities.</p> <p>This Rule is not met as evidenced by: Refer to "K" tag found on federal form 2567 1) K 052 - Alarm system maintenance</p>			

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

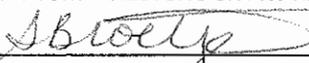
Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>06 - MINI GYM #1</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>The Mini Gym #1 is the multi-purpose building constructed in November 2002 as an unattached Type V (III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;"><b>RECEIVED</b> <b>JUL 16 2014</b> <b>FACILITY STANDARDS</b></p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrative Director</b>	(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>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>06 - MINI GYM #1</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>The Mini Gym #1 is the multi-purpose building constructed in November 2002 as an unattached Type V (III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p><b>RECEIVED</b></p> <p><b>JUL 16 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	

Idaho form

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

TITLE

(X6) DATE



**Administrative Director**

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

Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 11 - POOL - THERAPY  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The Therapy Pool building was built in January 1984 and is Type V(III) construction. The facility currently uses the unattached building as a therapy pool which makes up 70% of the interior floor space inside.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><b>RECEIVED</b> <b>JUL 16 2014</b> <b>FACILITY STANDARDS</b></p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

*SB Burbank*

**Administrative Director**

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>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 11 - POOL - THERAPY  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>The Therapy Pool building was built in January 1984 and is Type V(III) construction. The facility currently uses the unattached building as a therapy pool which makes up 70% of the interior floor space inside.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p><b>RECEIVED</b></p> <p><b>JUL 16 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*S. Burbank*  
**Administrative Director**

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

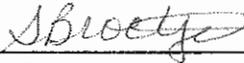
Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>12 - RAMSEY</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>Ramsey is an unattached single story building and is Type V(III) construction. The building is used as group recreational hall on campus. There is a fire alarm system installed throughout the building with horn strobe units in offices and classrooms and is off site monitored. The building was constructed in 1951 and has a partial basement. Exiting classification is remote capability.</p> <p>The building was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><b>RECEIVED</b></p> <p><b>JUL 16 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrative Director</b>	(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>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 12 - RAMSEY  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>Ramsey is an unattached single story building and is Type V(III) construction. The building is used as group recreational hall on campus. There is a fire alarm system installed throughout the building with horn strobe units in offices and classrooms and is off site monitored. The building was constructed in 1951 and has a partial basement. Exiting classification is remote capability.</p> <p>The building was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p style="text-align: center;"><b>RECEIVED</b> <b>JUL 16 2014</b> <b>FACILITY STANDARDS</b></p>	

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

TITLE

(X6) DATE

*S. Broetje*

**Administrative Director**

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

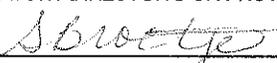
Printed: 07/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 13 - CHAPEL  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>The Chapel is an unattached building that is Type V(III) construction built in January 1974. The building has a smoke detection system installed. Exiting classification is remote capability.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><b>RECEIVED</b></p> <p><b>JUL 16 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrative Director</b>	(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>13G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>13 - CHAPEL</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>SOUTHWEST IDAHO TREATMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687</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>16.03.11 Initial Comments</p> <p>The Chapel is an unattached building that is Type V(III) construction built in January 1974. The building has a smoke detection system installed. Exiting classification is remote capability.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on June 24, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70 and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID).</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p><b>RECEIVED</b></p> <p><b>JUL 16 2014</b></p> <p><b>FACILITY STANDARDS</b></p>	

Idaho form  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*SBurbank* \_\_\_\_\_ **Administrative Director**