



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
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August 1, 2014

Rex Redden, Administrator
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #1 Bellin, Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Idaho Falls Group Home #1 Bellin, on July 23, 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

Rex Redden, Administrator
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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 **August 14, 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 August 13, 2014. If a request for informal dispute resolution is received after August 13, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1664 SOUTH BELLIN IDAHO FALLS, ID 83405		
(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	INITIAL COMMENTS The facility is a single story Type V (000) residential building that was constructed in 1988. It is sprinklered in all habitable areas with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for eight (8) ICF-MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 23, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and in accordance with 42 CFR 483.470 (j). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K0018	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. This Standard is not met as evidenced by: Based on observation, operational testing and	K0018	K0018 1. The doors that were found to not close and latch will be fixed. 2. All individuals have the potential to be affected by this practice. All facilities will be inspected by maintenance personnel to ensure that all doors are closing and latching appropriately. 3. The Home Inspection Form will be revised to incorporate checking all doors in all facilities to ensure they are closing and latching appropriately. Maintenance personnel will check this monthly	

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AUG 13 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Alex A Redder* TITLE: *Administrator* (X6) DATE: *8/11/14*

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: 13G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1664 SOUTH BELLIN IDAHO FALLS, ID 83405		
(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
K0018	<p>Continued From page 1</p> <p>interview, the facility failed to ensure that client room doors would completely latch upon closing. Failure to ensure doors completely latch would allow smoke and dangerous gases to pass freely and hinder the ability to resist the passage of smoke during a fire. This deficient practice affected 8 clients on the date of the survey. The facility is licensed for 8 ICF/ID beds and had a census of 8 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 23, 2014 from 10:00 AM to 10:45 AM, operational testing of the client bedroom doors found that 3 of 6 tested would not close and latch. Interview of the Maintenance staff revealed that he was not aware of these doors not latching.</p> <p>Actual NFPA standard:</p> <p>33.2.3.6.3 Doors shall be provided with latches or other mechanisms suitable for keeping the doors closed. No doors shall be arranged to prevent the occupant from closing the door.</p>	K0018	<p>K0018 cont'd</p> <p>4. The completed Home Inspection Forms will be submitted to the Administrator on a monthly basis for review and accuracy.</p> <p>5. Target date for completion will be September 30, 2014.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1664 SOUTH BELLIN IDAHO FALLS, ID 83405		
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M 000	16.03.11 Initial Comments The facility is a single story Type V (000) residential building that was constructed in 1988. It is sprinklered in all habitable areas with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for eight (8) ICF-MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 23, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies Impractical Evacuation Capability, in accordance with 42 CFR 483.470 (j) and IDAPA 16.03.11, Rules Governing Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	M 000		
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 national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Please refer to "K" tag on CMS 2567 K 018 Doors	MM309	MM309 Refer to K0018	

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

TITLE

(X6) DATE

Rex A Redden

Administrators

8/14/14