



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 1, 2014

Rex Redden, Administrator
Idaho Falls Group Home #4 Summit
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #4 Summit, Provider #13G071

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 #4 Summit, 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
August 1, 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 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,

A handwritten signature in black ink, appearing to read 'MPG', followed by a long horizontal line extending to the right.

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: 13G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #4 SUMMIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3612 SUMMIT TRAIL IDAHO FALLS, ID 83402
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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>INITIAL COMMENTS</p> <p>The facility is a single story, type V (III) building built in 1999. The facility is protected by a 13 D automatic fire sprinkler system with quick response heads in habitable spaces. There is a complete fire alarm/smoke detection system installed. Currently the building is licensed for six (6) beds.</p> <p>The following deficiencies were cited at the above facility 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 and Care Occupancies in accordance with 42 CFR 483.470 (j).</p> <p>The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED AUG 13 2014 FACILITY STANDARDS</p>	
K0046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical appliances and installations were in compliance with NFPA standards. Failure to ensure proper electrical equipment installations could result in electrocution or fire. This deficient practice affected 6 clients in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 6 ICF/ID beds and had a census of 6 on the day of the survey.</p>	K0046	<p>K0046</p> <p>1. A cover will be installed in the mechanical room. The dryer duct will be reinstalled in order to be in compliance with the NFPA standard.</p> <p>2. All individuals have the potential to be affected by this practice. All facilities will be inspected by maintenance personnel to ensure that covers are placed on all outlets, even if the outlets are not operational, and that the dryer ducts are installed correctly.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dee 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.

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K0046	<p>Continued From page 1</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 23, 2014 from 10:45 to 11:15, observation of the outlet located in the mechanical room found that there was no outlet wired, and no cover installed. When interviewed, the Maintenance staff stated this outlet was not operational and that he was not sure why no cover was installed.</p> <p>2) During the facility tour conducted on July 23, 2014 from 10:45 to 11:15, observation of the dryer duct from the laundry room to the exterior of the building found it was haphazardly installed. Interview of the Maintenance staff revealed he was not aware who installed this duct.</p> <p>Actual NFPA standard:</p> <p>33.2.5.1 Utilities. Utilities shall comply with Section 9.1.</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>9.2.2 Ventilating or Heat-Producing Equipment. Ventilating or heat-producing equipment shall be in accordance with NFPA 91, Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists, and Noncombustible Particulate Solids; NFPA 211, Standard for Chimneys, Fireplaces, Vents, and Solid Fuel-Burning Appliances; NFPA 31, Standard for the Installation of Oil-Burning Equipment; NFPA 54, National Fuel Gas Code; or NFPA 70, National</p>	K0046	<p>K0046 Cont'd</p> <p>3. The Home Inspection Form will be revised to incorporate checking outlet covers and installation of dryer ducts. Maintenance personnel will check this monthly.</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>	

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K0046	Continued From page 2 Electrical Code, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K0046		
K0053	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3. Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system. Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.	K0053	K0053 1. The smoke detector that was covered with drywall texture in the downstairs dayroom will be replaced. 2. All individuals have the potential to be affected by this practice. All facilities will be inspected by maintenance personnel to ensure all smoke detectors are free from debris and are functioning correctly. 3. The Home Inspection Form will be revised to incorporate checking smoke detectors in all facilities to ensure they are free from debris and are functioning correctly. Maintenance personnel will check this monthly. 4. The completed Home Inspection Forms will be submitted to the Administrator on a monthly basis for review and accuracy. 5. Target date for completion will be September 30, 2014.	

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K0053	<p>Continued From page 3</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke detection devices were maintained. Failure to ensure smoke devices are maintained would result in inadequate notification during a fire. This deficient practice affect 6 residents in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 6 ICF/ID beds and had a census of 6 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 23, 2014 from 10:45 to 11:15, observation of the smoke detector in the downstairs dayroom revealed the detector had been sprayed over with drywall texture, coating the sensor. When asked, the Maintenance staff stated he was unaware of the detector being covered with this material.</p> <p>Actual NFPA standard:</p> <p>1) 9.6.2.10.2 Smoke alarms, other than battery-operated devices as permitted by other sections of this Code, or battery-operated devices complying with 9.6.1.4 and the low-power wireless system requirements of NFPA 72, National Fire Alarm Code, shall receive their operating power from the building electrical system.</p> <p>2) 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the</p>	K0053		

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K0053	Continued From page 4 authority having jurisdiction.	K0053		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The facility is a single story, type V (III) building built in 1999. The facility is protected by a 13 D automatic fire sprinkler system with quick response heads in habitable spaces. There is a complete fire alarm/smoke detection system installed. Currently the building is licensed for six (6) beds. The following deficiencies were cited at the above facility 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 and Care Occupancies in accordance with 42 CFR 483.470 (j) 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		
MM311	16.03.11.110.01(a) Structurally Sound The facility must be structurally sound and must be maintained and equipped to assure the safety of residents, employees and the public. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the structure was substantially sound for the protection of residents. Failure to provide a complete seal from the basement area to the upper floor would allow a fire to spread uncontrolled. This deficient practice affected 6 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 6 ICF/ID beds and had a census of 6 on the day of the survey.	MM311	MM311 1. The open holes in the mechanical room downstairs will be fixed. The hole in the downstairs office will be sealed where the previous sprinkler head was installed. A sprinkler escutcheon will be also be installed where it was found to be missing. 2. All individuals have the potential to be affected by this practice. All facilities will be inspected by maintenance personnel to ensure there are no open holes in the ceiling areas and to ensure that sprinkler escutcheon are installed.	

RECEIVED
AUG 13 2014
FACILITY STANDARDS

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

Rex A Redden

TITLE

Administrator

(X6) DATE

8/11/14

Bureau of Facility Standards

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MM311	Continued From Page 1 Findings include: 1) During the facility tour conducted on July 23, 2014 from 10:45 AM to 11:15 AM, observation of the downstairs mechanical room found the high/low combustion air vents had an approximately four inch wide by twelve inch long open hole surrounding the pipes. Further investigation of this room revealed the sprinkler head installed in the room had an approximately 1/2 inch wide gap surrounding the head. Both penetrations exposed the floor above. When asked, the Maintenance staff stated he had been working on sealing these penetrations. 2) During the facility tour conducted on July 23, 2014 from 10:45 AM to 11:15 AM, observation of the downstairs office found that the sprinkler head installed had been moved and the abandoned hole had never been sealed. Investigation of the installed sprinkler head revealed there was no sprinkler escutcheon installed.	MM311	MM311 cont'd 3. The Home Inspection Form will be revised to incorporate checking ceilings in all facilities to ensure there are no open holes and that all sprinkler heads have sprinkler escutcheons installed. Maintenance personnel will check this monthly. 4. The completed Home Inspection Forms will be submitted to the Administrator on a monthly basis for review and accuracy. 5. Target date for completion will be September 30, 2014.	
MM344	16.03.11.110.06(e) Automatic Sprinkler Systems Automatic sprinkler systems, if installed, must be serviced at least annually by an authorized servicing agency. Servicing must be in accordance with the applicable NFPA Standard 13a (1978 edition), "Care and Maintenance of Sprinkler Systems." This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinkler system components were maintained per manufacturer's specifications. Failure to maintain sprinkler systems would result in the suppression system not operating as designed. This deficient practice affected 6 residents in 1 of 2 smoke	MM344	MM344 1. The sprinkler caps in the downstairs dayroom and sensory room will be cleaned or replaced as needed to ensure they are free from drywall texture. 2. All individuals have the potential to be affected by this practice. All facilities will be inspected by maintenance personnel to ensure that all sprinkler caps are free from debris.	

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MM344	<p>Continued From Page 2</p> <p>compartments on the date of the survey. The facility is licensed for 6 ICF/ID beds and had a census of 6 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 23, 2014 from 10:45 AM to 11:15 AM, observation of sprinkler caps in the downstairs dayroom and sensory room found them to be sprayed over with drywall texture. When asked, the Maintenance staff stated that he was not sure when this occurred.</p> <p>Also see MM311 finding #2</p> <p>Actual NFPA standard:</p> <p>NFPA 13D 1-4* Maintenance. The owner is responsible for the condition of a sprinkler system and shall keep the system in normal operating condition</p>	MM344	<p>MM344 cont'd</p> <p>3. The Home Inspection Form will be revised to incorporate checking sprinkler heads in all facilities to ensure they are all free from debris. Maintenance personnel will check this monthly.</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> <p>Refer to MM311</p>	