



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
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Boise, Idaho 83720-0009
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FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 4, 2014

Eric Russell, Administrator
Yellowstone Group Home #4 Hollow
560 West Sunnyside
Idaho Falls, ID 83402

RE: Yellowstone Group Home #4 Hollow, Provider #13G066

Dear Mr. Russell:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Yellowstone Group Home #4 Hollow, on July 25, 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

Eric Russell, Administrator
August 4, 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 18, 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 17, 2014. If a request for informal dispute resolution is received after August 17, 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: 07/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTRIE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2014
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NAME OF PROVIDER OR SUPPLIER YELLOWSTONE GROUP HOME #4 HOLLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 370 HOLLOW DRIVE 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	INITIAL COMMENTS The facility is a single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13-R system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility is licensed for 6 ICF/MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on July 25, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, 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 and operational testing, the	K0018		

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FACILITY STANDARDS

Please see attached plan of correction

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sam Burbank</i>	TITLE <i>HSFSDP</i>	(X6) DATE <i>8/18/2014</i>
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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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K0018	<p>Continued From page 1</p> <p>facility failed to ensure client room doors would close and latch. Failure to ensure doors will latch would allow smoke and dangerous gases to enter during a fire event. This deficient practice affected 6 clients, staff and visitors 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 25, 2014 from 10:00 AM to 12:30 PM, testing of client room door #1, moving clockwise from the front door, would not close and latch. This finding was acknowledged by the Maintenance staff at the exit conference conducted on July 25, 2014 at 12:45 PM.</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		
K0056	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>PROMPT Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: In prompt evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of</p>	K0056		

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

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K0056	<p>Continued From page 2</p> <p>Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, is permitted. Automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 2: Not applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>SLOW</p> <p>Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p>	K0056		
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K0056	Continued From page 3 Exception No. 1: Not Applicable Exception No. 2: Not Applicable Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier. Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. Exception No. 5: Not Applicable Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5. IMPRACTICAL Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. 33.2.3.5.2. Exception No. 1: Not Applicable. Exception No. 2: In slow and impractical	K0056		

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K0056	<p>Continued From page 4</p> <p>evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 3: Not Applicable.</p> <p>Exception No. 4: Not Applicable.</p> <p>Exception No. 5: In impractical evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper sprinkler protection was maintained by not obstructing sprinkler spray patterns. Failure to ensure sprinkler protection as designed would result in possible damage and</p>	K0056		
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K0056	<p>Continued From page 5</p> <p>insufficient suppression during a fire. This deficient practice affected 6 clients, staff and visitors 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>1) During the facility tour conducted on July 25, 2014 from 10:00 AM to 12:30 PM, inspection of the #1 hall closet moving clockwise from the front door revealed the sprinkler head was blocked by books and records stored within approximately one inch of the head. Inspection of the #2 hall closet moving clockwise from the front door found it was also obstructed by storage. When asked, the Maintenance Supervisor stated he was not aware that staff had blocked the sprinklers.</p> <p>2) During record review of the facility conducted on July 25, 2014 from 9:00 AM to 10:00 AM, review of the annual fire sprinkler inspection report found that the sprinkler system installed was past due for a 5-year internal inspection. Interview of the Maintenance Supervisor revealed he was aware the inspection company had noted this on the annual report.</p> <p>3) During the facility tour conducted on July 25, 2014 from 10:00 AM to 12:30 PM, inspection of the sprinkler riser revealed the system installed was a 13-R system requiring a 5-year internal inspection to be performed.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 1) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion,</p>	K0056		

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K0056	<p>Continued From page 6</p> <p>foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected.</p> <p>3) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p>	K0056		
K0150	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>This Standard is not met as evidenced by: Based on record review, inspection and interview, the facility failed to ensure that curtain flame-spread ratings were in accordance with</p>	K0150		

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K0150	<p>Continued From page 7</p> <p>NFPA 701. Failure to ensure the flame resistive properties of curtains would allow fires to develop and spread beyond incipient stages. This deficient practice affected 6 residents, staff and visitors in 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>1) During record review of the facility conducted on July 25, 2014 from 9:00 AM to 10:00 AM, the facility could not provide documented evidence of flame spread ratings on installed curtains. When asked, the Maintenance Supervisor stated they did not have that documentation available.</p> <p>2) During the facility tour conducted on July 25, 2014 from 10:00 AM to 12:30 PM, physical inspection of the client bedroom and common area curtains found none of the decorative curtains inspected had been tagged per NFPA 701 or was any fire retardant noticeable.</p> <p>Actual NFPA standard:</p> <p>33.7.5.1 New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 10.3.1.</p>	K0150			

Bureau of Facility Standards

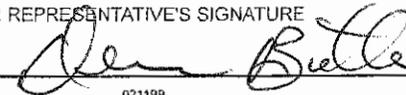
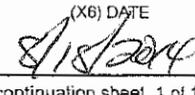
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M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story, type V (000) construction. It is fully sprinklered with Quick Response sprinklers and type 13-R system. Also there is a complete fire alarm/smoke detection system. The building was completed April 10, 1998. Currently the facility is licensed for 6 ICF/MR beds.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on July 25, 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 Individuals with Intellectual Disabilities (ICF/ID). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000	<p style="text-align: center;">RECEIVED SEP 04 2014 FACILITY STANDARDS</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> <p>This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2567</p> <p>K 018 Door Latches K 056 Sprinkler maintenance K 150 Flame retardent fabrics</p>	MM309		

Idaho form

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

STATE FORM 021199 68WL21 If continuation sheet 1 of 1

Fire life safety survey for Yellowstone group home Hollow dated July 25, 2014

The following is the plan of correction for this home's survey. I respectfully ask that Mr. Russell's name be removed from any further survey. They can be addressed to Mr. Butler or Mr. Weeks

K0018 –As noted one of the client's rooms doors would not close and latch as required. This specific item is on our monthly fire drill form to be tested. The lead workers and program supervisor for this home will receive in-service training as to the concern and why it was listed on the survey deficiencies for this home. All staff will receive training to report any of the concerns listed on our fire drill form as they perform their daily duties. A new comprehensive safety form labeled the universal home checklist will also be performed monthly as a quality assurance measure. The form was developed and it is required by the management Corporation Embassy. This will be completed by September 1. The responsible party will be the city director Ferren Weeks.

K0056 – To correct deficiency number one the shelving will be rearranged and marked to ensure proper clearance of the sprinkler head is adhered to. All staff will be trained and showed the new arrangement. This visual inspection will be included on the new safety format. As for the sprinkler system not being properly inspected, the city director will instruct the maintenance supervisor that this needs to be flagged to assure future compliance. The company completing the annual fire sprinkler inspection will be notified to complete the inspection by 9/15/14 or sooner if at all possible. City director will be responsible for following up with maintenance supervisor. The maintenance supervisor will follow up with the inspection contractor.

K0150 – a spray on retardant will be purchased and utilized. All staff will be trained as to the need of the fireproofing. No matter how good staff intentions are to buy new window coverings, this will be mandatory. This will also be added to universal home checklist to ensure compliance and documentation. This will be completed before 9/15/14 by the city director.

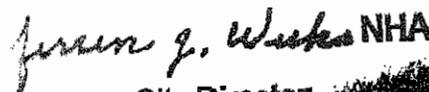
MM 309 please refer to the previous listed K tag deficiencies.

Program supervisor signature



Date

8-7-2014


City Director