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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

October 28, 2009

Ferren Weeks
Yellowstone Group Home #1 Springfield
560 West Sunnyside
Idaho Falls, ID 83401

RE: Yellowstone Group Home #1 Springfield, provider #13G063

Dear Mr. Weeks:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #1 Springfield, which was conducted on October 22, 2009.

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

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

For

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

for

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/mlw
Enclosure

Yellowstone
Group Homes

560 W Sunnyside
Idaho Falls, ID 83402

RECEIVED

NOV 04 2009

FACILITY STANDARDS

November 2, 2009

Jim Troutfetter
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder St
Boise, ID 83720-0036

Dear Jim Troutfetter:

This is the Plan of Correction for the survey concluded at Yellowstone group Home #1 Springfield, on October 22, 2009. I would like to take the opportunity to thank you and Matt Hauser for the helpful information you always share. The survey process is always a learning experience, and you certainly made it helpful as well as pleasant. Thanks so much.

Sincerely,

Steve Young
Administrator

Jerren J. Weeks
Admin / RMRP

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

PRINTED: 10/27/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	13G063		10/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YELLOWSTONE GROUP HOME #1 SPRINGFIELD	3335 SPRINGFIELD IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Yellowstone Group Homes - Springfield, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation. The surveyor conducting the survey was: Jim Troutfetter, QMRP, Team Lead Matt Hauser, QMRP	W 000	RECEIVED NOV 04 2009 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: AQMRP | (X6) DATE: 11-2-09

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.

PRINTED: 10/27/2009
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G063	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/22/2009
NAME OF PROVIDER OR SUPPLIER: YELLOWSTONE GROUP HOME #1 SPRINGFIE	STREET ADDRESS, CITY, STATE, ZIP CODE: 3335 SPRINGFIELD IDAHO FALLS, ID 83404		

(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 Yellowstone Group Home #1, Springfield is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)." The survey was conducted by: Jim Troutfetter, Team Lead Matt Hauser, QMRP	M 000	RECEIVED NOV 04 2009 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: AQMRP — (X6) DATE: 11-2-09

STATE FORM 6899 Q2AU11 If continuation sheet 1 of 1