IDAHO DEPARTMENT OF HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 18, 2009

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East Suite 703
Twin Falls, Idaho 83301

RE: Bitterroot Home, provider #13G022

Dear Ms. Stephens:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Bitterroot Home, on February 4, 2009.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,

Eric Mundell

ERIC MUNDELL, REHS
Health Facility Surveyor
Facility Fire Safety and Construction Program

EM/lj

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER BITTERROOT GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1806 BITTERROOT DRIVE TWIN FALLS, ID 83301		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 single story, residential Type V(000) construction built in 1992 and is fully sprinklered in habitable spaces. It has a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/MR beds. The facility was surveyed on February 4, 2009, under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability and 42 CFR 483.470 (j). No deficiencies were cited. The Survey was conducted by: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (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: 13G022	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2009
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M 000	16.03.11 Inital Comments The facility is single story, residential Type V(000) construction built in 1992 and is fully sprinklered in habitable spaces. It has a complete fire alarm/smoke detection system. Currently the facility is licensed for 6 ICF/MR beds. The facility was surveyed on February 4, 2009, under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board & Care Occupancies, Impractical Evacuation Capability, 42 CFR 483.470 (j) and IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF-MR). No deficiencies were cited. The Survey was conducted by: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety and Construction Program	M 000		

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