



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 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

January 13, 2015

Richard Davis, Administrator  
Boise Group Home #7 Daniel  
P.O. Box 4243  
Boise, ID 83711

RE: Boise Group Home #7 Daniel, Provider #13G055

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Boise Group Home #7 Daniel, on January 9, 2015.

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

Also enclosed is a Statement of Deficiencies/Plan of Correction 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Richard Davis, Administrator  
January 13, 2015  
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance 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 **January 25, 2015**, 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](http://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 January 25, 2015. If a request for informal dispute resolution is received after January 25, 2015, 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 us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,

  
ASHLEY HENSCHIED  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

AH/pmt  
Enclosures

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

PRINTED: 02/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #7 DANIEL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>11879 WEST DANIEL ST BOISE, ID 83704</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>Boise Group Home #7 Daniel is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for the annual recertification survey conducted from 1/7/15 to 1/9/15.</p> <p>The survey was conducted by: Ashley Henscheid, QIDP, Team Lead</p>	W 000			

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

TITLE

(X6) DATE

01/23/2015

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:  13G055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  01/09/2015
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NAME OF PROVIDER OR SUPPLIER  
**BOISE GROUP HOME #7 DANIEL**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**11879 WEST DANIEL ST  
BOISE, ID 83704**

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M 000

16.03.11 Initial Comments  
The following deficiency was cited during the annual licensure survey conducted from 1/7/15 to 1/9/15.

M 000

The survey was conducted by:  
Ashley Henscheid, QIDP, Team Lead

MM380

16.03.11.120.03(a) Building and Equipment  
The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.  
This Rule is not met as evidenced by:  
Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:

MM380

Replacement of carpet and cabinet fronts are planned for March. The need for these repairs were noted during the administrators monthly checks.

March 15<sup>th</sup>

The wall repair will be done as soon as manager has behavior plan in place, March 1<sup>st</sup>.

March 1<sup>st</sup>

1. An environmental review was conducted with the Home Supervisor on 1/8/15 from 10:30 - 10:55 a.m. During that time, the following concerns were identified:

- The lower cabinet to the right of the kitchen sink was missing the bottom hinge screw on the right hand door causing the door to swing away from the cabinet when opened.
- The door to the upper cabinet to the right of the stove was missing.

RECEIVED  
JAN 23 2015

FACILITY STANDARDS

Pen and Ink Change: Person responsible for repairs: Manager - per Administrator on 2.4.15.

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

Administrator

(X6) DATE  
1/23/15

DHW INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY \*\*

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
January 23, 2015 2:33:55 PM MST	2083761869	44	1	Received

01/23/2015 14:57 2083761869 RGR PAGE 01

Bureau of Facility Standards

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MM380	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- There was a section of wood trim under the kitchen counter, approximately 1.5 feet by 1 inch, that was separated from the wall.</li> <li>- There was an indentation in the hallway wall near the linen closet. The indentation was partially repaired. The Home Supervisor explained Individual #5 hit the wall with a closed fist, it was covered with plaster and then Individual #5 hit the same spot, causing the indentation to reoccur.</li> <li>- There was an indentation in the wall near the door to the backyard. The Home Supervisor stated it was where Individual #5 banged her head during a maladaptive behavior on 1/2/15.</li> <li>- There was an indentation in the wall of the master bathroom above the light switch. The Home Supervisor stated it was created by Individual #5 during a maladaptive behavior.</li> <li>- There were multiple large stains on the living room and hallway carpet.</li> </ul> <p>The facility failed to ensure environmental repairs were maintained.</p>	MM380		