



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

April 20, 2015

Thair Pond, Administrator  
Tomorrow's Hope - Deb  
1655 Fairview Ave, Suite 100  
Boise, ID 83702

RE: Tomorrow's Hope - Deb, Provider #13G083

Dear Mr. Pond:

This is to advise you of the findings of the complaint survey of Tomorrow's Hope - Deb, which was conducted on April 16, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid 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

Thair Pond, Administrator  
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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 **May 3, 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 May 3, 2015. If a request for informal dispute resolution is received after May 3, 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,

*Karen Marshall*  
*for Jim Troutfetter*

JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

*Nicole Wisenor*

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

PRINTED: 04/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/16/2015
NAME OF PROVIDER OR SUPPLIER  TOMORROW'S HOPE - DEB			STREET ADDRESS, CITY, STATE, ZIP CODE 3038 NORTH MERIDIAN ROAD MERIDIAN, ID 83646	
(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  The following deficiency was cited during the complaint survey conducted from 4/14/15 to 4/16/15.  The surveyors conducting your survey were:  Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD  Common abbreviations used in this report are:  BMP - Behavior Management Program DOP - Destruction of Property IEP - Individual Education Plan IPP - Individual Program Plan	W 000	<p>RECEIVED</p> <p>MAY - 1 2015</p> <p>FACILITY STANDARDS</p>	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure outside services met the needs for 1 of 4 individuals (Individual #1) who attended school. This resulted in a lack of coordination of services and communication with the school. The findings include:  1. Individual #1's IPP, dated 10/8/14, documented a 10 year old male whose diagnoses included mild mental retardation.  His record contained behavior management programs for the following maladaptive behaviors:	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 4/29/15

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/16/2015
NAME OF PROVIDER OR SUPPLIER  TOMORROW'S HOPE - DEB			STREET ADDRESS, CITY, STATE, ZIP CODE 3038 NORTH MERIDIAN ROAD MERIDIAN, ID 83646	
(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 120	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- Aggression, tantrum and DOP</li> <li>- Elopement</li> <li>- Reduce digging in trash</li> <li>- Maintaining personal space</li> <li>- False accusations</li> </ul> <p>His IEP, addendum dated 10/8/14, only contained an objective to reduce maladaptive behaviors which included hitting, swearing, kicking, spitting, throwing objects, climbing on tables and DOP.</p> <p>When asked on 4/16/15 from 10:56 - 11:00 a.m., Individual #1's teacher stated the BMPs being used at the school were from the IEP and would not be the same as the BMPs used at the facility. She further stated she was not aware of a program that addressed false accusations.</p> <p>When asked on 4/16/15 at 1:08 p.m., the Home Manager stated the programs had not been included in the IEP due to an oversight.</p> <p>The facility failed to ensure Individual #1's BMPs were sufficiently coordinated in his IEP.</p>	W 120	<p>Behavior plans for individual #1 have been given to school and a meeting set to update IEP QIIP Responsible by 5/15/15</p> <p>All individual in school will have all behavior plans given to the school. PA Responsible by 5/15/15</p> <p>When doing Quarterly Book Reviews QIIP will review to ensure IEP has same behavior goals we are tracking at home. QIIP Responsible by 5/15/15</p> <p>Quarterly Book Review will be update to check for communication between outside services, and the IEP is working on same behavior goals. PD Responsible by 5/30/15</p>	

Program director to review Quarterly Book Reviews and add any need action to the action list with who is responsible to fix by when  
PD responsible by 5/30/15

2015/05/04 10:37:53 2 /2

PRINTED: 05/01/2015  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  19G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 04/16/2015
NAME OF PROVIDER OR SUPPLIER  TOMORROW'S HOPE - DEB		STREET ADDRESS, CITY, STATE, ZIP CODE 3038 NORTH MERIDIAN ROAD MERIDIAN, ID 83646		
(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  The following deficiency was cited during the complaint survey conducted from 4/14/15 to 4/16/15.  The survey was conducted by:  Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000		
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation  Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and  This Rule is not met as evidenced by: Refer to W120.	MM859	Refer to W120 on POC from 4-16-15	

RECEIVED  
MAY 05 2015  
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

1 *[Signature]* ID 5/5/15



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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April 20, 2015

Thair Pond, Administrator  
Tomorrow's Hope - Deb  
1655 Fairview Ave, Suite 100  
Boise, ID 83702

Provider #13G083

Dear Mr. Pond:

An unannounced on-site complaint investigation was conducted from April 14, 2015 to April 16, 2015 at Tomorrow's Hope - Deb. The complaint allegation, findings, and conclusion are as follows:

**Complaint #ID00006955**

**Allegation:** The individuals who reside in the facility are subjected to physical and verbal abuse.

**Findings:** During the investigation observations and staff interviews were conducted. Individual records and the facility's Incident Report Investigations (I&As) were reviewed with the following results:

Observations were conducted at the facility on 4/14/15 from 4:15 to 5:30 p.m. and on 4/15/15 from 8:00 to 8:45 a.m. During the observations, staff were observed appropriately interacting with individuals, providing active treatment, and documenting activities.

On 4/15/15 interviews were conducted with 10 direct care staff who worked the morning, evening, and night shifts. The direct care staff stated they had not observed and were not told by any individual that another staff member or another individual physically, emotionally, or verbally abused any of the individuals.

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The facility's I&As, behavior reports, and records, from 11/1/14 to 4/13/15, for four individuals were reviewed. All instances of individual injury were thoroughly investigated and the investigations documented the cause or causes of the injury.

It could not be determined that the facility subjected individuals to physical or verbal abuse or injuries of unknown origin were not investigated, therefore the allegation was unsubstantiated.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

*Karen Marshall  
for Jim Troutfetter*

JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

*Nicole Wisenor*

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

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