



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

May 1, 2015

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

RE: Tomorrow's Hope - Eagle, Provider #13G047

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Eagle, which was conducted on April 21, 2015.

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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Thair Pond, Administrator
May 1, 2015
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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 13, 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:

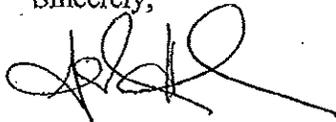
www.icfmr.dhw.idaho.gov

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 13, 2015. If a request for informal dispute resolution is received after May 13, 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: 04/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1067 RUSH ROAD EAGLE, ID 83818	
(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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint and annual recertification survey conducted from 4/14/15 to 4/21/15.</p> <p>The survey was conducted by:</p> <p>Ashley Henscheid, QIDP, Team Lead Trish O'Hara, RN</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment DCS - Direct Care Staff HRC - Human Rights Committee ICFs/ID - Intermediate Care Facilities for Individuals with Intellectual Disabilities IDAPA - Idaho Administrative Procedures Act IEP - Individual Education Plan IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record mg - milligram PQ - Para-Qualified Intellectual Disabilities Professional QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse</p>	W 000		
W 107	<p>483.410(b) COMPLIANCE W FEDERAL, STATE & LOCAL LAWS</p> <p>The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to health.</p>	W 107	<p>Individual # 2 med orders were taken into the pharmacy and filled LPR Responsible by 5/11/15</p>	

RECEIVED
MAY 12 2015
FACILITY STANDARDS

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

[Handwritten Signature]

TITLE

[Handwritten Title]

(X6) DATE

[Handwritten 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.

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W 107	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on review of state rules, record review and staff interview, it was determined the facility failed to maintain compliance with all applicable provisions of state rules. This failure directly impacted 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed and had the potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in unauthorized repackaging of medication by nursing and a lack of required professional nursing oversight. The findings include:</p> <p>1. Individual #2's IPP, dated 3/12/15, documented she was a 36 year old female with diagnoses including seizure disorder.</p> <p>Individual #2's MAR for 3/1/15 - 3/25/15 documented she had been receiving two 500 mg tablets of Depakote (an anti-epileptic drug) in the morning and in the evening, and one 500 mg tablet with a 250 mg tablet at noon each day. The MAR indicated Individual #2 was out of the facility 3/26/15 and 3/27/15. New Depakote orders were initiated at 8:00 p.m. on 3/27/15. Orders were entered and signed by the LPN on the MAR on 3/27/15 for one Depakote 500 mg tablet and one Depakote 250 mg tablet to be given at 7:00 a.m. and 8:00 p.m. each day.</p> <p>Individual #2's record included an entry in the nursing progress notes, dated 3/27/15, explaining Individual #2 had been discharged from a local hospital on that date with a dosage change for Depakote. The entry stated "Med changes made - repackaged Depakote for new order and MAR updated." The entry was signed by the LPN.</p> <p>In a telephone interview on 4/21/15 at 10:40 a.m.,</p>	W 107	<p>→ LPN will be trained when a client is discharged w/med. change a nurse to be there to receive new orders RN Responsible by 5/1/15</p> <p>→ will train w/ LPN if a resident is discharged w/ new med order & they need to have the order filled out the hospital if pharmacy is closed RN Responsible by 5/15/15</p> <p>→ will update a Nursing Service policy to include filling med orders PD Responsible by 5/20/15</p> <p>→ pharmacist to review new med orders on</p>		

a monthly basis and quarterly to ensure medication are packaged properly
Pharmacist Responsible by 5/30/15

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W 107	<p>Continued From page 2</p> <p>the LPN stated "I essentially repackaged 250 mg Depakote tablets" in order to provide Individual #2 with the new Depakote dose.</p> <p>In an undated written statement, received by this surveyor on 4/21/15 at 11:00 a.m., the same LPN wrote "The dose change was for a decrease in Depakote. There were sufficient meds on hand at the House [sic] to get through the weekend if repackaged in the appropriate dosing ordered. I repackaged Depakote, documented this in the Progress notes [sic] and informed the House Nurse [sic] on Sunday March 29, that a new order was written and that new meds would need to be picked up from Pharmacy [sic] on Monday."</p> <p>However, the rules of the Idaho State Board of Pharmacy (IDAPA 27.01.01) do not include allowances for LPNs to repackaging medications. The rules state:</p> <p>27.01.01.146. REPACKAGING. A pharmacy may repackaging a drug previously dispensed to a patient, pursuant to the patient or the patient's agent's request, if: (4-11-15)</p> <p>01. Unit Dose. The drugs are repackaged into unit dose packaging. (4-11-15)</p> <p>02. Pharmacist Verification. The repackaging pharmacist verifies: (4-11-15)</p> <p>a. The identity of the previously dispensed drug as matching the label on the container that the drugs were initially dispensed within; and (4-11-15)</p> <p>b. The validity and accuracy of the original prescription drug order. (4-11-15)</p>	W 107		

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W 107	Continued From page 3	W 107			
W 120	<p>In an interview on 4/20/15 at 10:00 a.m., the nursing supervisor said she was not aware that repackaging medications was outside the scope of practice for licensed nurses.</p> <p>The facility failed to ensure medications were package by authorized personnel in accordance with state law.</p> <p>2. Refer to W345 as it relates to the lack of professional nursing oversight of staff as required by the Idaho Board of Nursing at IDAPA 23.01.01. 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>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 1 individual (Individual #1) who attended a local school. This resulted in a lack of coordination of services with the school and an individual being placed in a time-out room where constant visual supervision could not be maintained. The findings include:</p> <p>1. Individual #1's IPP, dated 9/22/14, documented a 14 year old female whose diagnoses included autism and profound mental retardation. She attended a local middle school Monday through Friday from 8:30 a.m. to 3:30 p.m.</p> <p>An observation was conducted at Individual #1's</p>	W 120			

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W 120	<p>Continued From page 4</p> <p>school on 4/14/15 from 1:45 to 2:40 p.m. Individual #1's teacher was interviewed on 4/14/15 at 2:40 p.m. The teacher stated he communicated with the facility using a communication log and he would speak with and email the PQ. The teacher stated Individual #1 had come to school with unexplained injuries and that her clothes were too small for her. The teacher further stated Individual #1 had toileting accidents, but was not always sent with extra clothes to change into.</p> <p>The teacher also stated Individual #1 engaged in aggressive and elopement behavior. The teacher stated the PQ had attended Individual #1's IEP meeting, but he had not been invited to Individual #1's IPP meeting at the facility. The teacher stated he did not receive a copy of the IPP or any of Individual #1's training or behavior programs from the facility. The teacher stated Individual #1 did have a behavior plan at the school which had been developed by school staff. The teacher stated Individual #1's behavioral interventions at the school included the use of a quiet room. The teacher stated Individual #1 would only be placed in the quiet room for a maximum of 4 minutes as the room would make her angrier.</p> <p>The quiet room was observed on 4/14/15 at 3:10 p.m. The door to the room was metal with an approximately 12 inch by 6 inch window. The door handle had a lock on the outside of the door. The teacher, who was present during the observation, stated the door could be locked, but the lock was not used. The teacher stated when Individual #1 was placed in the quiet room, the door was shut until it latched and staff would hold the door shut with their foot. When standing outside of the room and looking through the door</p>	W 120		

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W 120	<p>Continued From page 6</p> <p>window, the front corners and the floor of the time-out room could not be seen.</p> <p>Individual #1's IEP and school behavior plan, dated 10/14/14, were reviewed. Information regarding the use of the quiet room could not be found.</p> <p>The communication log exchanged by the school and facility was reviewed. The entries were dated 2/10/15 - 4/14/15. One entry from the school, dated 2/25/15, documented Individual #1 engaged in a maladaptive behavior and was placed in the quiet room. Additional school-written entries documented requests for the facility to send clothing as well as notation of injuries.</p> <p>Interviews were conducted with three direct care staff on 4/17/15 from 12:36 - 3:13 p.m. DCS A stated the staff assigned to Individual #1 in the afternoon was responsible for reading the communication log and responding as needed. DCS A stated Individual #1's morning staff was responsible for entering a summary of Individual #1's morning. DCS B stated she was not sure who was responsible for writing to the school in the communication log, but she had written in the book before. DCS C stated she had never seen the communication log.</p> <p>... All three of the staff interviewed described the process for documenting items that came into, and out of, the facility. They each stated on a monthly basis individuals' clothes were checked for appropriate fit and "checked out" on the individual's inventory sheet, with initials from two staff, if they were ill-fitting or in bad condition.</p>	W 120			

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W 120	<p>Continued From page 6</p> <p>Additionally, each of the three staff stated they were trained to monitor for injuries. They each stated when an injury was noticed, they would notify a member of their supervisor team and/or the nurse and document the injury.</p> <p>During an interview on 4/20/16 from 11:00 a.m. - 12:16 p.m., the PQ was asked about the time-out room. The PQ stated she had not conducted an observation at the school and she had not observed the time-out room. Individual #1's IEP documented the PQ requested notification for any use of the time-out room and the PQ stated she had not received any notifications. The PQ stated she thought if they were going to use the time-out room, a staff would go into the room with Individual #1. The PQ stated the time-out room had not been incorporated into Individual #1's IEP or behavior plan.</p> <p>Further, the PQ stated she had shared Individual #1's programs with the school but she would send them again. The PQ stated she recognized that documentation in the communication log could improve, however, she stated she had additional communication directly with Individual #1's teacher via e-mail and telephone often. The PQ stated in that communication the teacher brought up Individual #1's toileting accidents and also reported Individual #1 was having problems with falling asleep in class. The PQ stated they discussed the issues at length and she provided the teacher with sleep charts to document the napping.</p> <p>Additionally, during the same interview, the PQ stated Individual #1 was a very active girl and her frequent injuries were documented in her record and in her communication log to school as much</p>	W 120		

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W 120	Continued From page 7 as possible. The PQ stated the origin of her injuries was always known. Individual #1's injuries, from 1/1/15 - 4/14/15, as documented in facility Progress Notes were reviewed with the PQ. On 4/21/15 at approximately 8:15 a.m., the PQ provided corresponding documentation for explanation of each of individual #1's documented injuries. During the interview on 4/20/15 at 11:00 a.m., the PQ stated the facility checked each individual's clothing monthly and discarded ill-fitting or tattered clothes and documented the disposal on the individual's inventory sheet with an explanation and the initials of two staff. During an interview on 4/21/15 from 11:10 - 11:47 a.m., the QIDP stated she was not aware of the time-out room used by the school because it was not incorporated into individual #1's IEP. The QIDP stated she had not conducted observations at the school. The facility failed to ensure individual #1's services were sufficiently coordinated with the school.	W 120	→ TC meet w/ school to ensure they are not using the time out room. to also ensure they know what needs to be communicate to home through com log or directly to TC. TC responsible by 5/8/15 → All com logs are were reviewed to ensure communication & information is being followed through. TC responsible by 5/15/15 → TC, HM and direct care staff trained on the use of com log and information to get and what to do with information received. QIDP responsible by 5/15/15	
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 136	→ All staff will sign com log's daily, HM should be checking com logs at least weekly with walk through to ensure follow through with all information received. TC to review com log at least monthly and direct to QIDP. TC responsible by 5/15/15	

→ QIDP will review all school contact at monthly QA (all emails & com log) and follow through or take action needed.
QIDP responsible by 5/15/15

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W 136	<p>Continued From page 8</p> <p>was determined the facility failed to ensure the opportunity to participate in community integration activities was offered to 2 of 3 individuals (Individuals #1 and #2) whose outing records were reviewed. This resulted in community integration opportunities being denied to the individuals. The findings include:</p> <p>1. Individual #1's IPP, dated 9/22/14, documented a 14 year old female whose diagnoses included autism and profound mental retardation.</p> <p>Her IPP contained a service objective which stated "[Individual #1] will go on desired community outings." Individual #1's behavior plans, dated 3/20/15 and 11/1/13, documented Individual #1 should "Go on outing [sic] at least once a week." Additionally, Individual #1's Elopement Behavior Intervention Plan, dated 3/20/16, documented she required 2 staff to accompany her in the community. Individual #1's IPP documented her interests as her bike, the computer, Teletubbies, Super Nintendo, walks, Legos, wooden puzzles and putting objects into her wagon.</p> <p>Community Recreation Notes, dated 1/2016 - 3/2015, were reviewed and documented she had participated in the following:</p> <p>January 2015 - The record documented Individual #1 was picked up from the bus stop seven times between 1/1 and 1/16. On 1/16 Individual #1 went to the gas station for a cracker. None of the activities were related to Individual #1's documented interests.</p> <p>February 2016 - The record documented on 2/6 Individual #1 "was picked up at school and came</p>	W 136			

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W 136	<p>Continued From page 9</p> <p>home." Additionally, Individual #1 went out for dinner on 2/19 and on 2/26 went shopping for clothes. None of the activities were related to Individual #1's documented interests.</p> <p>March 2016 - The record documented on 3/10 Individual #1 went to the grocery store and "wanted to interact with other kids." Individual #1 was taken out for dinner twice during the month. The activities were documented as "group outings" with no less than 3 of her roommates. On 3/22 Individual #1 went to the park with all of her roommates and on 3/25, Individual #1 was taken to a fast food restaurant for ice cream. Due to Individual #1's interest in taking walks, the 3/22 park visit would be the only outing related to Individual #1's documented interests.</p> <p>During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the PQ and Home Manager confirmed the collected data was correct. They stated the lack of community outings for Individual #1 was partially due to a lack of staff and partially due to Individual #1's recent increase in maladaptive behavior. The PQ and Home Manager stated at one point they only had 2 staff approved to drive the facility van. The PQ stated she was training staff about community documentation, as she recognized that being picked up from the bus stop did not constitute an outing.</p> <p>The facility failed to ensure Individual #1 was provided the opportunity to participate in community integration activities of her interest and choice.</p> <p>2. Individual #2's IPP, dated 3/12/15, documented a 36 year old female whose diagnoses included</p>	W 136		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83016	

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W 136	<p>Continued From page 10 profound mental retardation.</p> <p>Her IPP contained a service objective which stated "[Individual #2] will go on desired community outings. At least 4 times per month [sic]" and documented her interests as going to the store for a soda and hot dog, going for a ride, going out to eat, and seeing her guardian.</p> <p>Community Recreation Notes, dated 1/2015 - 3/2015, were reviewed. Her January and February 2015 notes did not document that she had consistently participated in activities of her interest and choice, as follows:</p> <p>January 2015 - The record documented Individual #2 went to the grocery store two times. No personal purchases were noted. She also went to the gas station to purchase a soda once. Only one activity reflected an activity related to Individual #2's interests or choices.</p> <p>February 2015 - The record documented one outing to a doctors appointment. One trip to a nearby winter carnival was counted as four outings, including two stops at gas station, restrooms enroute and lunch at a restaurant during the activity. Individual #2 also went to the grocery store twice with no personal purchases noted, and once to the gas station to purchase a soda. Only two outings were related to Individual #2's interests or choices.</p> <p>In an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the facility PQ confirmed the collected data was correct. She stated the lack of community outings for Individual #2 was due to new staff being hired but not trained to take individuals into the community.</p>	W 136	<p>→ Community program's update for Resident #1 and resident #2 to include where they enjoy going and things they like listed outing program. TC responsible by 5/15/15</p> <p>→ All Community programs to be reviewed to ensure outings are based on the residents wants and interests with a list of possible outings TC responsible by 5/15/15</p> <p>→ HM to put up a weekly Rec calendar to ensure residents are offered outings and to ensure adequate staff are present for the outings HM responsible by 5/15</p> <p>→ TC should be checking the Rec schedule a rec notes weekly to ensure residents are getting out when completing their weekly active treatment observation of the residents TC responsible by 5/15/15</p>	

→ TC to send all observations to QIDP at month adm meeting along with community notes QIDP to review to ensure all residents are getting out into community based on their wants and needs QIDP responsible by 5/15/15

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83816	
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W 136	Continued From page 11	W 136		
W 167	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>This STANDARD is not met as evidenced by: Based on observation, review of incident reports and investigations, policy review and staff interviews, it was determined the facility failed to ensure appropriate corrective action was taken, which directly impacted 2 of 6 individuals (Individuals #2 and #4) for whom incidents were reported and had the potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in a lack of sufficient corrective action being implemented. The findings include:</p> <p>1. The facility's abuse procedure, undated, included 3 levels of abuse, which included:</p> <ul style="list-style-type: none"> - Level 1: Minor individual rights violations, such as discussing individuals in front of others, not ensuring doors are closed to protect privacy, etc. - Level 2: Violations of the individuals' rights or abuse which may be emotionally or physically damaging such as displaying extreme anger, cursing, arguing, etc. - Level 3: Violations which may place the individuals in immediate danger, such as hitting, 	W 167	<p>→ All staff re-trained on individual #4 behavior plan that has been update by 5/15/15 QIDP Responsible</p> <p>→ All staff have been retrained on the Abuse Policy. The correct Abuse Policy date 4/14 was put into home. QIDP responsible by 5/15/15</p> <p>→ When there has been a violation of clients right or an abuse situation a weekly PSR will be complete to ensure training and recommendations are being followed through PSR to be turned in to QIDP.</p>	

→ at monthly QA and weekly PSR will be reviewed by PDE Adm. If any follow through needed added to Action list QIDP Responsible by 5/15/15

→ A Rights violation/Abuse PSR has been made to ensure follow through to be completed weekly (Next Psc)

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616
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W 157	<p>Continued From page 12</p> <p>kicking, or biting individuals, having sexual contact with individuals, etc.</p> <p>The procedure stated all violations would be reported, documented and corrective action would be taken.</p> <p>The facility's incident reports were reviewed and included a report, dated 7/21/14 at 11:15 a.m. The report documented staff found Individual #4 (who was a 21 year old male) and Individual #2 (who was a 36 year old female) in the basement of the facility. Individual #4 was holding Individual #2 by the shoulders and kissing her on the lips. The report documented Individual #2 was holding onto Individual #4's hips.</p> <p>The report stated Individual #4 had kissed others before and had a behavior plan in place to address his inappropriate touching of others. The report stated staff were trained not to leave Individual #4 unattended with other individuals, in response to the incident.</p> <p>However, on 4/17/15 at 8:33 a.m., Individual #4 was observed to be laying on top of Individual #2, who was laying on the couch in the downstairs living room. Staff were not observed to be present in the downstairs area.</p> <p>In an interview on 4/17/15 at 3:30 p.m., the PQ stated staff should have been supervising Individual #4 in the downstairs living room because Individual #2 was present.</p> <p>The facility failed to ensure the re-training of the staff to not leave Individual #4 unsupervised was sufficient to ensure Individual #4 did not inappropriately touch Individual #2.</p>	W 157	<p>for 3 months after the incident to ensure continual follow through and understanding by staff.</p> <p>TE-R @ PD responsible</p> <p>By: STJ/15</p>	
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W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 3 of 3 individuals (Individuals #1 - #3), and had the potential to impact all individuals (Individuals #1 - #6) residing in the facility. That failure resulted in a lack of sufficient QIDP monitoring and oversight being provided. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W120 as it relates to the facility's failure to ensure the QIDP ensured sufficient coordination was provided for outside services. 2. Refer to W136 as it relates to the facility's failure to ensure the QIDP ensured individuals had the opportunity to participate in community integration activities of their interest and choice. 3. Refer to W157 as it relates to the facility's failure to ensure the QIDP ensured sufficient appropriate corrective action was implemented in response to all incidents. 4. Refer to W186 as it relates to the facility's failure to ensure the QIDP ensured sufficient direct care staff were provided to manage and supervise individuals in accordance with their IPPs. 5. Refer to W216 as it relates to the facility's 	W 159	<p><i>Refer to W120</i></p> <p><i>Refer to W136</i></p> <p><i>Refer to W157</i></p> <p><i>Refer to W186</i></p> <p><i>Refer to W216</i></p>	

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W 159	Continued From page 14 failure to ensure the QIDP ensured individuals' dental needs were comprehensively assessed. 6. Refer to W249 as it relates to the facility's failure to ensure the QIDP ensured an individual received training and services consistent with his program plans. 7. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured an individual's behavioral intervention methods included sufficient information to direct staff.	W 159	<i>Refer to W249</i> <i>Refer to W289</i>	
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide sufficient direct care staff to manage and supervise individuals in accordance with their IPPs for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This had the potential to impede staffs' ability to consistently meet individuals' nighttime needs. The findings include: 1. During the entrance conference on 4/14/15 at approximately 9:00 a.m., the Administrator stated morning and afternoon shifts required 3 - 4 staff, and the preferred number of night shift (10:00	W 186		

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W 186	<p>Continued From page 15 p.m. - 6:00 a.m.) staff was 2.</p> <p>Individual #2's Behavior Intervention Plan for aggression, SIB and obsessing, dated 8/25/14, stated "Use 2 staff in the area when [Individual #2] begins to be difficult." Individual #2's Night Time Sleep Chart, from 1/2015 - 3/2015, was reviewed. The tracking documented multiple evenings Individual #2 was "Awake and Active" for 3 hours or more on the night shift. However, the facility's timecards from 1/1/15 - 4/15/15 did not document 2 staff were present, as follows:</p> <p>January 2015: Individual #2 was awake for 3 or more hours 12 nights of the month. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 1/3: Individual #2's tracking documented she was "Awake and Active" from 10:00 p.m. - 2:00 a.m. The facility's timecards documented only one staff on-duty for the entire shift. - 1/12: Individual #2's tracking documented she was "Awake and Active" from 10:00 p.m. - 3:30 a.m. Individual #2 then woke up for the day at 5:30 a.m. The facility's timecards documented only one staff on-duty for the entire shift. - 1/27: Individual #2's tracking documented she was "Awake and Active" the entire night shift (10:00 p.m. - 6:00 a.m.). The facility's timecards documented only one staff on-duty for the entire shift. <p>Further, the facility's timecards also documented only one staff for all, or most, of the night shift on 1/1, 1/4, 1/6, 1/7, 1/8, 1/9, 1/11, 1/13 - 1/16, 1/18 - 1/26 and 1/28 - 1/31.</p>	W 186		

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W 186	<p>Continued From page 16</p> <p>February 2015: Individual #2 was awake for 3 or more hours 7 nights of the month. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 2/2: Individual #2's tracking documented she was "Awake and Active" the entire night shift (10:00 p.m. - 8:00 a.m.). The facility's timecards documented only one staff on-duty for the entire shift. - 2/11: Individual #2's tracking documented she was "Awake and Active" the entire night shift (10:00 p.m. - 6:00 a.m.). The facility's timecards documented only one staff on-duty until a morning staff arrived at 4:00 a.m. - 2/27: Individual #2's tracking documented she was "Awake and Active" from 10:00 p.m. - 12:30 a.m. and from 1:00 - 2:30 a.m. Individual #2 then woke up for the day at 5:30 a.m. The facility's timecards documented only one staff on-duty for the entire shift. <p>Further, the facility's timecards also documented only one staff for all, or most, of the night shift on 2/1, 2/3 - 2/6, 2/9, 2/19, 2/26 and 2/28.</p> <p>Merch 2015: Individual #2 was awake for 3 or more hours 10 nights of the month. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 3/1: Individual #2's tracking documented she was "Awake and Active" the entire night shift (10:00 p.m. - 8:00 a.m.). The facility's timecards documented only one staff on-duty for the entire shift. - 3/8: Individual #2's tracking documented she was "Awake and Active" from 10:00 p.m. - 1:30 	W 186	<p>a 2nd graveyard has been hired to ensure graveyard shift works with 2 people HR responsible by 5/18/15</p> <p>HR review the schedule weekly to ensure there are adequate staff HR responsible</p> <p>HR will be had been trained to ensure minimum staff have been hired HR responsible by 5/30/15</p> <p>Admin review weekly schedules to ensure adequate staff are scheduled by Admin responsible by 5/30/15</p>	

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W 186	Continued From page 17 a.m. Individual #2 then woke up for the day at 3:30 a.m. The facility's timecards documented only one staff on-duty for the entire shift. - 3/15: Individual #2's tracking documented she was "Awake and Active" from 11:00 p.m. - 6:00 a.m. The facility's timecards documented only one staff on-duty for the entire shift. Further, the facility's timecards also documented only one staff for all, or most, of the night shift on 3/2 - 3/5, 3/7, 3/9 - 3/13, 3/16 - 3/18, 3/24 - 3/26 and 3/31. With only one staff on duty, it would not be possible to implement Individual #2's plan for aggression, SIB and obsessing. On 4/17/16 at approximately 10:00 a.m., the Home Manager stated they had been short staffed for at least 6 months. She stated they tried to share staff from sister facilities and fill shifts as best they could. The facility failed to ensure individuals were provided with sufficient direct care staff on the night shift.	W 186		
W 216	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' CFAs include comprehensive health information for 2 of 3 individuals	W 216		

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1067 RUSH ROAD EAGLE, ID 83616	
(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 216	<p>Continued From page 18 (Individuals #2 and #3) whose CFAs were reviewed. This resulted in a lack of information being available on which to base program intervention and health decisions. The findings include:</p> <p>1. Individual #2's IPP, dated 3/12/15, documented she was a 36 year old female whose diagnoses included profound mental retardation and seizure disorder.</p> <p>Individual #2's record contained documentation showing she had been to a dentist's office on 3/21/14. An evaluation was not performed due to Individual #2's non-compliance. Subsequently, a comprehensive dental exam and treatment was performed at a local hospital, under general anesthetic, on 10/2/14.</p> <p>Individual #2's CFA, dated 3/10/15 and signed by the PQ, did not address Individual #2's need for a dental desensitization program to decrease her dependence on general anesthetic for dental evaluation and treatment.</p> <p>In an interview on 4/20/15 at 11:00 a.m., the PQ confirmed she had completed the CFA for Individual #2 and had not identified the need for a dental desensitization program.</p> <p>The facility failed to ensure Individual #2's record included comprehensive assessment information.</p> <p>2. Individual #3's IPP, dated 2/26/15, documented she was a 37 year old female whose diagnoses included profound mental retardation, seizure disorder and blindness.</p>	W 216	<p>→ Individual #2 & #3 CFA were update to indicate issues with dental appointments QIDP responsible by 5/15/15</p> <p>→ all individuals CFA were reviewed and update to ensure any issues with dental or other appointments had been assessed.</p> <p>QIDP Responsible by 5/15/15</p> <p>→ program were put in place Based up assessed needs regarding health needs QIDP Responsible by 5/20/15</p> <p>→ CFA and IPP will be reviewed at least quarterly to ensure health needs are being addressed w/ a book reviewed completed</p>	

QIDP Responsible by 5/30/15

→ Book reviews will be reviewed by PD and all need action/follow through will be added to action list PD Responsible by 5/30/15

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W 216	Continued From page 19 Individual #3's record contained documentation showing she had been to a dentist's office on 2/6/14. An evaluation was not performed due to Individual #3's non-compliance. Subsequently, a comprehensive dental exam and treatment was performed at a local hospital, under general anesthetic, on 6/2/14. Individual #3's CFA, dated 2/25/15 and signed by the PQ, did not address Individual #3's need for a dental desensitization program to decrease her dependence on general anesthetic for dental evaluation and treatment. In an interview on 4/20/15 at 11:00 a.m., the PQ confirmed she had performed the comprehensive assessment for Individual #3 and had not identified the need for a dental desensitization program.	W 216			
W 249	The facility failed to ensure Individual #3's record included comprehensive assessment information. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	W 249			

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1067 RUSH ROAD EAGLE, ID 83616	
(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 GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
W 249	<p>Continued From page 20</p> <p>ensure individuals received training and services consistent with their program plans for 2 of 4 individuals (Individuals #1 and #4) whose behavior programs were reviewed. This resulted in individuals' behavior programs not being implemented. The findings include:</p> <p>1. Individual #4's 11/13/14 IPP stated he was a 21 year old male whose diagnoses included autism and profound mental retardation.</p> <p>Individual #4's record included a behavior plan, dated 11/19/13, which stated he engaged in inappropriate touching of other people. The plan stated individual #4 would get to close to others and try to rub their face with his hands, kiss them, thrust his groin against them or lay on top of them.</p> <p>The plan stated Individual #4 was not to be unsupervised in a room with other individuals.</p> <p>However, on 4/17/15 at 8:33 a.m., Individual #4 was observed to be laying on top of Individual #2, who was laying on the couch in the downstairs living room. Staff were not observed to be present in the area.</p> <p>In an interview on 4/17/15 at 3:30 p.m., the PQ stated staff should have been supervising Individual #4 in the downstairs living room because Individual #2 was present.</p> <p>The facility failed to ensure Individual #4's behavior plan was implemented.</p> <p>2. Individual #1's IPP, dated 9/22/14, documented a 14 year old female whose diagnoses included autism and profound mental retardation.</p>	W 249	<p>→ Individual #1 & #4 program's were retrained to ensure staff are implementing correctly w/ all materials needed TC Responsible by 5/30/15</p> <p>Behavior → all program's reviewed and trained to ensure staff are implementing correctly and all the materials were available TC Responsible by 5/30/15</p> <p>→ TC comp Active treatment PSR to include the observation of the implementation of behavior plans will be update PD responsible by 5/30/15</p> <p>→ TC to complete a weekly Active treatment PSR that</p>

Includes observation of the implementation of beh plans
TC Responsible by 5/30/15

→ All PSR (Active TR) will be reviewed by PD and any follow through ~~not~~ added to action list
PD Responsible By 5/30/15

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NAME OF PROVIDER OR SUPPLIER YOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616
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W 249	Continued From page 21 Individual #1's Elopement Behavior Intervention Plan documented under "Environmental Controls/prevention [sic]" Individual #1 was to "Use her picture schedule so she knows what she is doing and what is coming up." However, during observations conducted in the facility on 4/14/15 and 4/15/15 for a cumulative 4 hours 15 minutes, Individual #1 was not noted to utilize a picture schedule. Interviews were conducted with three direct care staff on 4/17/15 between 12:36 and 3:13 p.m. None of the staff had seen a visual schedule for Individual #1. During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the PQ stated they were still trying to figure out how to implement a picture schedule that Individual #1 would utilize.	W 249		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility failed to ensure Individual #1's behavior plan was implemented. The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	W 289		

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W 289	<p>Continued From page 22</p> <p>ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 1 of 4 individuals (Individual #1) whose behavioral interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure an individual's behavioral needs were met. The findings include:</p> <p>1. Individual #1's IPP, dated 9/22/14, documented a 14 year old female whose diagnoses included autism and profound mental retardation.</p> <p>Individual #1's Behavior Functional Assessment, dated 4/13/16, documented she engaged in maladaptive behaviors which included tantrum and elopement. Individual #1's Behavior Intervention Plans for each assessed behavior were reviewed. The plans did not include comprehensive instructions, as follows:</p> <p>a. The Aggression, Tantrum & Property destruction [sic] Behavior Intervention Plan, dated 11/1/13, defined tantrum behavior for Individual #1 as throwing herself to the floor or into objects, crying, screaming and throwing objects.</p> <p>However, the plan did not include any instructions to staff for how to intervene if Individual #1 engaged in tantrum behavior.</p> <p>During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the PQ stated staff were to ask Individual #1 what she wanted, block and protect and then minimize communication until Individual #1 was calm. The PQ stated staff should also offer preferred activities or items.</p> <p>Interviews were conducted with three direct care</p>	W 289	<p>→ individual #1 behavior plan was updated to ensure it included clear instructions for intervention are in program GIDP Responsible by 5/30/15</p> <p>→ all Behavior plan's reviewed to ensure clear instructions for intervention are included in the behavior plan. GIDP Responsible by 5/30/15</p> <p>→ all staff retrained on individual #1 behavior plan to ensure they understand how to implement. TC responsible by 5/30/15</p> <p>→ A behavior PSR will be completed by ex prior to plans being put in place to ensure they are half clear instructions and how to intervene</p>	

GIDP Responsible by 5/30/15

→ all PSR will be reviewed by PD and any follow through will be added to action list.

PD Responsible by 5/30/15

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W 289	<p>Continued From page 23</p> <p>staff on 4/17/15 between 12:36 and 3:13 p.m. When asked what to do when Individual #1 engaged in tantrum behavior, staff stated the following:</p> <ul style="list-style-type: none"> - DCS A stated she would try to figure out what Individual #1 wanted. DCS A stated she would only intervene if Individual #1's behavior was a danger to herself or others. She stated she would offer Individual #1 calming activities or items, such as deep pressure, massage, a weighted blanket or a warm cloth. - DCS B stated she would apply deep pressure to Individual #1's palms or make funny noises to get Individual #1 to laugh. DCS B stated she extinguished Individual #1's screaming or the behavior would escalate. - DCS C stated she would not react to Individual #1's behavior or Individual #1 would escalate. <p>b. Individual #1's Elopement Behavior Intervention Plan, dated 3/20/15, documented the definition of elopement included "Trying to get out of the van on an outing or wandering away from staff on an outing." Additionally, the plan documented Individual #1 required two staff "in the community (transport) as she will try to get out of the van whenever it stops."</p> <p>The plan included elopement instructions if Individual #1 went out the front door or ran down the driveway. However, the plan did not include instructions to staff related to how to intervene if Individual #1 tried to elope from the van.</p> <p>During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the Home Manager stated Individual</p>	W 289		
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W 289	Continued From page 24 #1 unbuckled her seat belt in the van often, but typically responded to verbal cues to buckle herself back into the seat. Interviews were conducted with three direct care staff on 4/17/15 between 12:36 and 3:13 p.m. When asked what to do when Individual #1 tried to elope from the van, staff stated the following: - DCS A stated she had not seen Individual #1 exhibit the behavior. DCS A stated she thought staff would pull the vehicle over and cue Individual #1 to sit back down and put on her seat belt. - DCS B stated she had not seen Individual #1 exhibit the behavior and was not sure what she would do. - DCS C stated one time Individual #1 unbuckled herself and got up in the van, but returned to her seat with verbal cues from staff. DCS C stated she was not sure what she would do if Individual #1 jumped, or attempted to jump, from the van. During an interview on 4/21/15 from 11:10 - 11:47 a.m., the QIDP stated Individual #1's behavior plans were recently updated but were pending approval from HRC and had not yet been implemented. She stated the new plans now included tantrum instructions, however, instructions for eloping from the van were missed. The facility failed to ensure techniques to manage Individual #1's maladaptive behaviors were sufficiently incorporated into her behavior plans.	W 289		
W 345	483.460(d)(3) NURSING STAFF	W 345		

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W 345	<p>Continued From page 25</p> <p>The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.</p> <p>This STANDARD is not met as evidenced by: Based on review of the Idaho Board of Nursing Rules and Regulations, record review and staff interviews, it was determined the facility failed to ensure their registered nurse was utilized as per this standard and as required by state law. This directly impacted 3 of 3 individuals (Individuals #1 - #3) whose medical records were reviewed, and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to experience negative impacts to their health. The findings include:</p> <p>1. The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) state, at IDAPA 23.01.01.401, that "in addition to providing hands-on nursing care, licensed registered nurses work and serve in a broad range of capacities including, but not limited to, regulation, delegation, management, administration, teaching, and case management. Licensed registered nurses, also referred to as registered nurses or as 'RNs,' are expected to exercise competency in judgment, decision making, implementation of nursing interventions, delegation of functions or responsibilities, and administration of medications and treatments prescribed by legally authorized persons."</p> <p>IDAPA 23.01.01.401.02(a) states the functions of the RN include "Assesses the health status of individuals and groups" and IDAPA 23.01.01.401.02(b) states the RN "Utilizes data</p>	W 345	<p>RN to come in and sign etc and review all quarterly nursing exams and nursing summaries for individuals #1-3 RN responsible by 5/30/15</p> <p>→ RN to review and sign all individual quarterly nursing exams and summaries RN responsible by 5/30/15</p> <p>→ RN will set up a regular schedule to be in the home to review and sign information as needed Adm responsible by 5/30/15</p> <p>→ will update nursing service policy to be updated to include documentation of RN contact and the delegation of responsibilities Adm responsible by 5/30/15</p>	

→ During quarter monthly ad review client files to ensure RN to reviewing at least quarterly
PD responsible by 5/30/15

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W 345	<p>Continued From page 26 obtained by assessment to identify and document nursing diagnoses..."</p> <p>IDAPA 23.01.01.460 states "Licensed practical nurses function in dependent roles. Licensed practical nurses, also referred to as LPNs, provide nursing care at the delegation of a licensed registered nurse..."</p> <p>IDAPA 23.01.01.460.02(a) states the functions of the LPN include "Contributes to the assessment of health status by collecting, reporting and recording objective and subjective data."</p> <p>The facility failed to utilize RNs as required by state law, as follows:</p> <p>a. Individual #1's 9/22/14 IPP stated she was a 14 year old female whose diagnoses included profound mental retardation and seizure disorder.</p> <p>Individual #1's medical record included Quarterly Nursing Examinations dated 1/20/15, 12/28/14, 9/25/14, and 6/25/14 that were completed and signed by the LPN. There was no documentation the examinations had been reviewed by the RN.</p> <p>Additionally, Individual #1's monthly Nursing Summaries from 7/2014 - 3/2015 were reviewed. The forms were signed by the LPN and the PQ, but the signature space for the RN was blank.</p> <p>b. Individual #2's 3/12/15 IPP stated she was a 36 year old female whose diagnoses include profound mental retardation and autism.</p> <p>Individual #2's medical record included Quarterly Nursing Examinations dated 1/12/15, 10/8/14, 7/29/14, and 4/17/14 that were completed and</p>	W 345		

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W 345	<p>Continued From page 27</p> <p>signed by the LPN. There was no documentation that examinations had been reviewed by the RN.</p> <p>Additionally, Individual #2's monthly Nursing Summaries from 9/2014 - 3/2015 were reviewed. The forms were signed by the LPN and the PQ, but the signature space for the RN was blank.</p> <p>c. Individual #3's 2/25/15 IPP stated she was a 37 year old female whose diagnoses included profound mental retardation and seizure disorder.</p> <p>Individual #3's medical record included Quarterly Nursing Examinatons dated 4/7/15, 1/8/15, 10/8/14, and 7/29/14 completed and signed by the LPN. There was no documentation that the examinations had been reviewed by the RN.</p> <p>Additionally, Individual #3's monthly Nursing Summaries from 9/2014 - 3/2015 were reviewed. The forms were signed by the LPN and the PQ, but the signature space for the RN was blank.</p> <p>None of Individual #1 - #3's Quarterly Nursing Examinations or Nursing Summaries documented they had been reviewed by the RN. Additionally, documentation that the RN had been present in the facility or reviewed any aspect of Individual #1 - #3's records from 4/1/14 to present could not be found.</p> <p>The facility utilized a contracted RN who was interviewed by telephone on 4/21/15 from 1:50 - 2:13 p.m. The RN stated she could not remember the last time she had been in the facility, but stated it could have been a year or more. The RN stated she would review and sign the Quarterly Nursing Examinations or Nursing Summaries when she was in the facility. If the</p>	W 345			

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W 345	Continued From page 28 reviews were not signed it would indicate she had not been present in the facility. The RN stated her "other job" prevented her from coming to the facility frequently. When asked about regulations governing ICFs/ID, the RN stated she was not aware of the specific regulations. The RN stated the facility's Nursing Supervisor made daily decisions related to the facility and would consult with the Social Worker and facility Administrator. The RN stated she would rely on the Nursing Supervisor to contact her if she had questions. The RN stated she was aware the Nursing Supervisor was an LPN. During an interview on 4/22/15 from 9:35 - 10:10 a.m., the facility LPN stated he had worked for the company for 18 months and had never met the RN. The Nursing Supervisor, who was present during the interview, stated the RN used to review records every 3 - 6 months, but she did not know the last time the RN was in the facility or had reviewed any of the medical records.	W 345			
W 440	The facility failed to utilize a registered nurse as appropriate and required by state law. 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for the facility and staff	W 440			

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W 440	<p>Continued From page 29 not being able to determine individuals' responses or identify problem areas. The findings include:</p> <p>1. The facility's evacuation drills were reviewed and did not include documentation that evacuation drills had been completed for the night shift (10:00 p.m. - 6:00 a.m.) during the first quarter (January - March) of 2015 and the third quarter (July - September) of 2014.</p> <p>During an interview on 4/21/15 at 8:15 a.m., the Home Manager stated the evacuation drills for the night shift had not been completed.</p> <p>The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.</p>	W 440	<p>→ HM trained on completing quarterly graveyard drills TC Responsible by 5/30/15</p> <p>→ a reminder will be sent to HM that they are due for their quarterly graveyard drills PD Responsible by 5/30/15</p> <p>→ All fire drills are discussed in at monthly QA by the 5th of the month HM Responsible by 5/30/15</p> <p>→ PD to review all fire drills and add to the yearly spread sheet to ensure all drills are completed PD Responsible By 5/30/15</p>	

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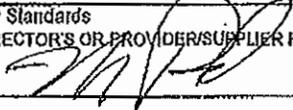
Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83618
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the complaint and annual licensure survey conducted from 4/14/15 to 4/21/15. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead Trish O'Hara, RN	M 000		
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W157.	MM177	Refer to W157	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W289.	MM197	refer to W289	
MM207	16.03.11.075.13 Freedom of Association Freedom of Association. Each resident admitted to the facility must be permitted to associate and	MM207		

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



TITLE

Adm

(X6) DATE

5/12/15

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NAME OF PROVIDER OR SUPPLIER
TOMORROW'S HOPE - EAGLE

STREET ADDRESS, CITY, STATE, ZIP CODE
1057 RUSH ROAD
EAGLE, ID 83616

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MM207	Continued From page 1 communicate privately with persons of his choice, and to participate in activities of social, religious, and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W136.	MM207	Refer to W136	
MM212	16.03.11.076.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W216 and W249.	MM212	Refer to W216 & 249	
MM262	16.03.11.100.01(c) Private Water Supply examination If water is from a private supply, water samples must be submitted to the Department through the District Public Health Laboratory for bacteriological examination at least once every three (3) months. Copies of the laboratory reports must be kept on file at the facility. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the facility's water supply was assessed for bacterial contamination at least once every three (3) months for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals residing in the facility to have adverse health consequences from contaminated water. The findings include:	MM262	→ well water has been tested HM Responsible by 5/1/15 → well water check added to The house PR which is completed monthly and turned in by 5th of the month for QA HM Responsible by 5/1/15	

→ well water quarterly checks are to be sent to the office for monthly QA HM Responsible by 5/30/15

6/1/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER
TOMORROW'S HOPE - EAGLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**1067 RUSH ROAD
EAGLE, ID 83818**

(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
MM262	Continued From page 2 1. The facility's well test records were reviewed and did not include documentation that the facility's well water had been tested for bacteriological contamination since 2/13/14. During an interview on 4/21/15 at approximately 8:15 a.m., the Home Manager stated the most recent test of the facility's well water was in February 2014. The facility failed to ensure its water supply had been tested for bacteriological contamination at least once every three months.	MM262	<i>MM262 Continues</i> <i>→ PD to record quarterly water checks on yearly spread check to ensure they are completed</i> <i>PD Responsible by 5/30/15</i> <i>→ PD to add water well water checks to action list month prior to due</i> <i>PD responsible by 5/30/15</i>	
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 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 4/16/15 from 11:02 a.m. - 12:00 p.m. with the Home Manager. During that time, the following was noted: - There was a section of unpainted plaster	MM380	<i>→ all needed items to be fixed or removed from or replaced the house. HM Responsible By 5/30/15</i> <i>→ HM to be completing a weekly walk through with all needed items add to the maintenance list</i> <i>HM Responsible by 5/30/15</i> <i>→ A monthly House PSR to be completed to ensure all items and house is</i>	

in good repair - all need items noted and added to maintenance list

→ PD to Review weekly walk throughs & House PSR and add all need items to action list PD Responsible by 5/30/15

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616
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MM380	<p>Continued From page 3</p> <p>approximately 1 foot by 6 inches on the wall between the maintenance closet and the medication room.</p> <ul style="list-style-type: none"> - The downstairs couch was missing cushion covers. - There was a black chair with an approximately 1 foot rip down the center of the seat cushion. - The downstairs bathroom floor was composed of peel and stick vinyl tile squares. Approximately 8 of the squares had shifted resulting in gaps between the tiles. - The laundry basket in the downstairs bathroom was broken. - There was a section of unpainted plaster approximately 1.5 feet by 1.5 feet on the wall at the top of the stairs. - The top drawer furthest to the left of the stove and the silverware drawer were both missing back stops to prevent them from falling out when opened. - Two of Individual #6's dresser drawers were missing back stops. - The top drawer of Individual #3's dresser was off the tracks. - The drawers of Individual #1's desk were off the tracks and missing back stops. - Individual #1's laundry basket was broken. - The oven was coated with food and debris. 	MM380	<p><i>m380 continue</i></p> <p><i>PD to get copy of the maintenance list to the maintenance guy each month.</i></p> <p><i>PD responsible by Ebooks</i></p>	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1067 RUSH ROAD EAGLE, ID 83816
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MM380	<p>Continued From page 4</p> <ul style="list-style-type: none"> - The cleaning closet door had a circular, broken area approximately 3 inches in diameter. The Home Manager, who was present during the review, stated it was possibly from Individual #1 hitting her head on the door. The closet door also had damage on the bottom left corner. - There were cigarette butts in the bark near the front door, on the ground around the ash tray on the side of the house, under the swings of the swingset and next to the driveway below the juniper bushes. <p>The facility failed to maintain the building and equipment in good repair.</p>	MM380		
MM602	<p>16.03.11.230.02(b) Work Schedules</p> <p>Daily work schedules, reflecting the daily adjustments of employees, shall be kept in writing, showing the personnel on duty at any given time for the previous three (3) month period. Personnel shall be identified by first and last names, including professional designation (R.N., L.P.N., Q.M.R.P., etc.), and position.</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure as-worked schedules reflective of daily adjustments were maintained for 21 of 21 staff (Staff A - U) whose limecards were reviewed. This impeded the facility's ability to monitor staffing patterns. The findings include:</p> <p>1. The facility's as-worked schedules from 1/2015 through 4/2015 were requested. The Home Manager provided staff limecards for the date range. The limecards documented a staff</p>	MM602		

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NAME OF PROVIDER OR SUPPLIER
TOMORROW'S HOPE - EAGLE

STREET ADDRESS, CITY, STATE, ZIP CODE
1057 RUSH ROAD
EAGLE, ID 83616

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MM602	Continued From page 5 member's name, followed by the dates and times worked for the month. When asked about monthly as-worked schedules, during an interview on 4/24/14 at 2:27 p.m., the Home Manager stated the timecards could be printed in daily view. However, the Home Manager stated timecards were the only documentation she had of staff time worked. The facility failed to maintain as-worked schedules which reflected the staff, including first and last names and professional designation, who worked each shift.	MM602	→ As worked schedule will be posted in home HM Responsible by 5/30/15 → training with HM on how to post as worked schedules HM responsible by 5/30/15 → when doing weekly work through will check for as work scheduled to ensure they are up to date. HM responsible	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	→ PD to update HM work through to ensure it includes: checking as worked schedule PD Responsible → work throughs turned into PD monthly and any follow through added to action list PD Responsible by 5/30/15	
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by:	MM760	Refer to W159	

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MM760	Continued From page 6 Refer to W345.	MM760	<i>Refer to W345</i>	
MM857	16.03.11.270.08(e) Qualified Training There must be sufficient appropriately qualified training and habilitation personnel and necessary supporting staff available to carry out the residents' training and habilitation program. This Rule is not met as evidenced by: Refer to W186.	MM857	<i>Refer to W186</i>	
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	<i>Refer to W120</i>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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May 1, 2015

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

Provider #13G047

Dear Mr. Pond:

An unannounced on-site complaint investigation was conducted from April 14, 2015 to April 21, 2015 at Tomorrow's Hope - Eagle. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006927

Allegation #1: The facility does not communicate with outside providers.

Findings #1: During the investigation, review of records and interviews with facility staff and an outside professional were conducted with the following results:

Three individuals were selected for review. One individual attended a local middle school Monday through Friday from 8:30 a.m. to 3:30 p.m.

The individual's teacher was interviewed on 4/14/15 at 2:40 p.m. The teacher stated he communicated with the facility using a communication log and he would speak with and email the Para-Qualified Intellectual Disabilities Professional.

The teacher stated the Para-Qualified Intellectual Disabilities Professional had attended the individual's school plan development meeting, but he had not been invited to the individual's plan development meeting at the facility. The teacher stated he did not receive a copy of the plan or any of the individual's training or behavior programs from the facility.

Thair Pond, Administrator
May 1, 2015
Page 2 of 4

The communication log exchanged by the school and facility was reviewed, the entries were dated 2/10/15 - 4/14/15. From 2/10 - 2/18, the school wrote in the communication log 11 times; the facility wrote 2 entries. During the month of March, the school wrote in the communication log 16 times; the facility wrote 6 entries. In April, from 4/1 - 4/14, the school wrote in the communication log 16 times; the facility wrote 8 entries.

Although the school wrote in the communication log more frequently than the facility, the facility was showing improvement over the time period reviewed.

Interviews were conducted with three direct care staff on 4/17/15 between 12:36 and 3:13 p.m. One staff stated the staff assigned to the school-aged individual in the afternoon was responsible for reading the communication log and responding as needed. She stated the individual's morning staff was responsible for entering a summary of the morning. A second staff stated she was not sure who was responsible for writing to the school in the communication log, but she had written in the book before. The third staff stated she had never seen the communication log.

During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the Para-Qualified Intellectual Disabilities Professional stated she had shared the individual's programs with the school in the past, but she would send them again. She stated she recognized that documentation in the communication log could improve, however, she stated she had additional communication directly with the individual's teacher via e-mail and telephone often.

Based on review of the communication log and staff interview, it could not be determined that the facility failed to communicate with outside providers and the allegation was unsubstantiated.

However, the facility failed to perform observations to ensure their services were coordinated with the school. Therefore, related deficient practice was identified and the facility was cited at W120.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals are not provided with appropriately sized clothing.

Findings #2: During the investigation, observations, review of records, an environmental review and staff interviews were conducted with the following results:

Observations were conducted in the facility on 4/14/15 and 4/15/15 for a cumulative 4 hours 15 minutes. During that time, individuals were noted to be dressed in clean clothing of appropriate size.

An environmental review was conducted on 4/16/15 from 11:02 a.m. - 12:00 p.m. During that time, the contents of each individual's dresser and closet were observed. Each individual was noted to have a sufficient supply of clean clothes.

Three individuals were selected for further review. The individuals' records contained inventory sheets, which were reviewed. The inventories included documentation of clothing being added to the individuals' possessions. Further, the documentation showed staff regularly examined individuals' wardrobes and removed any ill-fitting or tattered clothing.

Interviews were conducted with three direct care staff on 4/17/15 between 12:36 and 3:13 p.m. All three of the staff interviewed described the process for documenting items that came into, and out of, the facility. They each stated on a monthly basis individuals' clothes were checked for appropriate fit and "checked out" on the inventory sheets, with initials from two staff, if they were ill-fitting or in bad condition.

During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the Para-Qualified Intellectual Disabilities Professional stated the facility checked each individual's clothing monthly and discarded ill-fitting or tattered clothes and documented the disposal on the individual's inventory sheet with an explanation and the initials of two staff.

It could not be determined that individuals were not provided with appropriately sized clothing. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Staff engage in sexual behavior with individuals.

Findings #3: During the investigation, observations, review of records and staff interviews were conducted with the following results:

Three individuals were selected for review. Observations were conducted in the facility on 4/14/15 and 4/15/15 for a cumulative 4 hours 15 minutes. During that time, staff were noted to interact with individuals appropriately and respectfully.

The facility's incident reports, from 1/1/15 - 4/14/15, were reviewed. The reports did not document any instances of staff engaging in sexual behavior with the individuals.

The facility's abuse, neglect and mistreatment investigations, from 3/28/14 - 4/14/15, were reviewed. The investigations did not document any incident of staff engaging in sexual behavior with the individuals.

Thair Pond, Administrator
May 1, 2015
Page 4 of 4

Interviews were conducted with three direct care staff on 4/17/15 between 12:36 and 3:13 p.m. All three of the staff stated they had never seen a staff member engage in sexual behavior with the individuals, and would report the incident if they did.

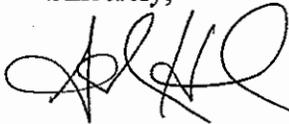
During an interview on 4/20/15 from 11:00 a.m. - 12:15 p.m., the Para-Qualified Intellectual Disabilities Professional stated an individual's school had reported an incident of a staff allegedly kissing the individual. The Home Manager, also present during the interview, stated she was present during the reported incident. The Home Manager stated the individual liked noises in her ear, and when she leaned in close to the staff, the staff made noises for her. The Home Manager stated she immediately recognized the potentially negative appearance of their close proximity and retrained the staff at that time.

It could not be determined that staff engaged in sexual behavior with the individuals. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt