



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 27, 2015

Richard Davis, Administrator
Boise Group Home #3 Holt
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #3 Holt, Provider #13G034

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure and Complaint survey, which was conducted at your facility, Boise Group Home #3 Holt, on May 21, 2015.

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

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Richard Davis, Administrator
May 27, 2015
Page 2 of 2

6. Include the 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 **June 9, 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:

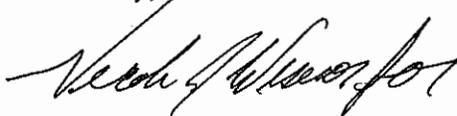
www.icfmr.dhw.idaho.gov

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 June 9, 2015. If a request for informal dispute resolution is received after June 9, 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,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/21/2015
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NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #3 HOLT	STREET ADDRESS, CITY, STATE, ZIP CODE 9874 WEST HOLT STREET BOISE, ID 83704
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(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 deficiencies were cited during a complaint and annual licensure survey conducted from 5/18/15 to 5/21/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Ashley Henscheid, QIDP	M 000		
MM269	16.03.11.100.04 Insect and Rodent Control Insect and Rodent Control. The facility must be maintained free from insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, used, and stored in the following manner: This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain living areas to ensure they were free of insects for 4 of 4 individuals residing in the facility (Individuals #1 - #4). This had the potential to negatively impact individuals' health. The findings include: 1. The facility was noted to have ant infestations, as follows: a. During the morning observation on 5/19/15, conducted from 7:05 - 8:45 a.m., a flying ant infestation was noted in the laundry room. b. During an environmental inspection on 5/20/15, conducted from 12:10 - 12:50 p.m., an ant infestation was noted in kitchen. During the environmental inspection, a Home Manager present stated they were aware of the	MM269	Facility has contracted with pest control service starting first application July 1, 2015. Quarterly application thereafter. Responsible change: Administrator will monitor quarterly and PRN per Administrator 7.1.15, umax	July 1 2015

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6/19/15
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Bureau of Facility Standards

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MM269	Continued From page 1 ant infestations and were working to eradicate the issue. The facility failed to maintain an environment free from insects.	MM269		
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 4 of 4 individuals (Individuals #1 - #4) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted with two Home Managers on 5/20/15 from 12:10 - 12:50 p.m. During that time, the following concerns were identified: - The paint on the trim on the outside of the facility was chipping away. - The eave over the main entry was saturated with water and the rain gutter was clogged with debris and growing plants. The wood of the eaves were visibly wet, swollen and cracked. - The remaining rain gutters were clogged with	MM380	Facility lost maint. man and has yet to find replacement. Facility's new manager will receive training. She should take care of small items or report immediately. Maint. man will be hired by July 15, 2015 by administrator Pen & into charge: Facility staff complete damage reports and send to Administrator PRN, and House Manager completes a weekly house check. per Administrator 7.1.15, -muc	7/15/15

Bureau of Facility Standards

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MM380	<p>Continued From page 2</p> <p>debris.</p> <ul style="list-style-type: none"> - In the areas where the outside trim came to a meeting point, the wood appeared to have been chipped away, leaving sawdust on the roof. One of the Home Managers present stated the issue was caused by woodpeckers. - The carpet of the front living room was unraveling and frayed at the seam to the dining area. There was no metal plate covering the threshold. - There were multiple tears in the vinyl flooring in the dining room, from approximately 2 to 6 inches in diameter. - There were no less than 6 chips, approximately a half inch in diameter, in the paint of the entryway to the hallway from the rear living room. - There were small pieces of wooden trim missing in the rear living room behind the fax machine stand and below the kitchen counter. - There was a 2 inch by 2 inch hole in the cover of the ceiling light fixture closest to the sink. - Behind the kitchen sink, the caulking was peeling or missing along an approximately 5 foot section. - The carpet was loose and wrinkled in the rear living room at the kitchen border and in the master bedroom leading into the hallway. - The carpet of the rear living room was unraveling and frayed at the seam to the breakfast nook. 	MM380		

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MM380	Continued From page 3 - There were no less than 11 scratches in the vinyl flooring in the breakfast nook. ✱ - The caulking along the base of the front of the shower in the hall bathroom was peeling and cracked. ✱ - The sink faucet in the hall bathroom was loose. - The left drawer in the hall bathroom was missing the drawer face. - The carpet of the hallway was unraveling and frayed at the seam to the laundry room. - There was a large hole, which appeared to be from the doorknob going through the wall, behind the door of the vacant bedroom. - The carpet in the closet of the master bedroom was detached from the subfloor and was curling up. - There was a hard, rough, unidentified black substance in the back corner of the master closet where the ceiling and wall met. The substance was in two spots approximately two inches by one inch each. - There was a tear, approximately 2 feet long, in the seat cushion as well as a large hole, approximately 1 foot by 3 feet, in the awning of the patio swing. The facility failed to ensure environmental repairs were maintained.	MM380		
MM412	16.03.11.120.04(m) Furniture and Equipment	MM412	See MM380	

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MM412	<p>Continued From page 4</p> <p>All furniture and equipment must be maintained in a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined facility failed to ensure all furniture was kept in good repair for 3 of 4 individuals (Individuals #1 - #3) residing in the facility. This resulted in dressers being kept in ill-repair and in a manner that did not permit ease of use. The findings include:</p> <p>1. An environmental review was conducted with two Home Managers on 5/20/15 from 12:10 - 12:50 p.m. During that time, the following concerns were identified:</p> <ul style="list-style-type: none"> - The left knob was missing from the bottom drawer of Individual #1's dresser. - The third drawer of Individual #2's dresser was broken from the tracks. - The top row of Individual #3's dresser contained two drawers. The faces of both drawers were detached. <p>The facility failed to ensure repairs were maintained for all furniture.</p>	MM412		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2015
FORM APPROVED
OMB NO. 0938-0391

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W 000	<p>INITIAL COMMENTS</p> <p>Boise Group Home - Holt is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for a complaint and the annual recertification survey conducted from 5/18/15 to 5/21/15.</p> <p>The survey was conducted by: Michael Case, LSW, QIDP, Team Lead Ashley Henscheid, QIDP</p>	W 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



IDAHO DEPARTMENT OF
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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May 27, 2015

Richard Davis, Administrator
Boise Group Home #3 Holt
P.O. Box 4243
Boise, ID 83711

Provider #13G034

Dear Mr. Davis:

An unannounced on-site complaint investigation was conducted from May 18, 2015 to May 21, 2015 at Boise Group Home #3 Holt. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00007001

Allegation: Individuals are not provided sufficient monitoring and oversight to address health and safety needs.

Findings: During the investigation, observations, record review and staff interviews were conducted with the following results:

The facility's accident and illness reports from 1/1/15 - 5/18/15 were reviewed for incidents that potentially resulted from insufficient monitoring and oversight. The reports documented individuals' illnesses, injuries of unknown origin, falls and significant health and medical events.

One report, dated 5/6/15 at 11:52 a.m., documented an individual choked during a meal at the day program resulting in emergency personnel being contacted and the individual being transported to the hospital.

Six day treatment staff and the day treatment program supervisor were interviewed on 5/19/15 from 10:42 - 11:28 a.m. and 12:35 - 1:20 p.m., and on 5/20/15 from 10:20 - 10:50 a.m. All 6 staff and the supervisor were able to explain each individual's supervision needs, including during meals.

Three of the staff interviewed were working at the day program and present in the dining room during the 5/6/15 choking incident. All 3 staff were able to describe the level of supervision that was being provided when the individual appeared to choke, stop breathing, and experience cardiac arrest.

Richard Davis, Administrator

May 27, 2015

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One staff stated she was assigned to the individual who experienced the choking incident. The staff stated she was responsible for two other individuals, both of whom had meal programs. She stated she cued the individual, who did not require dining supervision, to take a drink, to which the individual replied verbal confirmation. The staff stated she turned her focus back to the other 2 individuals, at which time she heard something behind her hit the ground. The staff stated she turned to see the individual lying on the ground with other individuals from the workshop around her.

The second staff stated she walked by the individual that experienced the choking incident no more than 2 minutes prior to her collapsing to the ground. The staff stated she looked at the individual and noted no concerns at that time. The staff stated the individual's assigned staff was facing away from her at the time. However, the staff stated she was unsure what the expectation for supervision of that individual was.

The third staff stated she was seated at the table with the individual who experienced the choking incident. She stated a staff asked the individual if she needed a drink, to which the individual replied "yes." The third staff stated another individual from the workshop walked by right before she heard the individual fall to the ground. The staff stated she immediately thought the individual had been pushed out her her chair, but quickly went to her side and saw the individual was experiencing a medical issue.

Each of the staff stated there were no warning signs (e.g. choking noises, requests for help from anyone present including other individuals, etc.) leading up to the individual's fall.

The 3 staff and the supervisor were able to describe the interventions that took place once the incident occurred. All information gathered during the interviews demonstrated the staff were providing appropriate supervision prior to the incident, and provided appropriate intervention during the incident.

One staff stated when she spotted the individual on the ground, she yelled for help. The staff stated she sat the individual up and attempted the Heimlich maneuver. She stated the Heimlich was unsuccessful and another staff present completed a finger swipe of the individual's mouth to remove any blockages. The staff stated other staff began CPR an estimated 45 seconds after the individual initially collapsed. She stated another staff was already on the phone with emergency services so she went outside to meet the ambulance. The staff stated she was told it had been 17 minutes from the time the individual first fell to the time she left in the ambulance.

The second staff stated when she heard the individual fall, she located the workshop supervisor to inform her. The staff stated two other staff were sitting the individual up for the Heimlich maneuver. She stated the staff laid the individual down to begin CPR and she left to call 911. The staff stated CPR was performed until the paramedics arrived, which took approximately 5 minutes. She stated from the time that the individual fell to the time that paramedics were able to assist her to breathe was 17 minutes.

The third staff stated she and another staff rushed to the individual's side. She stated they were at her side within 30 seconds and they yelled for the workshop supervisor. The staff stated they were not sure if the individual was experiencing a seizure, choking, or something else. She stated they noticed sandwich in her mouth and they removed as much as they could. The staff stated the individual had no pulse and was blue, so they performed CPR. She stated someone called 911. The staff stated when the paramedics arrived they provided instructions on how to continue CPR and when to start and stop compressions.

Richard Davis, Administrator
May 27, 2015
Page 3 of 3

The record of the individual who choked was reviewed and documented the facility had appropriate assessment information and treatment programs in place to meet the individual's supervision, health and safety needs.

Two additional individuals were randomly selected for review. Their records were found to contain sufficient assessment information and treatment programs to meet supervision, health and safety needs.

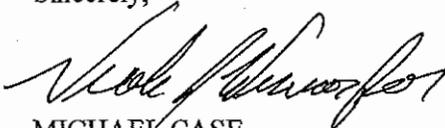
Further, observations were conducted at the facility on 5/18/15 from 3:35 - 4:25 p.m. and 5:10 - 6:15 p.m., and on 5/19/15 from 7:05 - 8:45 a.m. Additionally, an observation was conducted at the facility-operated day treatment program on 5/19/15 from 9:45 - 10:30 a.m. During those times, all individuals present were observed to be provided adequate supervision and monitoring to meet health and safety needs.

It could not be determined that staff were not providing sufficient monitoring and oversight to address individuals' health and safety needs. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

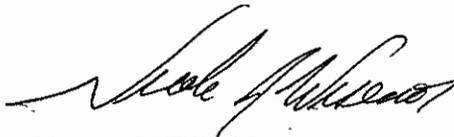
Conclusion: Unsubstantiated. Lack of sufficient evidence.

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,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt