



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 83720-0000
PHONE 208-334-6626
FAX 208-364-1888

June 29, 2015

Richard Davis, Administrator
Boise Group Home #4 Eshelman
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #4 Eshelman, Provider #13G042

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #4 Eshelman, which was conducted on June 26, 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

Richard Davis, Administrator
June 29, 2015
Page 2 of 2

6. Include dates when corrective action(s) will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 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:

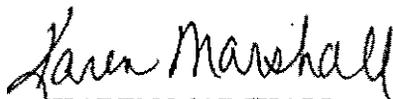
www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

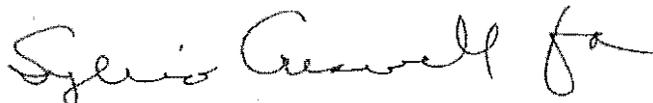
This request must be received by July 13, 2015. If a request for informal dispute resolution is received after July 13, 2015, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures

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

PRINTED: 06/26/2015
FORM APPROVED
OMB NO. 0938-D391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #4 ESHELMAN			STREET ADDRESS, CITY, STATE, ZIP CODE 9917 WEST ESHELMAN BOISE, ID 83704	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiency was cited during the complaint investigation and annual recertification survey conducted from 6/23/15 to 6/26/15. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Jim Troutfetter, QIDP Common abbreviations used in this report are: IDT - Interdisciplinary Team IPP - Individual Program Plan PT - Physical Therapist QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate general and preventative medical care was provided for 1 of 3 individuals (individual #1) whose medical records were reviewed. This resulted in an individual not receiving a comparative x-ray as recommended by a physical therapist. The findings include: 1. Individual #1's IPP, dated 11/24/14, documented a 46 year old male whose diagnoses included moderate mental retardation.	W 322	Some physician services related to therapies done in the home-OT,PT,Speech, were monitored by the QIDP, thus causing the problem cited at W322. Effective immediately all therapy reports will go to our nursing dept for review and followup. A copy to house manager and QIDP. Nursing will make appointments as recommended by the therapist. Our Director of Medical Services will monitor during meetings with nursing staff.	7/5/15

10/17/2015
JUL 23 2015
PROPERTY OF...

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
[Signature] *[Signature]* 7/28/15

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

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

PRINTED: 06/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #4 EHELMAN	STREET ADDRESS, CITY, STATE, ZIP CODE 9917 WEST EHELMAN BOISE, ID 83704
---	---

(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 322	<p>Continued From page 1</p> <p>Individual #1's record contained a physical therapy report, dated 3/11/15, documenting "I believe it has been six or seven years since [Individual #1] saw the orthopedist. An orthopedic consultation with comparison x-rays certainly seems appropriate."</p> <p>However, his record did not contain documentation of an orthopedic consultation or comparison x-rays.</p> <p>His record also contained IDT Meeting Minutes, dated 3/19/15 documenting "[Name], PT, evaluated [Individual #1] 3/11/15, and his report notes no change in [Individual #1's] gait regarding weight bearing or passive range of motion in his left ankle, therefore, the team determined that there was not any indication that [Individual #1] needed to see the Orthopedist at this time."</p> <p>When asked on 8/26/15 from 8:50 - 8:53 a.m., the QIDP stated she was not aware the report included a recommendation for comparison x-rays.</p> <p>The facility failed to ensure Individual #1 received comparison x-rays as recommended by the PT.</p>	W 322		
-------	---	-------	--	--

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER
BOISE GROUP HOME #4 ESHELMAN

STREET ADDRESS, CITY, STATE, ZIP CODE
**9917 WEST ESHELMAN
BOISE, ID 83704**

(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
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	see W322	

[Handwritten signature]
JUL 28 2015
[Handwritten signature]

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *7/28/15*

STATE FORM 8300 060J11 If continuation sheet 6 of 1



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTÉR – 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 208-334-6526
FAX 208-364-1888

July 2, 2015

Richard Davis, Administrator
Boise Group Home #4 Eshelman
P.O. Box 4243
Boise, ID 83711

Provider #13G042

Dear Mr. Davis:

An unannounced on-site complaint investigation was conducted from June 23, 2015 to June 26, 2015 at Boise Group Home #4 Eshelman. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007062

Allegation #1: Individuals sustain injuries from falls but the injuries are not reported accurately.

Findings #1: During the investigation staff interviews and record reviews were conducted.

Illness Reports and Injury Records, dated 9/11/14 - 6/1/15, were reviewed. All reports and records documented appropriate interventions were implemented when individuals sustained falls.

Interviews were conducted on 6/25/15 from 7:52 - 8:04 a.m. with 3 staff that worked both a.m. and p.m. shifts. All stated they were unaware of any individuals sustaining injuries that were not reported accurately.

It could not be determined staff were not reporting injuries inaccurately. Therefore, the allegation was unsubstantiated due to insufficient evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Richard Davis, Administrator
July 2, 2015
Page 2 of 4

Allegation #2: Staff sleep during their shift.

Findings #2: During the investigation staff was interviewed and video footage was reviewed.

Video footage from approximately 10:14 p.m. through 4:41 a.m. on 6/6/15 and 6/7/15, respectively, was reviewed with the following observations:

- At approximately 10:14 p.m., the night shift staff was observed to take an armful of laundry from the laundry room to the couch. She then placed it on the couch where only a small portion of the laundry was visible and sat down.
- At approximately 11:10 p.m., she was noted to get up and answer the phone. She then went back to the couch.
- At approximately 11:41 p.m. she was again noted to get up and go to the dining room and then back to the couch.
- At approximately 3:20 a.m. her bare feet were seen protruding from the laundry that was placed on the couch.
- At approximately 4:41 a.m. she was observed to get up from the couch.

When asked on 6/24/15 from 11:20 a.m. - 12:20 p.m. the Home Manager stated staff were allowed to sleep during the graveyard shift.

Although it was verified that an employee did sleep on the night shift the Home Manager stated night shift could sleep during the shift. Therefore, the allegation was unsubstantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Individuals do not go to the intended destination for outings, instead staff took individuals to their homes and smoked marijuana.

Findings #3: During the investigation staff interviews, observation and record reviews were conducted.

Interviews were conducted on 6/25/15 from 7:52 - 8:04 a.m. with 3 staff that worked both a.m. and p.m. shifts. All staff stated they were not aware of or heard of any staff not taking individuals to the intended outing destination.

Richard Davis, Administrator
July 2, 2015
Page 3 of 4

Community Integration Activities records from 1/13/15 through 6/23/15 were reviewed. Outings ranged from 15 minutes (walk around the neighborhood) to 3 hours (to circus) in length. Receipts for outings were reviewed and compared to the Community Integration Activities records and showed outings requiring purchase had corresponding receipts. However, outings such as walks in the park or feeding ducks could not be verified.

Another individual was observed leaving on 6/23/15 at 4:20 p.m. and returning from shopping at 5:02 p.m.

Additionally, an individual was noted to leave the facility on 6/23/15 at approximately 5:57 p.m. to go out for dinner. The following day the individual was able to state what he had for his dinner outing.

It could not be established that individuals were not going to their intended destinations on outings. Therefore the allegation was unsubstantiated due to lack of sufficient evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Staff use drugs.

Findings #4: During the investigation staff interview and record reviews were conducted.

On 6/23/15 from 2:15 -2:45 p.m. a QIDP (Qualified Intellectual Disabilities Professional) was interviewed and stated an employee at the facility had tested positive for marijuana. The QIDP then presented the surveyors with an undated document that contained the following information:

Two of the company's QIDPs interviewed a direct care staff from a different facility within the company. The direct care staff stated an employee of this facility smoked marijuana.

The document stated the accused employee had been drug tested on 6/10/15 and the results came back positive for marijuana. The document further stated the employee was given a written warning that the employee would be randomly retested within 30-45 days and any level of drug in their system would be cause for termination.

Although it was verified that an employee tested positive for marijuana, the facility had taken steps to rectify the situation. Therefore, the allegation was unsubstantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Richard Davis, Administrator
July 2, 2015
Page 4 of 4

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,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt