



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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September 16, 2015

Richard Davis, Administrator  
Boise Group Home #2 Molly Court  
P.O. Box 4243  
Boise, ID 83711

RE: Boise Group Home #2 Molly Court, Provider #13G018

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #2 Molly Court, which was conducted on September 11, 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  
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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 **September 29, 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.icfinr.dhw.idaho.gov](http://www.icfinr.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 September 29, 2015. If a request for informal dispute resolution is received after September 29, 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,

  
JIM TROUTFETTER  
Health Facility Surveyor  
Non-Long Term Care

  
NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

PRINTED: 09/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/11/2015
NAME OF PROVIDER OR SUPPLIER  BOISE GROUP HOME #2 MOLLY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 10244 MOLLY COURT BOISE, ID 83709	
(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 recertification survey conducted from 9/9/15 to 9/11/15.  The surveyor conducting your survey was:  Jim Troutfetter, QIDP  Common abbreviations used in this report are:  PRN - As needed	W 000	<p style="text-align: center;"><b>RECEIVED</b> OCT 14 2015 FACILITY STANDARDS</p> <p>The cabinet is now locked and key to the locked box is in the manager's office. This will ensure only trained staff have ready access to the Diastat. Program director will monitor by randomly checking cabinet. Completed 9/30/15</p>	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure outside services met the needs for 2 of 3 individuals (Individuals #1 and #3) who attended the facility's day program. This resulted in the potential for unauthorized individuals to have access to controlled drugs. The findings include:  1. Individual #1 and #3's records documented the need for Diastat (a controlled anticonvulsant drug for PRN seizure activity).  During an observation on 9/11/15 at 9:35 a.m., at the day program, the Workshop Supervisor was asked if their Diastat was present. The Workshop Supervisor then opened an unlocked cabinet that contained a locked box. On a shelf below the locked box was a plastic box that	W 120		

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

TITLE

(X6) DATE

*[Signature]*

Administrator

10/2/15

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  
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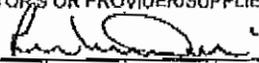
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #2 MOLLY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10244 MOLLY COURT BOISE, ID 83709</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	<p>Continued From page 1</p> <p>contained a key labeled "Diastat." The key opened the locked box that contained Individual #1 and #3's Diastat.</p> <p>When asked the Workshop Supervisor stated not all staff were certified to administer the drug and that the cabinet should have been locked.</p> <p>The facility failed to ensure the outside service ensured the Diastat was maintained under a double lock system and that only certified staff had access to the key.</p>	W 120			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/11/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #2 MOLLY COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10244 MOLLY COURT BOISE, ID 83709</b>
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M 000	16.03.11 Initial Comments  The following deficiency was cited during the state licensure survey conducted from 9/9/15 to 9/11/15.  The surveyor conducting your survey was:  Jim Troutfetter, QIDP	M 000		
MM080	16.03.11100 Governing Body and Management  The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer to W120.	MM080	refer to W120  <b>RECEIVED</b> <b>OCT 14 2015</b> <b>FACILITY STANDARDS</b>	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrative</i>	(X6) DATE <b>10/2/15</b>
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