



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T. – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 25, 2015

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

RE: Tomorrow's Hope - Navarro, Provider #13G061

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Navarro, which was conducted on September 24, 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  
September 25, 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 **October 8, 2015**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

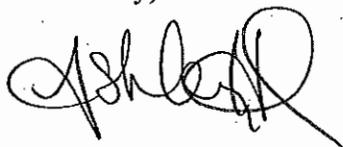
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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

This request must be received by October 8, 2015. If a request for informal dispute resolution is received after October 8, 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



**TOMORROW'S HOPE, INC.**  
1655 FAIRVIEW AVENUE, SUITE 100  
BOISE, ID 83702

PHONE: (208) 319-0760  
FAX: (208) 319-0765

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Nichole Wisenor, Co-supervisor  
Non-Long Term Care  
Bureau of Facility Standards  
PO Box 83720  
Boise, Idaho 83720-0009

RECEIVED  
OCT - 2 2015  
FACILITY STANDARDS

RE: Plan of Correction

October 1, 2015

Dear Ms. Wisenor,

Please find attached our plan of correction for deficiencies found during the recent survey of our Navarro home.

I believe all deficiencies have been address and corrected.

We consider the survey part of our QA process and appreciate the opportunity to improve.

Sincerely,

Thair Pond, Administrator

Cc: file, Navarro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TOMORROW'S HOPE - NAVARRO</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>946 NORTHWEST 12TH MERIDIAN, ID 83642</b>
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W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey conducted from 9/21/15 to 9/24/15.  The surveyors conducting your survey were:  Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP  Common abbreviations used in this report are:  ADHD - Attention Deficit Hyperactivity Disorder CAT - Computed Axial Tomography DCS - Direct Care Staff HRC - Human Rights Committee IPP - Individual Program Plan QIDP - Qualified Intellectual Disability Professional	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure guardians were provided with comprehensive information necessary to make informed decisions for 2 of 4 individuals (Individual #1 and #3) whose consents were reviewed. This	W 124		

**RECEIVED**  
**OCT - 2 2015**  
**FACILITY STANDARDS**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ther S. Bond</i>	TITLE <i>Admin</i>	(X6) DATE <i>10/21/15</i>
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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 124	<p>Continued From page 1</p> <p>resulted in insufficient information being provided to guardians on which to base consent decisions. The findings include:</p> <p>1. Individual #3's IPP, dated 2/27/15, documented a 21 year old male whose diagnoses included moderate mental retardation.</p> <p>Individual #3's record contained a Written Informed Consent, dated 7/22/15, which documented Individual #3 was scheduled for a CAT scan with oral sedation on 7/24/15. The consent documented risks included a possible "Adverse reaction to sedation." The consent was signed by the guardian on 7/22/15 and by the HRC on 7/24/15.</p> <p>Individual #3's record contained a physician's order, undated, for Valium (an anxiolytic drug) 10 mg prior to the CAT scan. Individual #3's 7/2015 Medication Flow Sheet documented Individual #3 received the 10 mg dose of Valium on 7/24/15 at 8:45 a.m.</p> <p>However, the consent did not contain information related to Valium, including possible side effects of the medication.</p> <p>When asked if the guardian or HRC had been informed of the medication to be used, the risks, etc., during an interview on 9/23/15 from 2:32 - 3:15 p.m., the QIDP stated the guardian was aware Valium was going to be used, but informed consent providing comprehensive information related to Valium had not been obtained.</p> <p>The facility failed to ensure informed consent was obtained for Individual #3's Valium use.</p>	W 124	<p>→ medication consent for individual #1 has been update with correct dose and guardians have been notified QIDP Responsible by 10/1/15</p> <p>→ all med consent and and medical procedures will be reviewed to ensure they have all need information to provide informed consent QIDP Responsible by 10/1/15</p> <p>→ Training with Nurse to ensure she includes if oral sedation is being use that the consent contains med / dose and side effects PD Responsible by 10/1/15</p> <p>→ Will update medical obtain informed consent SOP for medical procedures</p>	
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PD Responsible by 10/9/15

→ Training will Professionals Complete medication PSR ensuring they look at all information on PSR.  
PD Responsible By 10/9/15

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W 124	Continued From page 2 2. Individual #1's IPP, dated 11/6/14, documented a 15 year old male whose diagnoses included mild mental retardation.  Individual #1's record contained a Medication Consent, dated 10/9/14, for Strattera (an ADHD drug). The consent documented the Strattera was increased from 60 mg to 80 mg on 2/20/15. Further, Individual #1's Medication Flow Sheet, dated 3/2015, documented Individual #1 began receiving 100 mg of Strattera on 3/18/15. Individual #1's Physician's Orders, dated 9/2015 documented Individual #1 continued to receive the 100 mg dose.  However, Individual #1's record did not contain documentation of updated consent for the 100 mg dose of Strattera.  During an interview on 9/23/15 from 2:32 - 3:15 p.m., the QIDP stated updated consent for the increased dose had not been obtained.	W 124		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS  If the alleged violation is verified, appropriate corrective action must be taken.  This STANDARD is not met as evidenced by: Based on review of investigations and staff interview, it was determined the facility failed to ensure appropriate corrective action was taken in response to all investigations. That failure directly impacted 1 of 1 individual (Individual #8) who had been discharged, and had the potential to impact	W 157		

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W 157	<p>Continued From page 3</p> <p>all individuals (Individuals #1 - #7) residing in the facility. This resulted in a lack of sufficient corrective action being identified and implemented. The findings include:</p> <p>1. During the survey, 6 investigations for potential abuse, neglect, and mistreatment were reviewed. One investigation, dated 4/5/15, documented an allegation that DCS A had screamed at Individual #8. At the time of the survey, Individual #8 no longer resided at the facility.</p> <p>The documentation stated Individual #8 was exhibiting maladaptive behavior and was being physically aggressive towards DCS B and DCS C. DCS B and DCS C had implemented a standing restraint. Individual #8 dropped to the ground during the restraint, but kept kicking at the staff. DCS A, without being asked by DCS B or DCS C, left the individual she was working one-on-one with and implemented a prone restraint with Individual #8. After the restraint and once Individual #8 had begun to calm, he was looking for meal alternatives. DCS B and DCS C offered him options for meals. DCS A "screamed" at Individual #8, stating "I'm not the one eating and stop being a crybaby."</p> <p>The incident occurred on 4/5/15 at 5:45 p.m. However, the incident was not identified as potential abuse until the morning of 4/6/15 when the House Manager reviewed the behavior documentation. At that time, the House Manager reported the incident to the Administrator.</p> <p>The corrective action documented the facility would attempt to retrain DCS A in appropriate behavior management. During an interview on 9/21/15 at 10:52 a.m., the QIDP stated DCS A</p>	W 157		
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W 157	<p>Continued From page 4</p> <p>indicated she was implementing an emergency restraint. As a result, the facility addressed the incident as inappropriate behavior intervention and attempted to restrain DCS A. DCS A was placed on a "last chance" contract, but had ultimately been terminated from employment.</p> <p>However, three other staff (DCS B, DCS C, and DCS D) were present at the time of the incident. There was no documentation indicating corrective action related to the failure of the other staff present to intervene or report the incident had been addressed.</p> <p>During an interview on 9/21/15 at 10:52 a.m., both the House Manager and the QIDP stated they could not remember if the failure of the other three staff to intervene and report had been addressed, but would have training notes if it had.</p> <p>During a follow-up interview on 9/23/15 from 2:35 - 3:15 p.m., the QIDP stated there was no additional documentation related to the incident or retraining of staff on intervening or reporting.</p> <p>The facility failed to ensure appropriate corrective action for an investigation of abuse had been taken.</p>	W 157	<p>- all corrective action from JNA from 4/15/15 has been trained all staff on abuse Policy. QIDP responsible BY 10/1/15</p> <p>- all corrective actions from JNA &amp; investigations have been added to the monthly action list which is reviewed at monthly QA PD responsible by 9-1-15</p> <p>→ Investigation form and SOP have been update to ensure adequate information and follow through PD responsible by 10-1-15</p> <p>→ Corrective action and investigation follow through reviewed at monthly QA PD responsible by 10/1/15</p>	

Bureau of Facility Standards

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MERIDIAN, ID 83642**

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M 000	<p>16.03.11 Initial Comments.</p> <p>The following deficiencies were cited during the licensure survey conducted from 9/21/15 - 9/24/15.</p> <p>The surveyors conducting your survey were:</p> <p>Ashley Henscheid, QIDP, Team Lead Michael Case, LSW, QIDP</p>	M 000		
MM134	<p>16.03.11200 Client Protections</p> <p>The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W124 and W157.</p>	MM134	<p style="text-align: center;"><b>RECEIVED</b> OCT - 2 2015 <b>FACILITY STANDARDS</b></p> <p style="text-align: center;"><i>refer to W124 &amp; W157</i></p>	
MM215	<p>16.03.11711.01 Good Repair</p> <p>Each building used by the ICF/ID and its equipment must be in good repair.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 9/22/15 from 10:25 - 11:11 a.m. The facility maintenance person was present. During that time, the following was noted:</p>	MM215		

Bureau of Facility Standards

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

*Cher S. [Signature]*

*Adm [Signature]*

TITLE

*10/1/15*

(X6) DATE

Bureau of Facility Standards

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MM215

Continued From page 1

- There was a hole, approximately 2 inches by 3 inches, in the bottom left panel on the inside of the door to the bedroom shared by Individual #1 and Individual #5. Additionally, there was a crack, approximately 8 inches in length, running from the bottom of the hole toward the bottom of the door.
- The hinges on the cabinet doors under the sink in the hall bathroom were bent causing the doors to overlap and preventing them from closing properly.
- One of the two mounting bolts of the toilet in the hall bathroom was missing the bolt cover.
- The hinges on the cabinet doors under the sink in the bathroom off of the bedroom shared by Individual #2 and Individual #4 were bent causing the doors to overlap and preventing them from closing properly.

During the environmental review, the maintenance person stated the items needed to be repaired.

The facility failed to ensure environmental repairs were completed and maintained.

MM215

- all listed items will be repaired by the maintenance team  
Maintenance Responsible by 10/15/15

- HM will complete a monthly House maintenance ~~list~~ check and a weekly walk through - Noting needed items that are in need of repair and add to maintenance list  
HM responsible by 10/15/15

MM218

16.03.11711.01(c) Clean and Sanitary

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 and staff interview, it was determined the facility failed to ensure the building was kept clean and sanitary for 7 of 7

MM218

- PD to review all House maintenance PSK and weekly walkthrough and add needed repairs to action list  
PD responsible by 10/15/15

- PD to send a monthly maintenance list to maintenance  
PD responsible by 10/15/15

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MM218	<p>Continued From page 2</p> <p>individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment not being kept clean. The findings include:</p> <p>1. An environmental review was conducted at the facility on 9/22/15 from 10:25 - 11:11 a.m. The facility maintenance person was present. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- There was a brownish-yellow substance splattered on the wall and ceiling to the right of the window in the bedroom shared by Individual #1 and Individual #5.</li> <li>- There were dark stains on the center of the carpet in the bedroom shared by Individual #1 and Individual #5.</li> <li>- There were multiple reddish-brown spots on the living room ceiling near the dining area.</li> <li>- There was a black spot, approximately 6 inches by 2 inches, that appeared to have a fuzzy texture on the ceiling above the shower in the hall bathroom.</li> </ul> <p>During the environmental review, the maintenance person stated he did not know what the black spot or brownish-yellow spots were. He stated the carpet stain was ink, and the spots on the living room ceiling had been there for some time.</p> <p>The facility failed to maintain all surfaces in the facility in a clean and sanitary condition.</p>	MM218	<p>- all staff trained on sanitation and cleanliness HM responsible by 10/15/15</p> <p>→ House cleaning checklist to be update to include wipe up stains of floor, walls and ceiling HM responsible by 10/15/15</p> <p>→ update weekly walk through to include checking the walls and ceiling for stain's PD responsible by 10/15/15</p>	
MM263	<p>16.03.11712.08 Beds</p> <p>Each individual must be provided with his own</p>	MM263		

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MM263	Continued From page 3  bed that is thirty-six (36") inches wide or more, substantially constructed, and in good repair. Roll-away beds, cots, and folding beds cannot be used. Each individual's bed must be clean and:  This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure beds were maintained in good repair for 1 of 7 individuals (Individual #1) residing in the facility. This resulted in an individual's box-spring being in ill-repair. The findings include:  1. An environmental review was conducted at the facility on 9/22/15 from 10:25 - 11:11 a.m. The facility maintenance person was present. During that time, the following was noted:  Individual #1's box-spring was ripped on the bottom right corner, exposing the wood and top foam padding, and the springs were collapsed causing the bottom right corner of the bed to droop.  During the environmental review, the maintenance person stated the box-spring needed to be replaced.  The facility failed to ensure Individual #1's box-spring was in good repair.	MM263	⇒ Individual # 1 box spring will be replaced Hm Responsible by 10/15/15  ⇒ Bed's should be checked weekly with weekly walk through and monthly on House maintenance will train on doing a thorough review when completing walk through AD responsible by 10/15/15	
MM268	16.03.11712.10 Furnishings and Equipment  Each ICF/ID must have furniture and equipment that is maintained in a sanitary manner, kept in good repair, and is located to permit convenient use by its individuals.	MM268	Hm will add needed repair and new items to maintenance list. PD to add to action list	

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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
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MM268	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure furnishings were maintained in good repair for 5 of 7 individuals (Individuals #1, #2, #4, #5, and #7) residing in the facility. This resulted in individuals' dressers being in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 9/22/15 from 10:25 - 11:11 a.m. The facility maintenance person was present. During that time, the following was noted:</p> <ul style="list-style-type: none"> <li>- All 4 drawers of Individual #1's dresser fell forward and out of the dresser when opened.</li> <li>- The top 4 drawers in Individual #2's dresser fell forward and out of the dresser when opened.</li> <li>- All 4 drawers of Individual #4's dresser fell forward and out of the dresser when opened.</li> <li>- Eight of 9 drawer pulls on Individual #5's dresser were broken.</li> <li>- All of the drawers of Individual #7's dresser fell forward and out of the dresser when opened.</li> </ul> <p>During the environmental review, the maintenance person stated the dressers needed to be repaired.</p> <p>The facility failed to ensure individuals' dressers were maintained in good repair.</p>	MM268	<p><i>Dressers will be fixed or repaired.</i></p> <p><i>refer to m268 for further action</i></p>	
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