



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK -- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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October 9, 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 Fire Life Safety Survey, which was concluded at Tomorrow's Hope-- Eagle, on October 7, 2015.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health 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,

Thair Pond, Administrator
October 9, 2015
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5. Include dates when corrective action 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 22, 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:

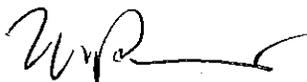
www.icfmr.dhw.idaho.gov

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 October 22, 2015. If a request for informal dispute resolution is received after October 22, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,



MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2015
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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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(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
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven ICF/ID beds with a census of six on the date of survey.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on October 6 and 7, 2015. The facility was surveyed under the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j).</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>RECEIVED OCT 21 2015 FACILITY STANDARDS</p> <p><i>Re: 404 Electrical work noted to be installed. Maintenance Supervisor responsible for install Home Manager to check for comprehensive survey w/ the bulk program + electrical at monthly GA Program Director 10/10/15</i></p>	
K0046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were in accordance with NFPA 70. Failure to ensure electrical systems are installed properly could result in fire by arcing or electrocution. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 7 ICF/ID beds and had a census of 7</p>	K0046		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Sam</i>	(X8) DATE <i>10/10/15</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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K0046	<p>Continued From page 1 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on October 7, 2015 from 11:00 AM to 12:30 PM, observation of the sprinkler riser area revealed an electrical outlet without a coverplate. When asked, caregiver staff indicated she was not aware of the missing cover.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or</p>	K0046		

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K0046	Continued From page 2 mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.	K0046		

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M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven ICF/ID beds with a census of six on the date of survey.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on October 6 and 7, 2015. The facility was surveyed under the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j) and IDAPA 16.03.11 Intermediate Care Facilities for People with Intellectual Disabilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	M 000		
MM169	<p>16.03.11700 Physical Environment</p> <p>The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA 's Life Safety Code and IDAPA 07.03.01, " Rules of Building Safety. "</p> <p>This Rule is not met as evidenced by: Please refer to Federal "K" tags</p>	MM169		

RECEIVED
OCT 21 2015
FACILITY STANDARDS

MM/169
R. J. ...

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

[Signature]

TITLE

[Signature]

(X6) DATE

[Signature]

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MM169	Continued From Page 1	MM169		
	K-046 Electrical installations			
MM332	16.03.11740.04 Portable Fire Extinguishers Each ICF/ID must have portable fire extinguishers installed throughout the facility in accordance with applicable provisions of NFPA Standard 10, " Portable Fire Extinguishers. " This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure that portable fire extinguishers were inspected monthly in accordance with NFPA 10. Failure to inspect fire extinguishers could result in equipment deficiencies going undetected and equipment not operating as designed during an emergency. This deficient practice affected all clients, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on October 7, 2015 from 11:00 AM to 12:30 PM, observation of the inspection tags located on 5 of 5 fire extinguisher tags had not been signed monthly indicating their inspection. When asked, the house manager stated she was not aware these extinguishers had not been signed demonstrating inspection, but was aware of the requirement to do so. Actual NFPA standard: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be	MM332 <i>MM332 House Manager to which fire extinguisher for telephone inspect extinguishers to be inspected by House Manager by 10/13/15 House Manager to inspect extinguishers at least monthly during inspections and monthly PA during monthly PA. House Manager to inspect weekly by 10/13/15</i>		

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MM332	Continued From Page 2 inspected at more frequent intervals when circumstances require. 4-3.4.2 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. 4-3.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or in an electronic system (e.g., bar coding) that provides a permanent record.	MM332		
MM340	16.03.11741.01(d) Drill Requirements The facility must hold unannounced evacuation drills at least quarterly for each shift of personnel for a total of no less than twelve (12) per year. The evacuation drills must be irregularly scheduled throughout all shifts and under varied conditions. At least one (1) drill per shift must be held on a Sunday or holiday. The facility must actually evacuate individuals during at least one (1) drill each year on each shift. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff performed evacuation drills for each shift, each quarter. Failure to conduct emergency evacuation drills would result in a lack of preparedness for emergencies. This deficient practice affected all clients, staff and visitors on the date of the survey. The facility is licensed for 7 ICF/ID beds and had a census of 7 on the day of the survey. Findings include: During review of the facility's emergency	MM340	<i>MM332 These evacuation drills to be done. Done by Hanson/Manager responsible</i> <i>These unannounced quarterly evacuation drills must be completed during monthly walk throughs</i> <i>Documentation of drills to be reviewed at Monthly QA.</i> <i>Program Director 10/15/15</i> <i>by 10/15/15</i>	

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MM340	Continued From Page 3 evacuation drills provided on October 7, 2015 from 11:00 AM to 11:45 AM, the facility failed to demonstrate a night shift drill having been conducted for the 1st and 3rd quarters of 2015. When asked about the missing drills, the house manager stated the facility had undergone staffing changes during these quarters and failed to perform the night shift drills. Actual IDAPA standard: IDAPA 16.03.11.741.01(d) The facility must hold unannounced evacuation drills at least quarterly for each shift of personnel for a total of no less than twelve (12) per year. The evacuation drills must be irregularly scheduled throughout all shifts and under varied conditions. At least one (1) drill per shift must be held on a Sunday or holiday. The facility must actually evacuate individuals during at least one (1) drill each year on each shift.	MM340		