



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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 9, 2015

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

RE: Tomorrow's Hope - Meridian, Provider #13G033

Dear Mr. Pond:

On October 7, 2015, a follow-up of your facility was conducted to verify corrections of deficiencies noted during the survey of August 27, 2015.

We were able to determine that the Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Client Protections (42 CFR 483.420)** and **Active Treatment Services (42 CFR 483.440)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed, along with a full ICF/ID license. This license is effective October 07, 2015 through December 31, 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;

Thair Pond, Administrator
October 9, 2015
Page 2 of 2

5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
6. Include date 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 21, 2015**, and keep a copy for your records.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

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 21, 2015. If a request for informal dispute resolution is received after October 21, 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 we can be of any help to you, please feel free to call us 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



TOMORROW'S HOPE, INC.

1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760

FAX: (208) 319-0765

Michael Case

Health Facility Surveyor

Non-Long Term Care

Bureau of Facility Standards

PO Box 83720

Boise, Idaho 83720-0009

RECEIVED

OCT 22 2015

DIV OF LIC & CERT

21 October 2015

RE: Plan of corrections for Meridian

Dear Mr. Case,

Please find attached the Plan of corrections for deficiencies found during your recent survey of our Meridian ICF/IDF.

I believe all deficiencies have been addressed and corrected as per our plan.

As always the survey process is part of our QA and we appreciate your observations

Sincerely,

Thair Pond

Administrator

Cc: file, Meridian

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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/07/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642	
(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 deficiencies were cited during the follow-up survey conducted from 10/5/15 to 10/7/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: DCS - Direct Care Staff IPP - Individual Program Plan LPN - Licensed Practical Nurse TC - Training Coordinator	{W 000}	RECEIVED OCT 22 2015 DIV OF LIC & CERT	
{W 214}	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments contained accurate information for 1 of 4 individuals (Individual #4) whose assessments were reviewed. This resulted in reinforcement options being based on incomplete information. The findings include: 1. Individual #4's 2/26/15 IPP stated she was a 36 year old female whose diagnoses included profound mental retardation and cerebral palsy. Individual #4's record included a Reinforcement Assessment and Inventory, dated 9/28/15, used	{W 214}		

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

Shirley Bond

TITLE

Administrative

(X6) DATE

10/15/15

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.

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{W 214}	Continued From page 1 to determine the most effective form of positive reinforcement to be used. The assessment included multiple categories and a space for the assessor to score "not at all," "a little," "a fair amount," "much," "very much," and "do not know." The following categories were scored "much" or "very much" on Individual #4's assessment: - Listening to music and the radio. - Food items, including cookies, chips and salsa, hot dogs, hamburgers, tacos, and pizza. - Beverages, including juice, vanilla milk, and lemonade. - Excursions, including car rides and shopping. - Visual simulation, including bright colors and lights. - White noise. - Massage and deep pressure. A summary at the end of the assessment asked what type of reinforcement system or delivery would work best, under which was documented "Social praise, pat on back, soft massage, quiet time in her room, radio, music, soothing sounds."	{W 214}	→ individual #4 reinforcement has been reviewed and update TC responsible by 10/30/15 → all reinforcemen schedules will be review and compared to their behavior plan to ensure a high reinforcing items/activities are being used to increase the adaptive behaviors QIDP responsible by 10/30/15		
	This information was transferred to Individual #4's behavior intervention programs as her primary reinforcement process. However, "being praised" and "being touched hugs/pats on back" were both marked "a little" in the assessment. Additionally, quiet time in her room was not part of the assessment tool. Individual #4's assessment did not include information as to why those items with a strong potential to be used as positive reinforcement, other than music, the radio, and white noise, were		→ Reinforcement assessment has been update with instruction regarding the use of the which reinforcement should be used and why the reinforcement was chosen PD responsible by 10/30/15		

→ Reinforcement assessment's will be review at least quarterly to ensure they are accurate and effective
PD responsible by 10/30/15

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{W 214}	Continued From page 2 not included in the recommendations. Additionally, the assessment did not explain why primary reinforcement methods included items that were found to be only "a little" reinforcing or were not assessed at all. During an interview on 10/7/15 from 9:25 - 10:15 a.m., the TC stated she and the Home Manager both worked on the assessment which may have impacted the recommendations. The TC stated the assessment needed to be revised. The facility failed to ensure Individual #4's reinforcement assessment included accurate summary information.	{W 214}			
W 381	Repeat deficiency. 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all controlled drugs were maintained under a double locked system for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in controlled substances being maintained under a single lock. The findings include: 1. During record review on 10/6/15 at 9:45 a.m., the LPN was observed to unlock and remove a single padlock from the bottom drawer of a two-drawer file cabinet located in the office. The drawer contained individuals' medications which	W 381			

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W 381	Continued From page 3 included, but were not limited to, the following: - One blister pack of Lorazepam (an anxiolytic drug) 2 mg - One blister pack of Tramadol (an analgesic drug) 50 mg The Nursing 2016 Drug Handbook stated both drugs were schedule IV controlled substances, which would require them to be under a double-lock system. During an interview on 10/7/15 from 9:25 - 10:15 a.m., the TC stated the drawer in the office was used as overflow drug storage and the absence of a double-lock system was due to an oversight. The facility failed to ensure all controlled substances were maintained under a double-lock system.	W 381	→ The controlled drugs were double locked TC responsible by 10/16/15 → when doing walk through HM will ensure all medication are stored properly HM responsible → HM walk through update include check the overflow grid's to ensure they are stored properly		
W 383	483.460(1)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area.	W 383	PD responsible by 10/15/15 → PD to review all HM walk throughs at the monthly OA meeting PD responsible by 10/15/15		
	This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure only authorized persons had access to the key to the drug storage area for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for unauthorized persons to access individuals' drugs. The findings include: 1. During record review on 10/6/15 at 9:45 a.m.,				

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W 383	Continued From page 4 the LPN was observed to take a key out of a candy tin located on top of a two-drawer file cabinet in the facility office. The LPN then used the key to unlock a padlock on the bottom drawer of the file cabinet. The drawer contained individuals' medications which included, but were not limited to, the following: - One blister pack of Lorazepam (an anxiolytic drug) 2 mg - One blister pack of Tramadol (an analgesic drug) 50 mg - Two 16 ounce bottles of valproic acid (an anticonvulsant drug) 250 mg/5 ml - One bottle levetiracetam (an anticonvulsant drug) 100 mg/ml The facility office was accessible through an exterior door on the side of the facility, as well as through the garage. Storage of the key to the drawer in a candy tin on top of the cabinet would allow anyone entering the office to have access to the key. During an interview on 10/7/15 from 9:25 - 10:15 a.m., the TC stated she believed only medication certified staff had knowledge of the drug storage in the office, but stated all staff had access to the office and the exterior door was never locked. The facility failed to ensure only authorized persons had access to the keys to the medication storage area.	W 383	→ the key to overflow med's was added to the med key TC responsible by 10/6/15 → training w/ HMITA/Nurse to ensure the overflow med. key goes on med. key ring and that the meds need to be properly stored QID → PD responsible by 10/30/15 → HM walk through updated to include checking the overflow med's and the overflow med keys. PD responsible by 10/30/15	
(W 454)	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.	(W 454)	HM to complete the HM walk through weekly and turned in to PD at the	

monthly QA for review.

PD responsible by 10/30/15

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{W 454}	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 7 of 7 individuals (Individuals #1 - #7) residing at the facility, and had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. Observations were conducted at the facility on 10/5/15. During those times, staff were not observed to implement appropriate infection control practices. Examples included, but were not limited to, the following: a. An observation was conducted on 10/5/15 from 2:50 - 4:15 p.m. During that time, the following was observed: At 3:25 p.m., DCS D walked with Individual #4 out of her bedroom. DCS D was carrying a plastic bag. DCS D walked with Individual #4 through the kitchen, around through the living room, then back through the kitchen before sitting Individual #4 at the table. DCS D then carried the plastic bag out to the garage. Upon returning from the garage, DCS D obtained chocolate milk and juice from the refrigerator, showed them to Individual #4 and asked which she wanted. DCS D then poured chocolate milk into a glass for Individual #4. DCS D was not observed to wash his hands. When asked during the observation, DCS D stated he had assisted Individual #4 with toileting,	{W 454}			

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{W 454}	<p>Continued From page 6 and stated the plastic bag contained a soiled incontinence brief which was disposed of in the garage.</p> <p>At 3:30 p.m., DCS E was observed to serve Individual #1 raw carrots with her bare hands. DCS E used her bare hands and a rocker knife to cut the carrots. DCS E was not observed to wash her hands.</p> <p>b. An observation was conducted on 10/5/15 from 5:20 - 6:45 p.m. During that time, the following was observed:</p> <p>At 5:35 p.m., DCS A was observed taking the temperature of the fish to be served for dinner. DCS A wiped her nose with her bare hand. She then borrowed a pen from a peer, which she dropped on the floor. She picked up the pen and documented the food temperature. DCS A removed her glasses, scratched her eye, then replaced her glasses.</p> <p>DCS A donned a pair of gloves and used a spatula and her gloved hand to transfer the cooked fish filets to plastic plates. DCS A was not observed to wash her hands prior to donning the gloves.</p> <p>Individual #4 was sitting in her wheelchair in the kitchen while DCS A was transferring the fish. Individual #4 began to place a blanket in her mouth. DCS A redirected Individual #4's hands down with her gloved hand. When Individual #4 began to move the blanket back towards her mouth, DCS A used her gloved hand to redirect the blanket down, placing her hand over the spot Individual #4 had placed in her mouth. DCS A continued to transfer fish with the same gloved</p>	{W 454}			

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{W 454}	Continued From page 7 hand. At 5:40 p.m., DCS A removed the her gloves and carried a sensory box out to the backyard. Upon returning to the kitchen, DCS A removed a bowl of mixed vegetables from the microwave and donned a pair of gloves. DCS A was not observed to wash her hands. DCS A used her gloved hand to push her glasses up, then used a measuring spoon and her gloved hand to scoop vegetables into a food processor. At 5:45 p.m., DCS A answered the phone and removed her gloves while speaking on the phone. DCS A wiped her nose and pushed her glasses up with her gloved hand. DCS A hung up the phone, wrote a note in the communication log, then scratched under her nose with her bare hand. DCS A returned to pureeing food, but was not observed to wash her hands. At 6:10 p.m., DCS A was observed to wash her hands, scratch under her nose, then don new gloves. DCS A then transferred rice to serving bowls.	{W 454}	→ Hm to train all staff on proper handwashing techniques, when to wash hands Hm responsible by 10/30/15 → Staff to be observed during Hm walk through to ensure they are follow proper infection control Hm responsible by 10/30/15 → Handwashing and infection control procedures will be posted as reminders Hm responsible by 10/30/15 → Infection Control be will be trained at least quarterly by Nurse or Hm Hm responsible by 10/30/15		
	At 6:15 p.m., DCS B walked with Individual #4 out of her bedroom through the living room to the kitchen. DCS B was carrying a plastic bag. DCS B asked if another staff could take Individual #4 so she didn't have to carry a soiled incontinence brief through the kitchen. DCS D then began assisting Individual #4. DCS B then walked through the living room towards the garage, but entered the kitchen from the other side to speak with DCS A. DCS B was still carrying the bag with the soiled incontinence				

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{W 454}	Continued From page 8 brief. At 6:35 p.m., Individual #3 dropped a serving of pureed fish. DCS A cleaned the dropped fish from the floor, donned gloves, and pureed more fish. DCS A was not observed to wash her hands. During the 1 hour and 25 minute observation, DCS were not observed to engage in appropriate hand washing and glove use practices. Additionally, DCS were observed to transport soiled attends into the kitchen when food was being prepared for service. During an interview on 10/7/15 from 9:25 - 10:15 a.m., the Home Manager stated staff should be washing their hands upon entering the facility, when coming in from outside, before meals, after toileting, and any time gloves were removed. The TC, who was present during the interview, stated soiled incontinence briefs should not be carried through the kitchen at any time. The facility failed to ensure appropriate infection control procedures were implemented.	{W 454}			
W 473	Repeat deficiency. 483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure food was served at an appropriate temperature for 7 of 7 individuals (Individual #1 - #7) observed during a	W 473			

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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83842
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W 473	<p>Continued From page 9</p> <p>meal. This resulted in foods not being served in a timely manner after removal from a heat source, and the potential for food-borne illness to occur. The findings include:</p> <p>1. An observation was conducted at the facility on 10/5/15 from 5:20 - 6:45 p.m. During that time, the evening meal process was observed. Foods were observed to be served in excess of 15 minutes after removal from a heat source, as follows:</p> <p>a. Frozen fish filets were observed to be cooked in the oven. At 5:35 p.m., DCS A was observed to check the temperature of the fish, after which she transferred the fish to 2 plastic plates and covered them loosely with foil. DCS A then placed the plates in the microwave. The microwave was not turned on.</p> <p>DCS did not start serving the fish to Individuals #1 - #7 until 6:25 p.m., 50 minutes after it was removed from a heat source. While serving, Individual #4's pureed fish was dropped on the floor. DCS A pureed more fish and heated the freshly pureed fish in the microwave prior to serving it to Individual #4.</p>	W 473	<p>→ all staff trained on food being served at appropriate temp (hot/cold) HM responsible by 10/30/15</p> <p>→ Staff will be post recording temps of meat daily on food temp charts. HM responsible by 10/30/15</p> <p>→ HM will do periodic observation to</p>	
	<p>b. At 5:40 p.m., DCS A removed a large plastic bowl with mixed vegetables from the microwave. The microwave was not noted to be on. DCS A measured a portion of vegetables into a food processor and added cold milk from the refrigerator. DCS A then pureed the vegetables and transferred them to a separate container. The pureed vegetables were covered and placed in the microwave. The microwave was not turned on.</p>		<p>ensure food is served at the correct temp HM responsible by 10/30/15</p> <p>→ food temp's will be resp posted on in</p>	

The menu Book and the Protocol for serving food PD responsible by 10/30/15

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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/07/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642		
(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 473	<p>Continued From page 10</p> <p>The plastic bowl with the remaining vegetables were loosely covered with foil and sat on the counter next to the stove until they were served, along with the pureed vegetables. DCS did not begin serving the vegetables to Individuals #2 - #7 until 6:25 p.m., 45 minutes after they were removed from the microwave. However, the Home Manager, who was present during the observation, reheated the vegetables in the microwave prior to serving them to Individual #1.</p> <p>c. DCS A cooked rice in an electric skillet. At 5:45 p.m., DCS A unplugged the skillet and began blending portions of rice with cold milk. Once the rice was pureed, it was transferred to individual serving dishes, covered, and placed in the microwave. The microwave was not turned on.</p> <p>The remaining rice was then transferred from the skillet to plastic serving dishes, covered loosely with foil, and placed on the counter next to the stove. DCS did not begin serving the rice to Individuals #1 - #7 until 6:25 p.m., 40 minutes after it was removed from the heat source.</p> <p>DCS were not observed to recheck the temperature of any of the food items. Additionally, with the exceptions of the vegetables for Individual #1 and the pureed fish for Individual #4, DCS were not observed to reheat any of the food items prior to serving.</p> <p>During an interview on 10/7/15 from 9:25 - 10:15 a.m., the TC and Home Manager both stated food should be served within 10 - 15 minutes of being removed from a heat source. The TC and the Home Manager both stated the food should not have been placed in the microwave if individuals were not ready to eat, but held in a hot</p>	W 473			

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W 473	Continued From page 11 oven or reheated before being served. The facility failed to ensure all food items were served promptly after being removed from a heat source.	W 473			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
TOMORROW'S HOPE - MERIDIAN

STREET ADDRESS, CITY, STATE, ZIP CODE
**1821 GREENHEAD
MERIDIAN, ID 83642**

(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)	(X6) COMPLETE DATE
{M 000}	16.03.11 Initial Comments The following deficiencies were cited during the follow-up survey conducted from 10/5/15 to 10/7/15. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: DCS - Direct Care Staff TC - Training Coordinator	{M 000}		
{MM159}	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W214.	{MM159}	REFER TO W214	
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W381 and W383.	MM166	REFER TO W381 AND W383	

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REFER TO W214

REFER TO W381 AND W383

Bureau of Facility Standards

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

Shen S. Bond Administrator

TITLE

(X6) DATE

10/22/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/07/2015
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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 GREENHEAD MERIDIAN, ID 83642
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{MM169}	Continued From page 1	{MM169}		
{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: Refer to W454.</p>	{MM169}	<p><i>refer to W454</i></p>	
MM187	<p>16.03.11703.01 Rodent and Pest Control</p> <p>Each ICF/ID must be maintained free from insects, rodents, vermin, and other pests.</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 environment was free from insects for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in an excessive amount of flies being present in the facility. The findings include:</p> <p>1. The facility's back door was equipped with a closing mechanism. However, the door closed very slowly causing the door to remain open for long periods of time.</p> <p>During observations on 10/5/15 and 10/6/15, excessive numbers of flies were observed to be present. Examples included, but were not limited to, the following:</p>	MM187		

Bureau of Facility Standards

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MM187	Continued From page 2 a. An observation was conducted on 10/5/15 from 5:20 - 6:45 p.m. During that time, the evening meal was being prepared and served. No fewer than 18 flies were observed in the kitchen area on the walls, ceiling, cabinets and counters. b. An observation was conducted on 10/6/15 from 4:55 - 5:40 p.m. During that time, the evening meal was being prepared and served. No fewer than 2 dozen flies were observed in the kitchen area on the walls, ceiling, cabinets and counters. During the observations, the flies were noted to continually land on the clean silverware and plates, as well as the food containers and food processor used for pureeing individuals' food. During an interview on 10/7/15 from 9:25 - 10:15 a.m., the TC and Home Manager both stated the flies had been particularly bad. The Home Manager stated the facility had purchased fly strips, but did not know if they could be used around the individuals. The Home Manager also stated DCS were afraid to kill the flies while observations were taking place. The facility failed to ensure the environment was free from insects.	MM187	→ the door to be adjusted so it closes better. Maintenance Responsible By 10/30/15 → a new Door Net to be put on in time of insect issue HM? Responsible by 10/30/15 → House maintenance to include the latching of door and full door's close properly PD responsible by 10/30/15	

→ House maintenance will be reviewed at monthly QA and all needed items added to action list. PD responsible by 10/30/15