



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

G.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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November 10, 2015

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

RE: Tomorrow's Hope - Nampa, Provider #13G080

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Nampa, which was conducted on November 3, 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  
November 10, 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 **November 23, 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:

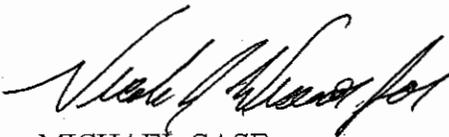
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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 November 23, 2015. If a request for informal dispute resolution is received after November 23, 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,



MICHAEL CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/pmt  
Enclosures

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

PRINTED: 11/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2015
NAME OF PROVIDER OR SUPPLIER  TOMORROW'S HOPE - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 EAST ARUBA NAMPA, ID 83686	
(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 recertification survey conducted from 11/3/15 to 11/4/15.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD	W 000		
W 481	483.480(c)(2) MENUS  Menus for food actually served must be kept on file for 30 days. This STANDARD Is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 6 of 8 individuals (Individuals #1 - #6), and had potential to impact 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include:  1. An observation was conducted at the facility on 11/3/15 from 6:30 - 7:30 a.m. During that time, individuals were observed eating breakfast. The menu consisted of one-half a bagel, 1 tablespoon of cream cheese or 1 teaspoon of margarine, 1 ounce of mozzarella cheese, 1 cup of apple slices, and 8 ounces of milk. However, the following food was observed to be eaten:  - Individual #1 was observed to eat cold cereal.  - Individual #2 was observed to eat scrambled eggs, an English muffin, and chocolate milk.	W 481	RECEIVED NOV 23 2015 FACILITY STANDARDS  - the meal chart was updated for any meal replacement. Hm responsible by 11/13/15  → the staff have been trained to ensure who is responsible to document meal changes. Kitchen staff responsible. Hm responsible for 11/13/15  → House manager to continue check w/ weekly walk through complete a PSR	

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

*John S. [Signature]*

*[Signature]*

Hm responsible by 11/13/15

TITLE

(X6) DATE

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.

→ Program Director will review

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W 481	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- Individual #3 was observed to eat one-half a bagel with nothing on it, scrambled eggs, and coffee.</li> <li>- Individual #4 was observed to eat 2 chipotle beef hot pockets.</li> <li>- Individual #5 was observed to eat scrambled eggs and chocolate milk.</li> <li>- Individual #6 was observed to eat an English muffin, scrambled eggs, and milk.</li> </ul> <p>During an environmental review on 11/3/15 from 8:45 - 9:25 a.m., a substitutions menu was observed to be hanging on the refrigerator. However, the menu was blank.</p> <p>During an interview on 11/3/15 at 10:30 a.m., the Home Manager stated staff were to document menu substitutions for each individual on the substitution menu. The Home Manager stated he had directed two direct care staff to fill in the substitutions for the morning meal, but confirmed the menu was blank. There was no additional documentation related to meal substitutions.</p> <p>The facility failed to ensure accurate documentation of food actually served was kept.</p>	W 481			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2015
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NAME OF PROVIDER OR SUPPLIER  
**TOMORROW'S HOPE - NAMPA**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2311 EAST ARUBA  
NAMPA, ID 83686**

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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the licensure survey conducted from 11/2/15 to 11/3/15.  The surveyors conducting your survey were:  Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD	M 000	<b>RECEIVED</b>  NOV 23 2015  FACILITY STANDARDS	
MM215	16.03.11711.01 Good Repair  Each building used by the ICF/ID and its equipment must be in good repair.  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 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include:  1. An environmental review was conducted at the facility on 11/3/15 from 8:45 - 9:25 a.m. The facility maintenance person and Home Manager were present. During that time, the following was noted:  - There was a break approximately 12 inches long running upwards from the bottom of the tub room door.  - Approximately 4 feet of metal corner edging was exposed on the wall to the left of Individual #5's closet. The wall to each side of the edging was patched for approximately 8 inches and was missing paint.	MM215	<i>All items have been added to the maintenance list. HM responsible by 11/30/15  → HM will ensure items are added to the maintenance list on a weekly basis when doing a walk through. HM responsible by 11/30/15  → the maintenance list will be reviewed at the monthly OA. HM responsible to turn in → item needing fix will</i>	

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*  
STATE FORM 6500

TITLE  
*be lister listing all need*  
11/24/15  
(X6) DATE  
If continuation sheet 1 of 3

*Items on PSR  
HM responsible by 11/30/15  
→ PD to review maintenance*

Bureau of Facility Standards

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MM215	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>- There was a patched section of wall to the left of Individual #5's sink, approximately 2 foot by 2 foot, that was missing paint.</li> <li>- The mirror in Individual #2's bathroom was missing, and there was a patched section of wall to the left of the toilet, approximately 1 foot by 8 inches, that was missing paint.</li> <li>- There was a patched section of wall to the right of the toilet in Individual #6's bathroom, approximately 1 foot by 1 foot, that was missing paint.</li> <li>- There were two patched sections of wall, one approximately 1 foot by 1 foot, and one approximately 8 inches by 6 inches, near Individual #6's bed that were missing paint.</li> <li>- There was a patched section of wall, approximately 10 inches by 10 inches, behind Individual #1's bedroom door that was missing paint.</li> <li>- The desk in the medication administration room was missing 2 of the 3 drawers, and the desk lamp was missing its shade.</li> <li>- The love seat and couch in the living room both had exposed staples along the backs with sharp edges exposed.</li> <li>- There was a rip, approximately 12 inches in length, on the bottom right side of the couch, and one approximately 8 inches in length on the back.</li> <li>- One of the kitchen drawers was missing.</li> </ul> <p>During the environmental review, the Home Manager stated the drawers in the medication</p>	MM215		

Bureau of Facility Standards

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MM215	Continued From page 2 administration room and kitchen were broken and were being repaired. The maintenance person, who was also present, stated repairs were ongoing.  The facility failed to ensure environmental repairs were completed and maintained.	MM215		
MM366	16.03.11800 Dietetic Services  The requirements of Sections 800 through 899 of these rules are modifications and additions to the requirements of 42 CFR 483.480 - 483.480(d)(5), Condition of Participation: Dietetic Services incorporated in Section 004 of these rules.  This Rule is not met as evidenced by: Refer W481.	MM366	<i>Refer to W481</i>	