



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 Eder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 7, 2015

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

RE: Tomorrow's Hope - Armga, Provider #13G014

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Armga, which was conducted on December 2, 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
December 7, 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 **December 21, 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 December 21, 2015. If a request for informal dispute resolution is received after December 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 you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures



TOMORROW'S HOPE, INC.

1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

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

Karen Marshall
Health Care Surveyor
Non-Long term Care
Bureau of Facility Standards
PO Box 83720
Boise, Idaho 83702

RECEIVED
DEC 22 2015
FACILITY STANDARDS

December 17, 2015

RE: Armga Survey

Dear MS Marshall

Please find attached our Plan of corrections for deficiencies found during your recent survey of our Armga ICF/ID.

We appreciated the opportunity to have your team survey us. It is part of our ongoing Quality Assurance program.

If you have any questions, please contact me at the above numbers.

Sincerely

Thair Pond

Administrator

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE 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 deficiencies were cited during the recertification survey conducted from 11/30/15 to 12/2/15. The surveyors conducting your survey were: Karen Marshall, MS, RD, LD, Team Lead Trish O'Hara, RN Common abbreviations used in this report are: IPP - Individual Program Plan MR - Mental Retardation QIDP - Qualified Intellectual Disabilities Professional	W 000			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review, 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. This directly impacted 1 of 7 individuals (Individual #4) observed during dining. This had the potential to provide opportunities for cross-contamination to occur and negatively impact the individual's health. The findings include: 1. Individual #4's 12/22/14 IPP stated he was a 28 year old male whose diagnoses included severe MR. His floor book instructed staff to	W 455		RECEIVED DEC 22 2015 FACILITY STANDARDS	

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

Chai S. Yone

TITLE

Administrator

(X6) DATE

12/17/15

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE 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 455	Continued From page 1 "ensure," when he was finished eating, that he took the black mat to the kitchen, wiped it down, and put it away. During an observation on 11/30/15 from 11:15 a.m. to 12:25 p.m., Individual #4 was observed eating his midday meal. At that time, his napkin, utensils, and plate of food from which he was eating, were located on the table on a large black upholstered mat measuring 5-inches in height, 20-inches wide, and 13-inches deep. Three corners of the mat were torn approximately 4-inches in length and not less than 1-inch wide exposing the tan sponge-type padding. There were no less than 9 tears on the area upon which the napkin, utensils, and plate of food were located. The tears were 1-2 inches in length. In addition, there were numerous white, brown, and grey areas of dried fluids and debris. When asked at 12:22 p.m., the home manager said that Individual #4 was to clean his mat after each meal. The home manager also said the mat needed to be cleaned. When asked about infection control procedures on 11/30/15 at 3:20 pm., the QIDP said the mat should have been cleaned after each meal and needed to be repaired. The facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases.	W 455	→ The mat has been cleaned. HM Responsible by 12/3/15 → All adaptive staff trained on proper infection control procedures to ensure that mats is cleaned after each meal. HM responsible by 12/10/15 → HM to have mat repaired to ensure there are no tears HM Responsible by 12/10/15 → HM to ensure checking all equipment when doing weekly walk through to ensure clean and good repair. HM Responsible by 12/10/15	
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by:	W 473		

→ Weekly walk throughs turned into Program Director for review at monthly QA meeting all needed repairs will be added to action list
PD Responsible by 12/10/15

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE 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 473	<p>Continued From page 2</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure food was served at an appropriate temperature. This directly impacted for 3 of 7 individuals (Individuals #2, #5 and #6) observed during an evening meal and had the potential to impact all individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for food-borne illness to occur. The findings include:</p> <p>An observation of the evening meal was done on 11/30/15 from 4:45 - 5:45 p.m. Two dining areas were used, one in the kitchen and one in the living room. Individuals #2, #5 and #6 were seated at the dining area in the living room.</p> <p>Two pans of chicken enchiladas were removed from the oven. One pan was glass and one was metal. The glass pan was placed on the table in the living room and staff and individuals were served portions of the enchiladas. Individual #5 began to eat and immediately announced "This chicken is half raw!"</p> <p>Staff immediately retrieved a thermometer from a kitchen drawer and measured the temperature of chicken pieces in both pans. The chicken in the glass pan was found to be 120 degrees. The chicken in the metal pan was found to be 180 degrees. The glass pan of chicken enchiladas was returned to the oven.</p> <p>Upon immediate interview, staff said she had removed both pans from the refrigerator and placed them in the oven to bake for "almost an hour." She also said she had checked the temperature of food in the metal pan, but not the temperature of food in the glass pan.</p>	W 473	<p>→ HM trained all staff to ensure the food temp is checked and what the proper temp should be and where to record the temp. HM Responsible by 12/10/15</p> <p>→ HM will review the temp logs to ensure they are being completed when doing weekly walk through HM Responsible by 12/10/15</p> <p>→ Kitchen zone will be trained they are responsible to temp foods HM Responsible by 12/10/15</p>		

→ HM to turn weekly walk throughs in at monthly Qx meeting to program Director when needed tasks added to action list.
PP Responsible by 12/10/15

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/02/2015
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE 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 473	<p>Continued From page 3</p> <p>However, the Food Temperature Log for the month of November was reviewed on 12/1/15 at 10:30 a.m. and did not show that any food temperatures had been taken prior to the evening meal being served the night before.</p> <p>Further, the log showed food temperatures were taken only eleven times in thirty days, at the evening meal. Two of the eleven temperatures recorded were below the recommended safe temperature.</p> <p>The facility failed to ensure food was served at a safe temperature.</p>	W 473			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA	STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE 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) COMPLETE DATE	
M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the state licensure survey conducted from 11/30/15 to 12/2/15.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD Team Lead Trish O'Hara, RN</p>	M 000	<p style="text-align: center;"><i>RECEIVED</i></p> <p style="text-align: center;"><i>DEC 22 2015</i></p> <p style="text-align: center;"><i>FACILITY STANDARDS</i></p>		
MM166	<p>16.03.11600 Health Care Services</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to W455.</p>	MM166		<p style="text-align: center;"><i>refer to W455</i></p>	
MM366	<p>16.03.11800 Dietetic Services</p> <p>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.</p> <p>This Rule is not met as evidenced by: Refer to W473.</p>	MM366			<p style="text-align: center;"><i>refer to W473</i></p>

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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

12/17/15