



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

January 27, 2016

Richard Davis, Administrator
Boise Group Home #7 Daniel
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #7 Daniel, Provider #13G055

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #7 Daniel, which was conducted on January 21, 2016.

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

Richard Davis, Administrator
January 27, 2016
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 **February 8, 2016**, 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.

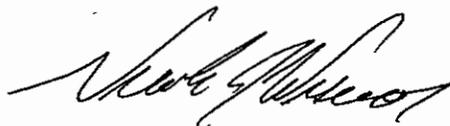
This request must be received by February 8, 2016. If a request for informal dispute resolution is received after February 8, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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,



JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures

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

PRINTED: 01/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #7 DANIEL			STREET ADDRESS, CITY, STATE, ZIP CODE 11879 WEST DANIEL ST BOISE, ID 83704	
(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 1/19/16 - 1/21/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP Common abbreviations used in this report are: QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 368	483.450(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to administer drugs as ordered by the physician for 1 of 3 individuals (Individual #4) observed to take medications. This resulted in an individual receiving a medication in a manner which was inconsistent with physician orders. The findings include: 1. Individual #4's record stated she was a 49 year old female whose diagnoses included profound intellectual disability. Individual #4's record included a physician's order, dated 11/13/15, which documented she was to receive Calcium Citrate/vitamin D (a supplemental drug) 600/400 mg three times a day.	W 368	<p style="text-align: center;">RECEIVED FEB 11 2016 FACILITY STANDARDS</p> <p>Corrective Action: The pharmacy did not have the dosage the Dr. ordered. SO made substitution. The nurse should have caught the change. She has been reprimanded for the error.</p> <p>Others Potentially Affected: Just individual #4.</p> <p>System Change: None</p> <p>Monitoring: Nurse will monitor monthly.</p> <p>Completion Date: Feb 8, 2016</p>	

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

TITLE

(X6) DATE

[Signature]

Administrator

2/11/16

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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NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #7 DANIEL			STREET ADDRESS, CITY, STATE, ZIP CODE 11879 WEST DANIEL ST BOISE, ID 83704	
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W 368	Continued From page 1 The blister packs containing Calcium Citrate/vitamin D for Individual #4 were checked on 1/21/16 at 11:55 a.m. and were confirmed to contain Calcium Citrate/vitamin D 315/250 mg, which did not match the physician's orders. The QIDP, who was present, also confirmed the discrepancy. Additionally, all three of the blister packs were noted to have had the Calcium Citrate/vitamin D supplement dispensed through 1/20/16. During an interview on 1/21/16 at 2:55 p.m., the nurse stated the pharmacy had been filling the the orders with the 315/250 mg dosage instead of the 600/400 mg dosage as ordered by the physician. She further stated they should have identified the error. The facility failed to ensure Individual #4's order for Calcium Citrate/vitamin D was administered without error.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 3 individuals (Individual #4) observed to take medications. This resulted in an individual's medication not being properly administered. The findings include:	W 369	<i>please refer to W368</i>	

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NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #7 DANIEL			STREET ADDRESS, CITY, STATE, ZIP CODE 11879 WEST DANIEL ST BOISE, ID 83704	
(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 369	Continued From page 2 1. Individual #4's record stated she was a 49 year old female whose diagnoses included profound intellectual disability. Individual #4's record included a physician's order, dated 11/13/15, which documented she was to receive Calcium Citrate/vitamin D (a supplemental drug) 600/400 mg three times a day. During observations on 1/19/16 from 4:01 - 4:10 p.m. and 7:05 - 7:15 p.m., Individual #4 was observed to receive Calcium Citrate/vitamin D 315/250 mg. During an interview on 1/21/16 at 2:55 p.m., the nurse stated the pharmacy had been filling the the orders with the 315/250 mg dosage instead of the 600/400 mg dosage as ordered by the physician. She further stated they should have identified the error. The facility failed to ensure Individual #4's Calcium Citrate/vitamin D was administered correctly.	W 369		

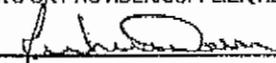
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #7 DANIEL	STREET ADDRESS, CITY, STATE, ZIP CODE 11879 WEST DANIEL ST BOISE, ID 83704
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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
M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 1/19/16 - 1/21/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP	M 000		
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 W368 and W369.	MM166	Please refer to W368	

RECEIVED
FEB 11 2016
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 2/11/16
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