



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, Idaho 83720-0009
PHONE: (208) 334-6626
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February 5, 2016

Richard Davis, Administrator
Boise Group Home #8 Delmar 2
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #8 Delmar 2, Provider #13G069

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #8 Delmar 2, which was conducted on February 4, 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;

Richard Davis, Administrator
February 5, 2016
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5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
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 18, 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

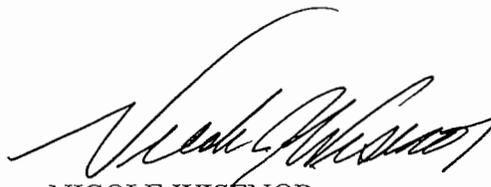
Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by February 18, 2016. If a request for informal dispute resolution is received after February 18, 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: 02/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2016
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #8 DELMAR 2			STREET ADDRESS, CITY, STATE, ZIP CODE 12495 WEST DELMAR STREET BOISE, ID 83713	
(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 deficiency was cited during the recertification survey conducted from 2/1/16 - 2/4/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP Common abbreviations used in this report are: CNA - Certified Nursing Assistant IPP - Individual Program Plan 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a guardian was provided with comprehensive information necessary to make informed decisions for 1 of 4 individuals (Individual #1) whose consents were reviewed. This resulted in insufficient information being provided to a guardian on which to base consent decisions. The findings include: 1. Individual #1's record documented a 45 year old female whose diagnoses included profound mental retardation.	W 000		
W 124	PROTECTION OF CLIENTS RIGHTS	W 124	<p>RECEIVED FEB 22 2016 FACILITY STANDARDS</p> <p>W124</p> <p>Corrective Actions: Individual #1's parents are active in her life. Mother visits 2-3 times a month. House manager probably discuss deferring Pap smear in past years. Our failure to contact her was just an oversight. Mother was called the day of survey.</p> <p>Individuals Affected: Yes, all women. See system change</p> <p>System Changes: Consent letter will be sent to parent/guardian prior to H&P.</p> <p>Monitoring: We will continue to keep parents informed by having secretary keep track of mailing and receipt of consent.</p> <p>Completion Date: February 22, 2016</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 2/18/16

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.

TIME RECEIVED February 22, 2016 10:27:33 AM MST REMOTE CSID 2083761869 DURATION 87 PAGES 3 STATUS Received

02/22/2016 10:27 2083761869 BGR

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** DHM INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/04/2016
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #8 DELMAR 2			STREET ADDRESS, CITY, STATE, ZIP CODE 12495 WEST DELMAR STREET BOISE, ID 83713		
(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 124	<p>Continued From page 1</p> <p>Her annual physical, dated 1/26/16, documented her last Pap smear had occurred 2/2012. However, the American Cancer Society recommends women 30 to 65 have Pap tests performed every 3 years.</p> <p>Her annual physical documented "- discontinue paps at this time, as pt [patient] has very low likelihood of cervical cancer, due to no history of being sexually active or of abuse in conjunction with the risks presented by need to sedate pt to perform pap."</p> <p>However, her record did not contained documentation that Individual #1's guardian had been informed of the benefits and risks of deferring the Pap smear for Individual #1.</p> <p>When asked on 2/4/16 at 10:08 a.m., the CNA stated she could not find documentation of informed consent related to the deferral of Individual #1's Pap smear.</p> <p>The facility failed to ensure the guardian was fully informed of the benefits and risks of deferring Individual #1's Pap smear.</p>	W 124			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/04/2016
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NAME OF PROVIDER OR SUPPLIER
BOISE GROUP HOME #8 DELMAR 2

STREET ADDRESS, CITY, STATE, ZIP CODE
**12495 WEST DELMAR STREET
BOISE, ID 83713**

(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 deficiency was cited during the licensure survey conducted from 2/1/16 - 2/4/16. The surveyor conducting your survey was: Jim Troutfetter, QIDP	M 000		
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W124.	MM134	Refer to W124	

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

[Signature]

TITLE

Administrator

(X8) DATE

2/18/16