



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

February 17, 2016

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

RE: Tomorrow's Hope - Eagle, Provider #13G047

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Eagle, which was conducted on February 12, 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

Thair Pond, Administrator
February 17, 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 29, 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 29, 2016. If a request for informal dispute resolution is received after February 29, 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 TROUFFETTER
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures



TOMORROW'S HOPE SATELLITE SERVICES, INC.

1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

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

Jim Troutfetter

Health Care Surveyor

Non-Long Term Care

Bureau Of facility Standards

3232 Elder

Boise, Idaho

Mar 1, 2016

RECEIVED

MAR - 1 2016

FACILITY STANDARDS

RE: Eagle Survey 2016

Dear Mr. Troutfetter,

Please find attached our plan of corrections for deficiencies found during your recent survey of our Eagle ICF/ID. I believe all deficiencies have been correct.

As always we appreciate your professionalism and ability to make this as little disruptive as possible for our residents. Surveys are an important part of our Quality Assurance program.

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

Sincerely,

Thair Pond

Administrator

Inc:

Cc: file, eagle

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2016
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616	
(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 2/8/16 - 2/12/16. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: IPP - Individual Program Plan PD - Program Director TC - Training Coordinator	W 000		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual's IPP included an objective to meet an identified need for 1 of 4 individuals (Individual #1) whose IPPs were reviewed. This resulted in a lack of program plans designed to address an individual's aggression. The findings include: Individual #1's IPP, dated 9/22/15, documented a 67 year old female whose diagnoses included profound intellectual disability. Her record contained a Functional Behavior Assessment, dated 2/8/16, which documented	W 227	RECEIVED MAR - 1 2016 FACILITY STANDARDS an objective for aggression was added to individual #1 IPP QIDP responsible by 2/16/16 all IPPs to be review to ensure all priority needs have an objective PD responsible by 2/15/16 Book review to be updated to ensure to check priority needs with objective PD responsible by 2/29/16 Quarterly Book Reviews will be	

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

Shari S. Ford

TITLE

Administrator

(X6) DATE

3/1/16

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.

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2016
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616		
(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 227	Continued From page 1 she engaged in aggressive behavior and instructed the reader to refer to her behavior management program. However, her record did not contain a behavior management program or an objective related to aggression. When asked during a follow up interview on 2/16/16 at 9:40 a.m., the PD stated Individual #1's IPP did not include an objective related to her aggressive behavior. The facility failed to ensure a specific objective for Individual #1's aggressive behavior was developed and implemented.	W 227	Quarterly Book Reviews will be completed to ensure all priority needs have an objective at the QA meeting PID Responsible By 3/15/16		
W 382	483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all biologicals were maintained under locked conditions, which had the potential to impact 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a biological. The findings include: On 2/11/16 at approximately 10:15 a.m., a tube of benzoyl peroxide (an anti acne drug) was noted to be sitting on the downstairs bathroom counter. The tube of benzoyl peroxide was also noted to	W 382	Book Reviews will be reviewed by Program Director and all needed items added to action List PID Responsible By 3/15/16		

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

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2016
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616		
(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 382	Continued From page 2 have a pharmacy label with Individual #5's name on it. When asked on 2/11/16 at 10:15 a.m., the TC stated the biological should have been locked up. The facility failed to ensure all biologicals were maintained under locked conditions.	W 382	the benzoyl peroxide tube was locked up HM responsible by 2/11/16 - training with all staff was completed to ensure prescription cream's & lotion's are locked up immediately after use HM responsible by 3/5/16 - Med Passer will ensure the prescription not given in the med area are returned to the med cupboard when done HM responsible by 3/5/16 - Half HR check to be updated to include cream's & lotion have been returned to med cupboard		

PD responsible by 3/5/16

- Nurse to check accountability sheets to ensure they are being filled out and to identify any needs
Nurse responsible by 3/5/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP-CODE 1057 RUSH ROAD EAGLE, ID 83616
--	--

(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 state licensure survey conducted from 2/8/16 - 2/12/16. The surveyors conducting your survey were: Jim Troutfetter, QIDP, Team Lead Karen Marshall, MS, RD, LD	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 W227.	MM159	<i>refer to W 227</i>	
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 W382.	MM166	<i>Refer to W 382</i>	

RECEIVED
MAR - 1 2016
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrative</i>	(X6) DATE <i>3/11/16</i>
---	--------------------------------	-----------------------------