



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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April 5, 2016

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

RE: Tomorrow's Hope - Sapphire, Provider #13G038

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Sapphire, which was conducted on March 23, 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  
April 5, 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 **April 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:

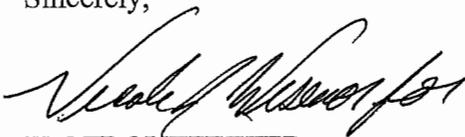
[www.icfmr.dhw.idaho.gov](http://www.icfmr.dhw.idaho.gov)

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

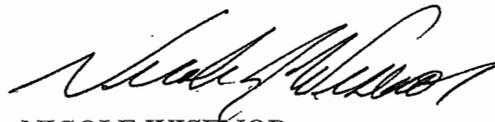
This request must be received by April 18, 2016. If a request for informal dispute resolution is received after April 18, 2016, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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 WISEÑOR  
Co-Supervisor  
Non-Long Term Care

JT/pmt  
Enclosures

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

PRINTED: 03/31/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/23/2016
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NAME OF PROVIDER OR SUPPLIER  TOMORROW'S HOPE - SAPPHIRE	STREET ADDRESS, CITY, STATE, ZIP CODE 2154 SAPPHIRE PLACE MERIDIAN, ID 83642
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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) COMPLETION DATE
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W 000	INITIAL COMMENTS  The following deficiency was cited during the recertification survey conducted from 3/21/16 to 3/23/16.  The surveyors conducting your survey were:  Jim Trouffetter, QIDP, Team Leader Karen Marshall, MS, RD, LD  Common abbreviations used in this report are:  DCS - Direct Care Staff IPP - Individual Program Plan LPN - Licensed Practical Nurse	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 6 individuals (Individual #3) and had the potential to impact 6 of 6 individuals residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact the individual's health. The findings include:  1. Individual #3's 4/28/15 IPP documented a 16 year old male whose diagnoses included severe intellectual disability.	W 455		

RECEIVED  
APR 15 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Adm</i>	(X6) DATE 4/15/16
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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: 03/31/2016  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/23/2016
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NAME OF PROVIDER OR SUPPLIER  TOMORROW'S HOPE - SAPPHIRE	STREET ADDRESS, CITY, STATE, ZIP CODE 2154 SAPPHIRE PLACE MERIDIAN, ID 83642
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W 455	Continued From page 1  During a medication pass observation on 3/22/16 from 6:20 - 6:30 a.m., Individual #4 was observed to take his medications. When Individual #4's medication pass was complete, Individual #3 entered the medication pass room and sat down. The DCS then proceeded to assist Individual #3 with his medications. At no time was the DCS noted to sanitize his hands or use gloves between passing medications.  When asked about infection control procedures on 3/22/16 at 8:40 a.m., the LPN stated the DCS should have sanitized his hands between medication passes.  2. During the environment review on 3/22/16 from 8:45 - 9:15 a.m., two pillows and a large foam pad with a black cover were observed in direct contact with the floor of the hallway linen closet. The Home Manager, who was present, removed the items off the floor and said the items should not be in direct contact with the floor.  The facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases.	W 455	- all staff trained on infection control - washing hands, sanitizing hands, no lines on floor. HM responsible 4-15-16  - HM to observe med passes 1-2x week to ensure staff are following hand washing and hand sanitizing protocol. HM responsible by 4-15-16  - will put a reminder to wash hands & sanitize hands before meds. between meds	
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			HM responsible by 4-15-16  - HM to complete walk through each week & it will include to observe infection control procedures are followed and lines are	
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NOT STATED ON PAGE  
HM responsible By 4-15-16

- Program director will review weekly ~~monthly~~ walk throughs at monthly QA with needed items added to action list  
PD responsible By 4-15-16

PRINTED: 03/24/2016  
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  03/23/2016
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NAME OF PROVIDER OR SUPPLIER  
**TOMORROW'S HOPE - SAPPHIRE**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2154 SAPPHIRE PLACE  
MERIDIAN, ID 83642**

(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 state licensure survey conducted from 3/21/16 to 3/23/16.  The surveyors conducting your survey were:  Jim Troutfetter, QIDP, Team Leader Karen Marshall, MS, RD, LD	M 000		
MM169	16.03.11700 Physical Environment  The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety."  This Rule is not met as evidenced by: Refer to W455.	MM169	Refer to W455	

**RECEIVED**  
APR 15 2016  
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

*[Signature]*

*[Signature]*

4/15/16