



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

August 8, 2016

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

RE: Boise Group Home #2 Molly Court, Provider #13G018

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #2 Molly Court, which was conducted on August 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;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

Richard Davis, Administrator
August 8, 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 **August 22, 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 August 22, 2016. If a request for informal dispute resolution is received after August 22, 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 the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care 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



IDAHO DEPARTMENT OF
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September 12, 2016

Richard Davis, Administrator
Boise Group Homes #2 Molly Court
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Homes – #2 Molly Court, Provider #13G018

Dear Mr. Davis:

We have received your plan of correction for the survey completed at Molly Court on August 4, 2016. After careful review, it has been determined that additional information is needed before your plan can be accepted. Please add the information, described below, to your plan of correction for W327 – Physician Services (42 CFR 483.460), and return it to our office by September 23, 2016.

The submitted PoC identified the completion date as 8/4/16. However, the date when Individual #1's TB test result was administered is not identified. Please indicate Individual #1's TB test date and modify the plan of correction completion date accordingly.

Please indicate what was put into place to ensure individuals who are new admissions will be screened to determine their TB status and the title of the person responsible for implementing the acceptable plan of correction.

Thank you, in advance, for your cooperation. If you have any questions, please do not hesitate to contact this office at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/pmt

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

FORM APPROVED
OMB NO. 0938-0391

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|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| (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 |
| | | | <p>Corrective action:</p> <p>Resident #1 received TB screening on 8/5/2016, 2 months after her admission date. We admit a new person every 2-3 years. Our new nurse has never been part of admission and T.B. screening information was not relayed to her. Our policy states that new admissions must have T.B. prior to admission.</p> <p>Other residents affected: Her T.B. screening was negative. No other resident affected.</p> <p>Systemic changes:</p> <p>Policy was in place, nurse made an error and now knows policy.</p> <p>Monitor:</p> <p>One time error.</p> <p>Completion date: August 8, 2016</p> <p>Person responsible for implementing: Director of medical services</p> <p style="text-align: right;">RECEIVED OCT - 4 2016 FACILITY STANDARDS</p> | |

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

10/2/16

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: 08/05/2016
FORM APPROVED
OMB NO. 0938-0391

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|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G018 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/04/2016 |
|--|--|--|--|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #2 MOLLY COURT | STREET ADDRESS, CITY, STATE, ZIP CODE 10244 MOLLY COURT 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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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|-------|--|-------|--|--|
| W 000 | INITIAL COMMENTS The following deficiency was cited during the recertification survey conducted from 8/2/16 - 8/4/16. The surveyor conducting your survey was: Karen Marshall, MS, RD, LD Common abbreviations used in this report are: CDC - Centers for Disease Control and Prevention CNA - Certified Nurse Aide IPP - Individual Program Plan LPN - Licensed Practical Nurse TB - Tuberculosis | W 000 | | |
| W 327 | 483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined that the facility failed to ensure that policies and procedures were in place to ensure individuals received TB screening upon admission to the facility. This directly impacted 1 of 1 individual (Individual #1) who was recently admitted to the facility. Without appropriate testing, it would not be possible for | W 327 | Corrective action: This omission was an error on part of nursing staff. We have never missed TB screening upon admission. Policy will be reviewed and updated. Other residents affected: All residents in the home. Systemic Changes: See corrective action Monitor: This was a 1x error. Completion date: 8/4/2016 | |

RECEIVED
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FACILITY STANDARDS

| | | |
|--|----------------------------|--------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 8/21/16 |
|--|----------------------------|--------------------------|

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

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|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #2 MOLLY COURT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 10244 MOLLY COURT 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 327 | <p>Continued From page 1</p> <p>the facility to take precautionary measures to prevent the spread of the communicable disease. The findings include:</p> <p>1. The CDC's website (www.cdc.gov) accessed on 8/4/16 stated some people develop TB disease soon after becoming infected (within weeks) before their immune system can fight the TB bacteria. Other people may get sick years later, when their immune system becomes weak for another reason. For people whose immune systems were weak, the risk of developing TB disease was much higher than people with normal immune systems.</p> <p>The CDC stated people can become exposed to TB when in contact with people who have the disease: family members, friends, neighbors, and people they spend time with every day. After exposure to the TB bacteria, the bacteria can live in the body without making a person sick. This is known as latent TB infection. People with latent TB infection may develop TB disease if they do not receive treatment for the latent TB infection.</p> <p>The CDC identified medical conditions that weaken the immune system, which included low body weight. The CDC also identified the body mass index (bmi) of a person who was 4 feet, 1 inch tall and weighed 51 pounds as 14.9 (less than 18.5 was an underweight range).</p> <p>Individual #1's 7/7/16 IPP documented she was a 50 year old female whose diagnoses included Cornelia de Lange syndrome and profound intellectual disability. She was admitted to the facility on 6/8/16.</p> <p>During an interview on 8/4/16 at 11:02 a.m.,</p> | W 327 | | | |

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| W 327 | <p>Continued From page 2</p> <p>Individual #1's Guardian stated prior to being admitted to the facility, Individual #1 had resided at two different home care settings within the past year. Additionally, Individual #1's record was reviewed. Her height was 4 feet 1 inch and her weight was 51 pounds.</p> <p>Both residing at other care facilities and her low body weight increased Individual #1's risk of exposure to the TB disease and inability of her immune system to fight the TB bacteria.</p> <p>However, there was no documentation of her TB status. Further, the facility's policies and procedures for screening new clients for TB was reviewed. The policies and procedures did not include screening new clients for TB.</p> <p>When asked, during an interview on 8/3/16 at 1:45 p.m., the facility's CNA stated Individual #1's TB status had not been assessed. The facility's LPN, who was present during the interview, stated Individual #1 was going to her physician that afternoon and the LPN would speak with the physician regarding a TB screening.</p> <p>During a follow-up interview on 8/4/16 at 10:25 a.m., the facility's CNA stated Individual #1 received a TB skin test and her physician would assess her skin in 3 days. The CNA also stated the facility's policies and procedures did not include screening new clients for TB.</p> <p>The facility failed to ensure policies and procedures were developed and implemented to ensure individuals received TB screening upon admission to the facility.</p> | W 327 | | | |

Bureau of Facility Standards

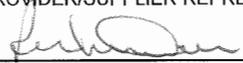
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| M 000 | 16.03.11 Initial Comments The following deficiency was cited during the state licensure survey conducted from 8/2/16 - 8/4/16. The surveyor conducting your survey was: Karen Marshall, MS, RD, LD | M 000 | | |
| MM166 | 16.03.11600 Health 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 W327. | MM166 | see W327 | |

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FACILITY STANDARDS

| | | |
|---|---------------|-----------|
| Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|  | Administrator | 8/21/16 |