



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

March 28, 2014

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 March 26, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid 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; and,
5. Include dates when corrective action 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

Richard Davis, Administrator  
March 28, 2014  
Page 2 of 2

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 10, 2014**, 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 10, 2014. If a request for informal dispute resolution is received after April 10, 2014, 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.

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

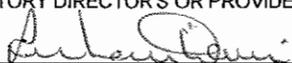
PRINTED: 03/27/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  03/26/2014
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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
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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 3/24/14 - 3/26/14.  The survey was conducted by: Jim Troutfetter, QIDP, Team Leader Michael Case, LSW, QIDP  Common abbreviations used in this report are:  QIDP - Qualified Intellectual Disability Professional	W 000		
W 426	483.470(d)(3) CLIENT BATHROOMS  The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.  This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 1 of 1 individual (Individual #1) who was unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include:  1. An environmental review was conducted on 3/25/14 from 8:15 - 8:55 a.m. During that time, water temperatures were as follows:  Hall bathroom - 115.2 degrees Fahrenheit	W 426	The administrator will have plumber install mixing valve and set temp. at 110°. The valve allow a more accurate water temp setting than the water tank setting. The manager will monitor temps daily until repair is completed.  5/1/14	RECEIVED APR 10 2014 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin.	(X6) DATE 4/9/14
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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: 04/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G069</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #8 DELMAR 2</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>12495 WEST DELMAR STREET BOISE, ID 83713</b>	
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W 426	<p>Continued From page 1</p> <p>Back bathroom - 116.9 degrees Fahrenheit</p> <p>The QIDP was present during the environmental review and was notified of the high water temperatures. The QIDP stated Individual #1 was the only individual who could turn on the water independently. All other individuals required staff assistance to turn on the water. Staff regulated water temperatures for those individuals. The QIDP stated Individual #1 was not able to adjust water temperatures independently and did not have a program to teach him to do so.</p> <p>The facility failed to ensure water temperatures were maintained at 110 degrees Fahrenheit or below for Individual #1.</p> <p>Note: Water temperatures were re-checked on 3/26/14 at 10:20 a.m. and found to be within an acceptable range.</p>	W 426		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #8 DELMAR 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>12495 WEST DELMAR STREET BOISE, ID 83713</b>
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M 000	<p>16.03.11 Initial Comments</p> <p>Boise Group Homes #8 - Delmar 2 is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)" for the annual licensure survey conducted from 3/24/14 to 3/26/14.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Michael Case, LSW, QIDP</p>	M 000		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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