



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 208-364-4888

June 23, 2014

Richard Davis, Administrator  
Boise Group Home #3 Holt  
P.O. Box 4243  
Boise, ID 83711

RE: Boise Group Home #3 Holt, Provider #13G034

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #3 Holt, which was conducted on June 19, 2014.

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  
June 20, 2014  
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 **July 3, 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 July 3, 2014. If a request for informal dispute resolution is received after July 3, 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,



KAREN MARSHALL  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

KM/pmt  
Enclosures

September 4, 2014

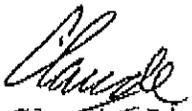
Michael Case  
Health Facility Surveyor  
Non-Long Term Care  
Bureau of Facility Standards  
3232 Elder Street  
PO Box 83720  
Boise, Idaho 83720

Michael:

Per your request for additional information regarding corrective action at the Holt home and follow up conversations with you and Nicole:

To insure that all appointments are completed in a timely manner and as recommended by individual service providers the facility employs an appointment calendar as well as an ongoing appointment list for each individual. The person who attends an appointment is responsible for entering new appointments on this list and notifying the Medical Coordinator of these appointments. The Medical Coordinator will review this list on a monthly basis to insure that new appointments have been noted appropriately. The Medical Coordinator will also review the medical record for each person on an annual basis as part of his/her annual staffing to identify and double check the completion or scheduling of appointments to insure that consultant recommendations are completed.

Please contact me if you have further questions.



Claude Pickett  
Program Director  
Boise Group HOMes

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SEP 04 2014

FACILITY STANDARDS

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

PRINTED: 08/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/19/2014
NAME OF PROVIDER OR SUPPLIER  BOISE GROUP HOME #3 HOLT			STREET ADDRESS, CITY, STATE, ZIP CODE 9874 WEST HOLT STREET BOISE, ID 83704	
(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 6/16/14 to 6/19/14.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD Team Lead Michael Case, LSW, QIDP  Common abbreviations used in this report are:  H&P - History and Physical IPP - Individual Program Plan	W 000		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.  This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure vision and hearing exams were completed for 1 of 3 individuals (Individual #3) whose records were reviewed. This resulted in the potential for an individual's vision and hearing difficulties to go undetected. The findings include:  1. Individual #3's IPP, dated 9/24/13, documented a 41 year old male with diagnoses including profound intellectual disability and Trisomy 17 Syndrome.  a. Record review showed Individual #3's most recent vision exam occurred on 7/13/10, he had	W 323	It is the facility's intent to insure that appropriate physical examinations including an evaluation of vision be provided for each individual. Until recently Medicaid has not been paying for any vision related services unless there is currently a disease process existing in the eyes. As a result the facility has been relying on the person's physician to provide an exam and follow the health of the person's eyes. Recently Medicaid has determined that vision exams will be paid for and an appointment has been scheduled for the identified individual. In addition each person's record has been reviewed to insure that evaluations are current and provide an accurate description of each person's needs. Any person needing further services will have appropriate appointments scheduled.  By Whom: Medical Coordinator, Nurse Consultant, QIDP Completion Date: July 1, 2014	

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JUL 14 2014  
FACILITY STANDARDS

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

TITLE

(X6) DATE

*Claudia Pickett*

*Program Director*

7-13-14

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: 07/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #3 HOLT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9874 WEST HOLT STREET BOISE, ID 83704</b>		
(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 323	<p>Continued From page 1 glasses, and a recommendation for follow-up in approximately 3 years.</p> <p>During observations on 6/16/14 at from 3:30 to 4:15 p.m. and from 5:25 to 6:12 p.m., and on 6/17/14 from 6:15 to 8:22 a.m., Individual #3 was observed to wear glasses.</p> <p>b. Individual #3's most recent hearing exam occurred on 4/9/09 with a recommendation for retest in 3 years.</p> <p>Record review also showed Individual #3's most recent H&amp;P, dated 10/1/13, documented they were unable to test his vision and hearing as he was non-verbal.</p> <p>In an interview on 6/19/14 from 2:15 - 3:00 p.m., the facility's Medical Coordinator confirmed the hearing and vision exams were not performed as recommended for Individual #3.</p> <p>The facility failed to ensure Individual #3 received recommended vision and hearing exams.</p>	W 323			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/19/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #3 HOLT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9874 WEST HOLT STREET BOISE, ID 83704</b>
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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the annual licensing survey conducted from 6/16/14 to 6/19/14.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD Team Lead Michael Case, LSW, QIDP</p>	M 000		
MM749	<p>16.03.11.270.02(d)(i) Examination of Vision and Hearing</p> <p>Examination of vision and hearing; and This Rule is not met as evidenced by: Refer to W323.</p>	MM749	<p>MM749</p> <p>Please refer to W323</p>	

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FACILITY STANDARDS

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

*Claude Poter*

TITLE

*Program Director*

(X5) DATE

*7-13-14*