



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

September 15, 2014

Richard Davis, Administrator
Boise Group Home #4 Eshelman
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #4 Eshelman, Provider #13G042

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey of Boise Group Home #4 Eshelman, which was conducted on September 10, 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
September 15, 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 **September 28, 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

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 September 28, 2014. If a request for informal dispute resolution is received after September 28, 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: 09/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #4 ESHELMAN	STREET ADDRESS, CITY, STATE, ZIP CODE 9917 WEST ESHELMAN BOISE, ID 83704
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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 deficiencies were cited during the recertification survey conducted from 9/8/14 to 9/10/14. The survey was conducted by: Jim Troutfetter, QIDP Common abbreviations used in this report are: IED - Intermittent Explosive Disorder IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional SIB - Self Injurious Behavior	W 000	<p>RECEIVED</p> <p>SEP 26 2014</p> <p>FACILITY STANDARDS</p>	
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #2) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug	W 312		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/24/14
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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.

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W 312	Continued From page 1 without a plan that identified the drug's usage and how it may change in relation to progress or regression. The findings include: 1. Individual #2's IPP, dated 9/25/13, documented a 39 year old male whose diagnoses included severe mental retardation, IED, and SIB. Individual #2's record contained Physician's Orders, dated 1/1/14, documenting he received Zoloft (an antidepressant drug) 75 mg. His Medication Reduction Plan, dated 9/25/13, documented a reduction in Zoloft would be considered after the use of Risperdal (an antipsychotic drug) was discontinued. His record also contained a Nursing Summary, dated 9/25/13, that documented Individual #2's Risperdal had been discontinued on 3/14/13. However, his record did not contain a medication reduction plan for the use of Zoloft. When asked during an interview on 9/10/14 from 11:05 - 11:50 a.m., the QIDP stated Individual #2 did not have a medication reduction plan for Zoloft.	W 312	The reduction plan was completed on 9/18/14. Current practice is to review medication reduction plan at annual treatment plan date. Policy will change to review all medications used to control inappropriate behavior twice a year during our medication review with our psychiatrist. Effective immediately, responsible staff is Program Director/QIDP.	
W 369	The facility failed to ensure Individual #2's had a medication reduction plan for the use of Zoloft. 483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

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W 369	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without error for 1 of 3 individuals (Individual #4) observed to take medications. This resulted in an individual receiving the incorrect dosage of fish oil. The findings include:</p> <p>1. Individual #4's record documented a 55 year old male whose diagnoses included severe mental retardation.</p> <p>Individual #4's record contained a Physician's Orders, dated 5/1/14 which documented he was to receive 2 capsules of fish oil (a supplemental drug) 1200 mg daily.</p> <p>However, during an observation on 9/9/14 from 7:35 - 7:52 a.m., the direct care staff assisting with medications was observed to assist Individual #4 in taking two fish oil capsules from a container labeled 1000 mg.</p> <p>When asked during an interview on 9/9/14 at 11:45 a.m., the LPN stated he should have received 2 capsules of fish oil at 1200 mg each.</p> <p>The facility failed to ensure Individual #4's fish oil was accurately administered.</p>	W 369	<p>Staff are taught to compare doctor orders with label on medication bottle and blister pack. Staff failed to follow procedure. House manager will increase med pass observation/training for new staff to 6 times a month for 3 months and thereafter for all staff 2 times a month. Start date is 10/1/14, responsible staff is house manager.</p>		

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing survey conducted from 9/8/14 to 9/10/14. The survey was conducted by: Jim Troutfetter, QIDP	M 000		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	REFER TO W312 PER PROGRAM DIRECTOR By Jim Troutfetter 9-29-14	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted at the facility on 9/9/14 from 9:00 - 9:25 a.m. During	MM380	Repairs will be completed by 10/6/14. The damage was reported, but administration was waiting to replace all door and drawer fronts and counter tops at the end of the year. Complete kitchen update by 12/15/14, responsible staff Administrator	

RECEIVED
SEP 26 2014
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jim Troutfetter</i>	TITLE Administrator	(X6) DATE 9/24/14
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Bureau of Facility Standards

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MM380	Continued From page 1 that time, the following was noted: - The upper drawer to the right of the dishwasher was missing. - There was a cutting board missing above the drawers at the end of the kitchen counter. The facility failed to ensure the environment was kept clean and repairs were completed and maintained.	MM380		
MM759	16.03.11.27.02(f)(v) Medication Error Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W369.	MM759	REFER TO W369 PER PROGRAM DIRECTOR By <i>Jain</i> 9-29-14	