



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 24, 2014

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

RE: Tomorrow's Hope - Deb, Provider #13G083

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Deb, which was conducted on September 18, 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

Thair Pond, Administrator
September 24, 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 **October 5, 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:

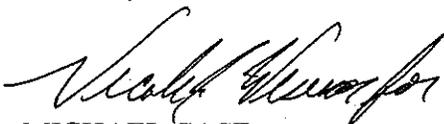
www.icfmr.dhw.idaho.gov

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 October 5, 2014. If a request for informal dispute resolution is received after October 5, 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,



MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/pmt
Enclosures



TOMORROW'S HOPE, INC.
1655 FAIRVIEW AVENUE, SUITE 100
BOISE, ID 83702

PHONE: (208) 319-0760
FAX: (208) 319-0765

Michael Case
Health Facility Surveyor
Non-long term Care
Bureau of Facility Standards
PO Box 83720
Boise, ID83720-0009

RECEIVED
OCT - 7 2014
FACILITY STANDARDS

October 6, 2014

RE: Statement of Corrections

Dear Mr. Case,

Please find our Statement of Corrections for deficiencies found during your recent survey of our Deb Facility.

I believe all deficiencies have been addressed.

Sincerely,

Thair Pond

Administrator

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OCT - 7 2014

PRINTED: 09/22/2014
FORM APPROVED
OMB NO. 0938-0391

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

FACILITY STANDARDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - DEB			STREET ADDRESS, CITY, STATE, ZIP CODE 3038 NORTH MERIDIAN ROAD MERIDIAN, ID 83646	
(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	W 000		
W 381	<p>The following deficiencies were cited during the recertification survey conducted from 9/15/14 to 9/18/14.</p> <p>The surveyors conducting your survey were:</p> <p>Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>LPN - Licensed Practical Nurse 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all controlled drugs were maintained under a double locked system for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in control substances being maintained under a single lock. The findings include:</p> <p>1. The facility's medication storage process utilized a cabinet with two separate keyed locks on the door to maintain a double lock system for controlled drugs. During an environmental review on 9/16/14 from 1:10 - 1:45 p.m., it was noted that only one of the two locks was engaged.</p> <p>The cabinet contained the following controlled drugs:</p>	W 381	<p>Cabinet was double locked when noted.</p> <p>→ All Staff trained on keeping both locks - locked at all times Nurse responsible by 10/1/14</p> <p>→ will add ensuring both locks are locked on the 1/2 hr med check Leadwork to check at end of each shift Leadworker Responsible by 10/1/14</p> <p>→ Will add the med cabinet's are double locked on the AM walk through - completed weekly HM Responsible by 10/1/14</p> <p>→ Program Director to review the weekly walk throughs at monthly QA PD responsible by 10/1/14</p>	

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

TITLE

(X6) DATE

10/6/14

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.

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W 381	Continued From page 1	W 381			
W 382	<p>- Individual #2's Vyvanse (a schedule II stimulant drug);</p> <p>- Individual #4's Diazepam (a schedule IV anxiolytic drug); and</p> <p>- Individual #6's Vyvanse (a schedule II stimulant drug), and Ritalin (a schedule II stimulant drug).</p> <p>The LPN, who was present during the environmental review, stated the cabinet should always be double locked.</p> <p>The facility failed to ensure all controlled drugs were maintained under a double lock system. 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include:</p> <p>1. An observation was conducted at the facility on 9/16/14 from 6:00 - 8:10 a.m. During that time, individuals were observed to be assisted with medication administration programs.</p> <p>At 7:45 a.m., Individual #6 entered the medication</p>	W 382	<p>→ Staff trained on the correct disposal of medication Nurse Responsible by 10/1/14</p> <p>→ will update the disposal policy and train all staff Nurse Responsible by 10/1/14</p> <p>→ Disposal of med policy will be posted in med room Nurse responsible by 10/1/14</p>		

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W 382	Continued From page 2	W 382			
W 481	<p>administration area. As part of his morning medication regimen, he received GummieVite (a supplemental drug), two tablets. During the observation, one of the pills dropped on the floor. The direct care staff working with Individual #6 re-dose the drug, then used a glove to pick up the dropped pill and throw it in the garbage.</p> <p>When asked during the observation, the direct care staff assisting Individual #6 with his medication administration program stated for any dropped pill, the staff was supposed to use a glove to pick up the drugs and either throw it in the garbage or store it in the medication cabinet for the nurse to dispose of at a later time. When asked how staff differentiated between which drugs could go in the garbage and which had to be saved for the nurse, the direct care staff stated things like vitamins were okay to put in the garbage, but "heavier" drugs would be held in the medication cabinet.</p> <p>During an interview on 9/16/14 at 1:35 p.m., the LPN stated all dropped drugs needed to be packaged in a plastic bag or glove, labeled, and stored in the medication cabinet for disposal by a nurse. The LPN stated no drugs should be thrown in the garbage.</p> <p>On 9/16/14 at 1:40 p.m., Individual #6's dropped GummieVite was found to still be in the garbage can in the medication administration area. The drug was removed from the garbage can and given to the LPN.</p> <p>The facility failed to ensure all medications were maintained under locked conditions.</p>	W 481			

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W.481	Continued From page 3 Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a record of food served was kept for 30 days, which directly impacted 1 of 6 individuals (Individual #3) residing at the facility and had the potential to impact all individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for individuals to not receive an adequate variety of food. The findings include: 1. A meal observation was conducted at the facility on 9/15/14 from 4:45 - 6:00 p.m. The facility's menu was reviewed and documented the meal was to consist of the following: - 1 cup Alfredo - 2 ounces chicken - 3/4 cup tossed salad - 1 slice french bread However, the following was observed: - At 5:50 p.m., Individual #3 was noted to refuse his dinner. Individual #3 and a direct care staff then went to the refrigerator in the pantry and got a rice and meat mixture which was heated up and served to Individual #3. - At 5:58 p.m. Individual #3 and a direct care staff were again noted to go to the refrigerator to get a second bowl of the rice meat mixture. On 9/16/14, the meal substitutions form was reviewed and contained no documentation of the two servings of rice and meat that had been	W.481	→ all staff trained on appropriate substitution and the documentation of the substitution HM Responsible by 10/15/14 → PQ will develop and individualized meal tracking form for Individual #3 and post on fridge PQ responsible by 10/15/14 → HM to monitor weekly the meal substitution when completing weekly walk through → HM Responsible by 10/15/14 → PD to review weekly walk through at monthly QA PD responsible by 10/15/14		

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W.481	Continued From page 4	W.481			
	<p>substituted for the main menu items for Individual #3.</p> <p>When asked on 9/16/14 at 1:03 p.m., the Home Manager stated the rice and meat substitutions for Individual #3 had not been documented but should have been.</p> <p>The facility failed to ensure accurate documentation of meals actually served was kept.</p>				

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments	M 000		
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	<p>The following deficiencies were cited during the licensure survey conducted from 9/15/14 to 9/18/14.</p> <p>The surveyors conducting your survey were:</p> <p>Michael Case, LSW, QIDP, Team Lead Jim Trouffetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>PQ - Para-Qualified Intellectual Disabilities Professional</p>			
MM269	<p>16.03.11.100.04 Insect and Rodent Control</p> <p>Insect and Rodent Control. The facility must be maintained free from insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, used, and stored in the following manner:</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain areas to ensure they were free from insects for 2 of 6 individuals (Individuals #1 and #6). The findings include:</p> <p>1. During an environmental observation on 9/16/14 from 1:15 - 1:40 p.m., it was noted there were no screens on the bedroom windows for the following bedrooms:</p> <ul style="list-style-type: none"> - The bedroom window of individuals #1 and #6 did not have a screen. - The bedroom window of the empty bedroom was missing the screen on the small window. 	MM269		

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		10/6/14

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments	M 000		
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MM269	<p>16.03.11.100.04 Insect and Rodent Control</p> <p>Insect and Rodent Control. The facility must be maintained free from insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, used, and stored in the following manner:</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to maintain areas to ensure they were free from insects for 2 of 6 individuals (Individuals #1 and #6). The findings include:</p> <p>1. During an environmental observation on 9/16/14 from 1:15 - 1:40 p.m., it was noted there were no screens on the bedroom windows for the following bedrooms:</p> <ul style="list-style-type: none"> - The bedroom window of individuals #1 and #6 did not have a screen. - The bedroom window of the empty bedroom was missing the screen on the small window. 	MM269	<p style="text-align: center;">RECEIVED OCT 09 2014</p> <p style="text-align: center;">FACILITY STANDARDS</p> <p>- Screens replaced and put into windows maintenance responsible by 10/5/14</p> <p>→ HM will check on weekly walk through that all windows screens are in place. HM responsible for 10/5/14</p> <p>→ PD will review weekly walk through a</p>	

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

monthly QA to ensure (X6) DATE
Screens are in place

PD responsible By 10/5/14

Bureau of Facility Standards

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MM269	Continued From page 1	MM269		
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MM271	<p>The facility failed to be maintained in such a way as to prevent insects from entering.</p> <p>16.03.11.100.04(b) Storage of Toxic Chemicals</p> <p>All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic chemicals were kept locked for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in toxic chemicals being unlocked and accessible. The findings include:</p> <p>1. The facility housed 6 individuals ranging in age from 9 - 20 years old. During an observation on 9/16/17 at 6:05 am, the following chemicals were found in an unlocked cabinet in the laundry room:</p> <ul style="list-style-type: none"> - 1 bottle of Great Value disinfectant spray - 2 bottles of Scrib-Free with bleach - 1 bottle of Lysol Power and Free bathroom cleaner - 1 bottle of Great Value glass cleaner - 1 bottle of Awesome window cleaner - 1 bottle Glass Plus glass cleaner - 1 bottle of Essential streak free glass cleaner - 1 bottle of Fabreze - 1 bottle of Glad carpet and room deodorizer <p>The above items were labeled "Keep out of reach of children."</p> <ul style="list-style-type: none"> - 2 bottles of The Works toilet bowl cleaner - 1 bottle of Great Value all purpose cleaner with bleach 	MM271	<p>The cabinets & chemicals were locked HM responsible By 9/20/14</p> <p>all staff re-trained on keeping chemicals locked at all times HM responsible By 10/1/14</p> <p>HM will check to ensure the chemicals are locked up on the weekly PSR HM responsible By 10/1/14</p>	
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→ Program Director to review weekly HM walk throughs at monthly QA PD responsible by 10/1/14

Bureau of Facility Standards

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MM271	Continued From page 2	MM271		
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MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>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.</p> <p>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 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. An environmental review was conducted at the facility on 9/16/14 from 1:15 - 1:40 p.m. During</p>	MM380	<p>all items added to the maintenance list and to be repaired by 10/30/14 maintenance responsible.</p>	
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Bureau of Facility Standards

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MM380	Continued From page 3 that time, the following was noted: - The top drawer of Individual #4's dresser was missing. - The stove door was broken and held on by a latch. - The bottom interior of the oven had burned food on it. - The top drawer to the right of the stove was missing the handle. - The light switch cover in Individual #1's room was broken. - The dining room table was missing a leg on the south west corner. - The faucet handle was missing on the exterior faucet by the mechanical room. - The faucet handle was missing on the exterior faucet by the gate to the backyard. - There was a broken cover on the wall socket by the west exit. - There was a drawer missing on the kitchen island across from Individual #1's bedroom. - There was a drawer missing on the kitchen island across from Individual #4's bedroom. - There was an 5 inch by 4 inch section of wall to the right of the shower that was missing texture and paint. - The veneer at the bottom of the doors in both	MM380		
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Bureau of Facility Standards

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3038 NORTH MERIDIAN ROAD
MERIDIAN, ID 83646

(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
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MM380	Continued From page 4	MM380		
MM696	<p>the tub room and the shower room was peeling and cracking.</p> <p>- The ceiling exhaust fans in both the tub room and the shower room were covered with a thick layer of dust.</p> <p>The facility failed to ensure the environment was kept clean and repairs were completed and maintained.</p> <p>16.03.11.250.09(d)(i) Refrigerator and Freezer</p> <p>Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each refrigerator was equipped with a reliable, easily read thermometer for 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential for food to be stored under unsafe conditions. The findings include:</p> <p>1. An environmental review was conducted at the facility on 9/16/14 from 1:15 - 1:40 p.m. During that time, the refrigerator in the kitchen was noted to be without a thermometer.</p> <p>The Home Manager, who was present during the environmental review, stated the refrigerator should have had a thermometer and stated it would be replaced.</p> <p>The facility failed to ensure the kitchen</p>	MM696	<p>→ thermometer replaced in the fridge HM responsible by 9/19/14</p> <p>→ check fridge thermometer's will be added to the HM weekly walk through HM responsible by 10/1/14</p> <p>→ PD will review weekly walk through's at monthly QA and note any problems and add to action list.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/18/2014
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - DEB		STREET ADDRESS, CITY, STATE, ZIP CODE 3038 NORTH MERIDIAN ROAD MERIDIAN, ID 83646		
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MM696	Continued From page 5	MM696		
MM753	refrigerator was equipped with a thermometer. 16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W381 and W382.	MM753	<i>Refer to W381 and W382</i>	