



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 - Lavin
1655 Fairview Ave, Suite 100
Boise, ID 83702

RE: Tomorrow's Hope - Lavin, Provider #13G082

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Lavin, 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 6, 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:

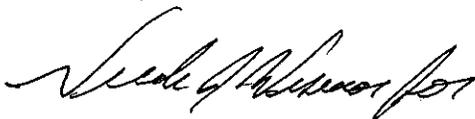
www.icfmr.dhw.idaho.gov

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 6, 2014. If a request for informal dispute resolution is received after October 6, 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,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures



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

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

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

RECEIVED
OCT - 6 2014
FACILITY STANDARDS

October 6, 2014

RE: Statement of Corrections

Dear Ms. Henscheid,

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

I believe all deficiencies have been addressed.

Sincerely,

Thair Pond

Administrator

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

PRINTED: 09/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - LAVIN	STREET ADDRESS, CITY, STATE, ZIP CODE 3034 NORTH MERIDIAN ROAD MERIDIAN, ID 83646
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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	W 000	Pen and Ink change:	
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W 218	<p>The following deficiencies were cited during the annual recertification survey and complaint investigation conducted from 9/15/14 to 9/18/14.</p> <p>The survey was conducted by:</p> <p>Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <p>Common abbreviations used in this report are:</p> <p>ENT - Ear, Nose and Throat IPP - Individual Program Plan PQIDP - Para-Qualified Intellectual Disabilities Professional</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include sensorimotor development.</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 sensorimotor assessments were updated as needed and contained comprehensive information for 1 of 4 individuals (Individual #4) whose assessments were reviewed. This resulted in an individual not receiving appropriate services consistent with his sensorimotor needs. The findings include:</p> <p>1. Individual #4's IPP, dated 6/6/14, documented he was a 34 year old male whose diagnoses included profound mental retardation and osteopenia.</p>	W 218	<p>Please see last 2 pages for additional plan of correction information. Per Program Director. on 10-29-14. <i>[Signature]</i></p> <p>RECEIVED OCT - 6 2014 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE 10/6/14
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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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 218

Continued From page 1

W 218

Individual #4's Physical Therapy Evaluation, dated 1/24/13, documented "Gait: He continues to be off balance and paraprofessionals have to hold him up by the gait belt as he went around the home leaning forward. When he was sitting and wanted something across the room he did move across the room without assist, but it did not appear very safe...He walks with short steps and weight shifted forward. [Individual #4] has no protective stepping response." The evaluation additionally documented "The paraprofessionals keep a gait belt on him at all times."

However, during observations on 9/15/14 and 9/16/14 for a cumulative 5 hours and 10 minutes, Individual #4 was not observed with a gait belt. Further, during an observation on 9/15/14 from 3:15 - 4:00 p.m., Individual #4 was noted to walk to the kitchen from the east living room. Two staff assisted Individual #4, supporting him on either side.

Additionally, Individual #4's record repeatedly noted Individual #4's difficulty with ambulation. Examples included, but were not limited to, the following:

- A Psychological Evaluation, dated 5/28/14, documented "[Individual #4] is less steady walking and sitting. He was moved to [facility name] in September 2013 because of its open floor plan. Although [Individual #4] can walk, he collapses if he encounters any piece of furniture."

- Individual #4's Fall Protocol, dated 6/6/14, documented "[Individual #4] appears to walk on his toes and has a forward posture. At times he appears to be top heavy. [Individual #4] does have instances in which he falls, and needs to be

→ will get a new referral for an update PT evaluation regarding individual #4 gait.

Nurse Responsible by 10/15/14

→ All professionals trained when doing book review and look over evaluation they look over the whole evaluation not just recommendation

PD responsible by 10/15/14.

→ all evaluations are reviewed at least quarterly with a book review filed out to ensure all need treatments and recommendations are in place

PD responsible by 10/15/14

→ all Book reviews are reviewed

by PD to ensure filled out and all needed items are added to the action list.

PD responsible by 10/15/14

→ Action list reviewed monthly to ensure needed items are addressed PD. Responsible by 10/15/14

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W 218	Continued From page 2	W 218			
	<p>monitored."</p> <p>- An Incident/Accident Report, dated 7/11/14, included a handwritten note in the Professional Staff section, written by the PQIDP and dated 7/14/14. The note documented "[Individual #4's] gait is unsteady working on obtaining apt w/ENT. Has fall protocol will review."</p> <p>- A pharmacist review, dated 7/15/14, documented "Really struggling with balance [illegible] unbalanced gait."</p> <p>- Individual #4's program for helmet use, dated 9/15/14, documented "[Individual #4] has a balance issue and can be unsteady on his feet; he will trip over his feet and will fall if even brushing up against objects. [Individual #4] has fallen recently causing injury to his head."</p> <p>However, Individual #4's record did not contain evidence that he had been re-evaluated by the physical therapist in relation to his balance struggles.</p> <p>During an interview on 9/18/14 from 8:02 - 8:40 a.m., the PQIDP stated Individual #4 was not admitted with a gait belt and she could not locate documentation related to the discontinuation of the equipment. The PQIDP stated the physical therapist had not been made aware of the change in gait belt use or balance issues as the 1/24/13 assessment was the most current.</p> <p>The facility failed to ensure Individual #4's Physical Therapy Evaluation contained updated, accurate information.</p>				

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments	M 000		
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MM380	<p>The following deficiencies were cited during the annual licensure survey and complaint investigation conducted from 9/15/14 to 9/18/14.</p> <p>The survey was conducted by:</p> <p>Ashley Henscheid, QIDP, Team Lead Karen Marshall, MS, RD, LD</p> <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 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include:</p> <p>1. On 9/16/14 from 3:00 - 3:30 p.m., an environmental review was conducted with the home manager. During that time, the following was noted:</p> <ul style="list-style-type: none"> - Individual #8's bedroom had a strong, urine-like odor. - There were drip marks from an unknown substance dried on the wall behind Individual #8's bed. 	MM380	<p><i>all need maintenance items have been added to the maintenance list and given to the maintenance man to be addressed</i></p> <p><i>Maintenance responsible</i></p> <p><i>By 10/30/14</i></p> <p>RECEIVED</p> <p>OCT - 6 2014</p> <p>FACILITY STANDARDS</p>	
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Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrative* (X6) DATE *10/6/14*

Bureau of Facility Standards

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MM380	Continued From page 1	MM380		
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	<ul style="list-style-type: none"> - The light, furthest from the door, in Individual #2 and Individual #5's bedroom would not turn on. - At the foot of Individual #5's bed was a cabinet which was used for clothing storage. The doors were improperly aligned, causing the left door to hang down and overlap the right door. - The bottom five drawers of Individual #6's dresser were missing stops on the backs to prevent the drawers from falling out when opened. - The paint on Individual #4's dresser was chipping off. - The west living room carpet had multiple stains of various sizes. - The recliner in the west living room had multiple stains of various sizes. <p>The facility failed to ensure environmental repairs were maintained.</p>			
MM724	<p>16.03.11.270.01(a) Assesments</p> <p>As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W218.</p>	MM724	<p><i>Refer to W218</i></p>	

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

TITLE

(X6) DATE

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.

Bureau of Facility Standards

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

STATE FORM 6899 6899 6899
Per ink changes: 6899 6899 6899
If continuation sheet 1 of 2

Per Program Director on 10/29/14 [Signature]

→ Program Director Reviews (by 10/31/14)
the weekly walk throughs and the monthly house maintenance PSR. all needed items added to the action list. Reviewed at monthly QA. PD responsible



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 24, 2014

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

RE: Tomorrow's Hope - Lavin, Provider #13G082

Dear Mr. Pond:

On **September 18, 2014**, a complaint survey was conducted at Tomorrow's Hope - Lavin. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006605

Allegation: Individuals are not provided with needed medical care.

Findings: An unannounced on-site investigation survey was conducted from 9/15/14 to 9/18/14. During that time record reviews, observations, and interviews were completed with the following results:

The facility utilized an "Infection Control" form, completed by the nurse supervisor, to document infections acquired by both individuals who resided at the facility and direct care staff who provided care for the individuals.

The Infection Control form, dated 2/1/14 - 8/4/14, documented standardized information related to staff and individual infections within the facility. Examples included, but were not limited to the following:

- On 4/24/14 three individuals were diagnosed with scabies by a physician.
- The other 5 individuals at the facility were treated for potential exposure to scabies.

Thair Pond, Administrator

September 24, 2014

Page 2 of 3

- The facility direct care staff were treated for potential exposure with Ivermectin (an oral antiparasitic agent).
- Furniture and carpets were vacuumed, and bedding, towels, and clothing were all laundered according to the recommendations from the Central Health District Epidemiologist.
- On 5/30/14, a direct care staff was diagnosed and treated for scabies
- On 6/13/14, a direct care staff had possible scabies and was treated for scabies.
- On 6/13/14, a direct care staff was suspect of, and treated for, scabies.
- On 7/27/14, a direct care staff reported she had scabies.
- On 8/1/14, two individuals were diagnosed with, and treated for, scabies.
- On 8/4/14, a different individual was provided preventive treatment for scabies exposure.
- On 8/5/14, two other individuals were provided preventive treatments for scabies exposure.

An interview was conducted with the Para-Qualified Intellectual Disabilities Professional (PQIDP) and the nurse supervisor on 9/17/14 from 2:40 - 3:05 p.m. Both the PQIDP and the nurse supervisor stated that on 4/24/14 the facility had 3 individuals diagnosed with scabies. Also on 4/24/14, two different direct care staff reported, that approximately one week prior, they each had been to a doctor and both were diagnosed with scabies. However, when the two staff were originally diagnosed with scabies, they did not report this to the PQIDP or the nurse supervisor. The PQIDP stated the two direct care staff were removed from working in the facility and were told they could not return to work until their physician released them to return to work. Both the PQIDP and nurse supervisor said all physicians were notified and all direct care staff were provided with medication for potential exposure to scabies. After 4/24/14, those staff who were diagnosed with scabies were removed from working at the facility and were also told they could not return to work until their physician released them to return to work.

During the same interview, the nurse supervisor said she contacted the Central District Health Epidemiologist and asked for assistance to ensure all scabies infection control measures were covered.

Training Notes, dated 11/1/13 - 9/17/14, were reviewed. The Notes documented facility staff were routinely trained related to standard infection control procedures.

Four individuals were selected for review. Each individual's record documented the individuals received appropriate medical care for their needs.

The survey team conducted observations of individuals who live at the facility on 9/15/14 from 3:15 - 5:45 p.m. and on 9/16/14 from 7:00 - 10:05 a.m., 12:10 - 12:45 p.m., and 1:00 - 2:10 p.m. During these observations, the direct care staff were observed to follow standard infection control procedures and concerns related to unaddressed health needs or issues were not identified.

Thair Pond, Administrator
September 24, 2014
Page 3 of 3

It could not be established that the facility did not provide needed medical care. Therefore, due to a lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



ASHLEY HENSCHIED
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt