



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T. – Chief
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October 28, 2014

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

RE: Tomorrow's Hope - Eagle, Provider #13G047

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Tomorrow's Hope - Eagle, on October 17, 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; 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

Thair Pond, Administrator
October 28, 2014
Page 2 of 2

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 **November 9, 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:

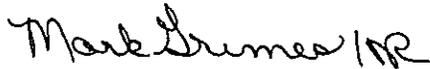
www.icfmr.dhw.idaho.gov

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 November 9, 2014. If a request for informal dispute resolution is received after November 9, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,



MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/pmt

Enclosure

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

Printed: 10/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2014
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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - EAGLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD EAGLE, ID 83616
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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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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven ICF/ID beds with a census of six on the date of survey.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on October 17, 2014. The facility was surveyed under the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j).</p> <p>The annual survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor</p> <p>Mark Grimes, Supervisor Facility Fire Safety & Construction</p>	K 000		
K0012	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>IMPRACTICAL Buildings are of any construction type in accordance with 8.2.1 other than Type II (000), Type III (200), or Type V (000) construction. 33.2.1.3.3.</p> <p>Exception: Buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5 are permitted to be of any type of construction.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility</p>	K0012		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Supervisor	(X6) DATE 11/06/14
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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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K0012	<p>Continued From page 1</p> <p>failed to assure that all smoke partitions would provide protection against passage of smoke between smoke compartments. This deficient practice affected staff and approximately six clients. The facility has the capacity for seven beds with a census of six the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 17, 2014 at approximately 10:00 a.m., it was observed that the basement pantry storage room was missing the ceiling that would allow the free passage of smoke in the event of a fire. Interview with the facility Maintenance Supervisor revealed the facility was unaware of the open penetration.</p> <p>2.) During the facility tour on October 17, 2014 at approximately 10:00 a.m., it was observed that the basement pantry around the smoke detector had a 1 " circular ceiling penetration that would allow the passage of smoke in the event of a fire. Interview with the facility Maintenance Supervisor revealed the facility was unaware of the open penetration.</p> <p>3) During the facility tour on October 17, 2014 at approximately 10:00 a.m., it was observed that the basement storage closet near the office room had a 3' x 5' ceiling penetration that would allow the passage of smoke in the event of a fire. Interview with the facility Maintenance Supervisor revealed the facility was aware of the open penetration.</p> <p>The findings were acknowledged by the Administrator at the exit interview on October 17, 2014</p> <p>Actual NFPA Standards:</p>	K0012	<p><i>K0012</i></p> <p><i>All missing ceiling structures and openings will be corrected to comply. Items missed at previous surveys, but will comply.</i></p> <p><i>House Manager to check for compliance weekly during House Maintenance check.</i></p> <p><i>Checks to be monitored during monthly QA</i></p> <p><i>House Manager + Maintenance Supervisor responsible by 12/04/14</i></p>	

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

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K0012	Continued From page 2 NFPA 101, 8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception*: Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum.	K0012		
K0046	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1 This Standard is not met as evidenced by: Based on observation, the facility failed to assure accessibility to the front of the electrical panel to have sufficient access, a minimum of three feet of clearance and a minimum width to be the width of the equipment or 2.5 feet, whichever is greater. This deficient practice prevents quick access to breakers in an emergency. The facility has the capacity for seven beds with a census of six the	K0046	<i>K0046 Crates removed from in front of electrical Box at time of survey. House Manager to Monitor During weekly PSR House Maintenance. R.R. to be reviewed at Monthly QA House Manager Responsible by 12/24/14</i>	

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K0046	Continued From page 3 day of survey. Findings include: During the facility tour on October 17, 2014 at approximately 10:00 AM, it was observed that the electrical panel located in the kitchen area was blocked by milk crates that were stacked on top of the underneath table. Interview with the house manager revealed the facility was unaware of the blocked electrical panel. Actual NFPA Reference: NFPA 70 110.26-(A) Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K0046		
K0051	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1. Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms. Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.	K0051	<i>K0051 Power Source to be connected to meet Regulations House Manager and Maintenance to comply by 12/24/14 House Manager to review during House Maintenance check and Reviewed at Q/A Monthly House Manager responsible by 12/24/14</i>	

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K0051	<p>Continued From page 4</p> <p>This Standard is not met as evidenced by: Based on observation, the facility failed to assure a reliable power source for the Fire Alarm Control Panel. This deficient practice could effect the means of signal initiation, transmission, and notification in the event of an emergency to the affected staff and approximately six residents. The facility has the capacity for seven beds with a census of six the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on October 17, 2014 at approximately 10:00 a.m., it appeared that the Fire Alarm Control Panel (FACP) was being powered by a 110 V plug that was plugged into the wall next to the FACP. Interview with the house manager revealed the facility was unaware of the FACP power supply</p> <p>Actual NFPA Reference:</p> <p>NFPA 72, 1-5.2.3 Power Sources. Fire alarm systems shall be provided with at least two independent and reliable power supplies, one primary and one secondary (standby), each of which shall be of adequate capacity for the application. Exception No. 1: Where the primary power is supplied by a dedicated branch circuit of an emergency system in accordance with NFPA 70, National Electrical Code, Article 700, or a legally required standby system in accordance with NFPA 70, National Electrical Code, Article 701, a secondary supply shall not be required. Exception No. 2: Where the primary power is supplied by a dedicated branch circuit of an optional standby system in accordance with NFPA</p>	K0051		

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K0051	Continued From page 5 70, National Electrical Code, Article 702, which also meets the performance requirements of Article 700 or Article 701, a secondary supply shall not be required. Where dc voltages are employed, they shall be limited to no more than 350 volts above earth ground	K0051		

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M 000	<p>16.03.11 Initial Comments</p> <p>The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven ICF/ID beds with a census of six on the date of survey.</p> <p>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on October 17, 2014. The facility was surveyed under the Life Safety Code, 2000 edition, Chapter 33, Existing Residential Board and Care Occupancy, Impractical Evacuation Capability, Impractical Evacuation Capability in accordance with 42 CFR 483.470 (j) and IDAPA 16.03.11, Rules Governing Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).</p> <p>The annual survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor</p> <p>Mark Grimes, Supervisor Facility Fire Safety & Construction</p>	M 000		
MM309	<p>16.03.11.110 Fire and Life Safety Standards</p> <p>Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities.</p> <p>This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p>	MM309	<p>MM309 Refer to K0013 K0046 and K0051</p>	

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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Adman

(X6) DATE
11/7/14

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MM309	Continued From Page 1 1. K012 Penetrations 2. K046 Utilities 3. K051 Fire Alarm Systems	MM309		
MM346	16.03.11.110.06(g) In-House Check The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems. This RULE: is not met as evidenced by: Based on record review, the facility failed to provide any documentation for the 30 seconds a month and 90 minute a year battery back-up testing of the emergency illumination system. This deficient practice can effect the rapid evacuation of staff and clients during an emergency. The facility is licensed for seven beds and had a census of six on day of survey. Findings include During the record review on October 17, 2014 between the hours of 10:00 AM and 11:00 AM observation revealed the facility failed to provide documentation of the required emergency illumination testing of 30 seconds per month and 90 minutes per year. Actual reference: IDAPA 16.03.11.110.06 (g) - The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems.	MM346	<i>MM 346 Lights to be checked during monthly house house maintenance check by House Manager. Documentation on PSR House Maintenance Form. Form and documentation to be reviewed monthly a + Q A Program Director Responsible by 12/24/14</i>	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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MM346	Continued From Page 2 NFPA 101 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	MM346		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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MM346	<p>16.03.11.110.06(g) In-House Check</p> <p>The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems.</p> <p>This RULE: is not met as evidenced by: Based on observation, the facility failed to assure that fire extinguishers were maintained and inspected properly. It is intended to give maximum assurance that a fire extinguisher will operate effectively and safely in the event of a fire. This deficient practice affected staff and approximately 7 residents. The facility has the capacity for 7 beds with a census of 6 the day of survey.</p> <p>Findings Include</p> <p>During the facility tour on October 17, 2014 at approximately 10:00 a.m., it was observed that the extinguisher located near kitchen was missing the safety seal. Interview with the Maintenance Supervisor revealed the facility was unaware of the missing safety seal.</p> <p>IDAPA 16.03.1110. 06(g)</p> <p>The facility must establish routine in house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems.</p> <p>NFPA 10, 4-3.2 Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) * Safety seals and tamper indicators not broken or missing</p>	MM346	<p><i>MM346</i> <i>Fire extinguisher to be fixed.</i> <i>House Manager/Maintenance responsible by 10/15/14</i></p> <p><i>House Manager to check for compliance during house maintenance monthly check. To be documented on PSR House Maintenance Form to be reviewed at Monthly QA Program Director responsible by 10/24/14</i></p> <p>RECEIVED NOV - 7 2014 FACILITY STANDARDS</p>	
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If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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MM346	Continued From Page 1 (e) Fullness determined by weighing or " hefting " (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place	MM346		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.