



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

November 14, 2014

Richard Davis, Administrator  
Boise Group Home #2 Molly Court  
P.O. Box 4243  
Boise, ID 83711

RE: Boise Group Home #2 Molly Court, Provider #13G018

Dear Mr. Davis:

This is to advise you of the findings of the Initial Medicaid/Licensure survey of Boise Group Home #2 Molly Court, which was conducted on November 14, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid 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  
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6. 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 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 27, 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 November 27, 2014. If a request for informal dispute resolution is received after November 27, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  13G018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/14/2014
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NAME OF PROVIDER OR SUPPLIER  BOISE GROUP HOME #2 MOLLY COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 10244 MOLLY COURT BOISE, ID 83709
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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 11/12/14 to 11/14/14.  The survey was conducted by:  Michael Case, LSW, QIDP 483.470(l)(1) EVACUATION DRILLS	W 000	<p style="text-align: center;"><b>RECEIVED</b> DEC 04 2014 <b>FACILITY STANDARD</b></p> <p>The home manager will have her fire drill documentation reviewed for 6 months by her supervisor to ensure all drills are completed across all shifts  Program director will monitor.</p>	
W 440	The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift of personnel for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include:  1. The facility utilized an "A - B" shift schedule where shift A worked from 6:00 a.m. - 10:00 p.m. Sunday - Tuesday and every other Wednesday, and shift B worked from 6:00 a.m. - 10:00 p.m. Thursday - Saturday and every other Wednesday.  The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the B shift of staff during the third quarter (July - September) 2014.  During an interview on 11/13/14 at 12:15 p.m., the Home Manager reviewed the evacuation drills	W 440		12/1/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Armando</i>	TITLE  Administrator	(X6) DATE  12/1/14
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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.

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

PRINTED: 12/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #2 MOLLY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10244 MOLLY COURT BOISE, ID 83709</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 440	Continued From page 1 and staff work schedules with the surveyor and stated two evacuation drills had been completed for the A shift by accident (one on 8/12/14 at 6:30 a.m., and one on 9/11/14 at 6:55 a.m.). The Home Manager stated a drill for the B shift had not been completed for the third quarter.  The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER  <b>BOISE GROUP HOME #2 MOLLY COURT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10244 MOLLY COURT BOISE, ID 83709</b>
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M 000	<p>16.03.11 Initial Comments</p> <p>Boise Group Homes #2 - Molly Court is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)" for the annual licensure survey conducted from 11/12/14 to 11/14/14.</p> <p>The survey was conducted by:</p> <p>Michael Case, LSW, QIDP</p>	M 000		

Bureau of Facility Standards

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

TITLE

(X6) DATE

12/01/14