



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 26, 2014

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

RE: Tomorrow's Hope - Nampa, Provider #13G080

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Nampa, which was conducted on November 20, 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

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 **December 8, 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 December 8, 2014. If a request for informal dispute resolution is received after December 8, 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,



KAREN MARSHALL
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

KM/pmt
Enclosures

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

PRINTED: 11/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 EAST ARUBA NAMPA, ID 83686		
(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 The following deficiencies were cited during the annual recertification survey conducted from 11/17/14 to 11/20/14. The survey was conducted by: Karen Marshall, MS, RD, LD, Team Lead Ashley Henscheid, QIDP Common abbreviations used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional	W 000			
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure nursing reviews had been completed on a quarterly basis for 1 of 4 individuals (Individual #3) whose medical records were reviewed. This resulted in the potential for medical problems to not be identified in a timely fashion. The findings include: 1. Individual #3's IPP, dated 10/28/14, documented he was a 9 year old male whose diagnoses included mild mental retardation.	W 336			

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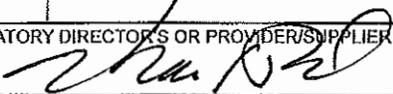
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FACILITY STANDARDS

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

TITLE

(X8) DATE



Adm

12/4/14

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 336	Continued From page 1 Individual #3's medical record was reviewed and did not include a completed nursing assessment for the first quarter (January, February, March) of 2014. During an interview on 11/20/14 from 11:09 a.m. - 12:25 p.m., the LPN stated the first quarter review had been missed. The facility failed to ensure Individual #3's nursing assessments had been completed on a quarterly basis.	W 336	unable to go back and do an exam on resident #3 → all books of residents have been reviewed to ensure all exams are up to date Nurse Responsible by 12/30/14		
W 434	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility floor was kept in good repair for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the environment being kept in ill-repair and the creation of unsanitary conditions. The findings include: 1. The House Manager accompanied the surveyor during an environmental review on 11/20/14 from 2:00 - 2:25 p.m. During that time, the following concerns were noted: - There were several stains, approximately 2 inches wide by 1 inch in length, outside of Individual #1 and Individual #7's room.	W 434	All residents will be put on a set schedule per home so all exams will be done. For clients in home in same month Nurse Responsible by 12/30/14 → All books are reviewed at least quarterly and monthly by GMRP responsible by 12/30/14 → PD to review all book reviews ^{at} will be reviewed by monthly QA and all needed items added to action list. PD Responsible by 12/30/14		

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W 434	Continued From page 2 - In the area between Individual #1 and Individual #7's room, it appeared the carpet had unraveled exposing a 5 1/2 foot long by one inch wide area. - In the dining room area, there were numerous stain patterns circular to irregular in shape and size ranging from 3 inches to 5 inches in diameter. - Carpet stains were also observed in Individual #1 - #5's rooms and Individual #7 - #8's rooms and the medication room. On 11/20/14 at 2:25 p.m., the House Manager acknowledged the carpeting had unraveled between Individual #1 and Individual #7's room and there were numerous stains throughout the facility. The facility failed to ensure the carpeting was maintained in a clean and sanitary manner.	W 434	W434 → Carpet & flooring to be replaced by 12/1/15 Adm Responsible by 1/30/15 → Hm to do a weekly walkthrough to identify any needed area that need to be cleaned with a PSR completed along with monthly mainten PSR Hm Responsible by 12/30/15 → All staff will be trained on cleaning up spills as they occur Hm Responsible by 12/30/15 → All house PSR will be Reviewed monthly at QA with all needed items added to maintenance list and given to the maintenance crew PD Responsible by 12/30/14		
W 440	483.470(i)(1) EVACUATION DRILLS 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 for 8 of 8 individuals (Individuals #1 - #8) residing in 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's evacuation drill records, dated	W 440			

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W 440	<p>Continued From page 3</p> <p>11/18/13 through 10/30/14, were reviewed and did not include evacuation drills for the following quarters on the following shifts:</p> <ul style="list-style-type: none"> - The second quarter of 2014 (April, May, June) for the night shift (10:00 p.m. - 6:00 a.m.). - The fourth quarter of 2013 or 2014 (October, November, December) for the night shift (10:00 p.m. - 6:00 a.m.). <p>When asked, the House Manager stated during an interview on 11/18/14 at approximately 7:45 a.m., the specified evacuation drills were missing.</p> <p>The facility failed to ensure evacuation drills were conducted on a quarterly basis for each shift.</p>	W 440	<p>→ training has been completed with the HM to ensure ^{all} fire drills are completed as required.</p> <p>Ⓚ Responsible by 12/30/14</p> <p>→ All fire drills are to be turned in to the PD at monthly QA for Review</p> <p>HM Responsible by 12/30/14.</p> <p>→ PD will add when fire drills are done at the monthly QA meeting</p> <p>PD responsible by 12/30/14</p>		

Bureau of Facility Standards

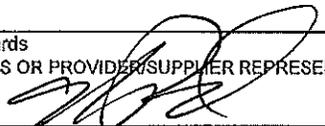
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensure survey conducted from 11/17/14 to 11/20/14. The survey was conducted by: Karen Marshall, MS, RD, LD, Team Lead Ashley Henscheid, QIDP	M 000		
MM380	16.03.11.120.03(a) 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: Refer to W434.	MM380	Refer to W434	
MM412	16.03.11.120.04(m) Furniture and Equipment All furniture and equipment must be maintained in a sanitary manner, kept in good repair, and must be so located to permit convenient use by residents. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined facility failed to ensure all furniture was kept in good repair for 1 of 8 individuals (Individual #5) residing in the facility. This resulted in Individual #5's chest of drawers being kept in ill-repair and in a manner that did not permit ease of use. The findings include:	MM412		

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TITLE



(X6) DATE

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Bureau of Facility Standards

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MM412	Continued From page 1 1. The House Manager accompanied the surveyor during an environmental review on 11/20/14 from 2:00 - 2:25 p.m. During that time, the following was noted for Individual #5's five-drawer chest of drawers: - Four of 10 drawer pulls were missing. - The track underneath the second drawer was detached from the back and when opened, the drawer fell forward out of the wooden frame. On 11/20/14 at 2:25 p.m., the House Manager said the pulls were missing and the track underneath the second drawer was detached from the back. The facility failed to ensure repairs were maintained for Individual #5's chest of drawers.	MM412	→ All items on will be fixed by 1/30/15 maintenance responsible by 1/30/15 → HM to complete weekly walk through with all items needing attention added to maintenance list HM responsible by 12/30/14 → A monthly House maintenance will be completed by the House manager with all items needing to be addressed added to the maintenance list HM responsible by 12/30/14 U → Program director to review all House walk throughs and House maintenance lists and add all need items to the maintenance action list - which will be given to the maintenance guy PD responsible by 12/30/14	
MM766	16.03.11.270.03(c)(iii) Periodic Reevaluation The periodic reevaluation of the type, extent, and quality of services and programming; and This Rule is not met as evidenced by: Refer to W336.	MM766		

MM766 refer to W336