



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 21, 2014

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

RE: Tomorrow's Hope - Navarro, Provider #13G061

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Tomorrow's Hope - Navarro, on November 20, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction 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
November 21, 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 **December 4, 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 4, 2014. If a request for informal dispute resolution is received after December 4, 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

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

PRINTED: 11/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - NAVARRO			STREET ADDRESS, CITY, STATE, ZIP CODE 946 NORTHWEST 12TH MERIDIAN, ID 83642		
(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	<p>INITIAL COMMENTS</p> <p>Tomorrow's Hope - Navarro is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Intellectual Disability for the annual recertification survey conducted from 11/17/14 to 11/20/14.</p> <p>The surveyors conducting your survey were:</p> <p>Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, QIDP</p>	W 000	<p>RECEIVED</p> <p>DEC - 2 2014</p> <p>FACILITY STANDARDS</p>		

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.

Lebha Toode + D 11/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - NAVARRO	STREET ADDRESS, CITY, STATE, ZIP CODE 946 NORTHWEST 12TH MERIDIAN, ID 83642
---	---

(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
--------------------	--	---------------	---	--------------------

M 000	16.03.11 Initial Comments The following deficiency was cited during the licensure survey conducted from 11/17/14 to 11/20/14. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Jim Troutfetter, 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: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. During an environmental review on 11/19/14 from 10:45 - 11:00 a.m., the following was noted: - There was mold in the window tracks of Individual #3's bedroom and Individual #5's bedroom window. - There was a hole in the wall approximately 1 inch by 1 and 1/2 inches to the right of the laundry room door.	MM380	<p style="text-align: right;">RECEIVED DEC -2 2014 FACILITY STANDARDS</p> <p>→ all items added to the maintenance list and given to maintenance man to be fixed by 12/30/14 maintenance responsible By 12/30/14</p> <p>→ House manager to complete weekly walk through to identify any items needing fix to be added to the maintenance list HM responsible by 12/15/14</p> <p>→ a monthly PSR will be completed on the house with all needed items added to maintenance list HM Responsible By 12/15/14</p>	

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

STATE FORM 6899 XYYY11 If continuation sheet 1 of 2

→ at weekly walk throughs and monthly PSR will be reviewed by Program Director and added to action list and given to maintenance PD Responsible By 12/15/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - NAVARRO	STREET ADDRESS, CITY, STATE, ZIP CODE 946 NORTHWEST 12TH MERIDIAN, ID 83642
---	---

(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
MM380	<p>Continued From page 1</p> <ul style="list-style-type: none"> - There was a hole in the wall protector approximately 1 and 1/2 inches by 1 and 1/2 inches where the door knob of the front door hits. - The tile in front of the refrigerator in the kitchen was separating at the seams, creating a gap approximately 1/4 inch wide. The refrigerator was leaning backwards, with the back side approximately 3/4 - 1 inch lower than the front due to the flooring sloping down towards the wall. - The flooring in front of the dishwasher, which was to the left of the refrigerator, was "spongy" and gave when walking on it. - The flooring in the master bathroom was "spongy" and uneven. In front of the tub, the flooring gave when walked on. - There was a patched area approximately 6 inches by 12 inches to the left of the tub faucet which was cracked, and a patched area approximately 10 inches by 10 inches to the right of the tub faucet which was cracked. The cracks would allow water to seep behind the tub/shower surround. - The wall where the tub plumbing was housed, which dividing the linen closet and the tub/shower surround, appeared to be separating from the ceiling and the floor around the base was "spongy." - The hinge on the left cabinet door below the sink was bent preventing the doors from closing properly. <p>The facility failed to ensure environmental cleaning and repairs were maintained.</p>	MM380		