



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

December 12, 2014

Richard Davis, Administrator
Boise Group Home #1 Pennfield
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #1 Pennfield, Provider #13G017

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Boise Group Home #1 Pennfield, on December 11, 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

Richard Davis, Administrator
December 12, 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 26, 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:

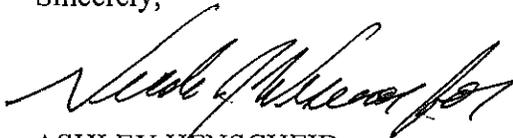
www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

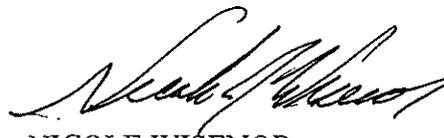
This request must be received by December 25, 2014. If a request for informal dispute resolution is received after December 25, 2014, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626, option 4.

Sincerely,



ASHLEY HENSCHER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

AH/pmt
Enclosures

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

PRINTED: 01/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #1 PENNFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 3855 PENNFIELD STREET BOISE, ID 83704	
(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>Boise Group Home #1 Pennfield is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Individuals with Intellectual Disabilities for the annual recertification survey conducted from 12/9/14 to 12/11/14.</p> <p>The survey was conducted by: Ashley Henscheid, QIDP, Team Lead</p>	W 000		

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

TITLE

(X6) DATE

01/04/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER
BOISE GROUP HOME #1 PENNFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE
**3855 PENNFIELD STREET
BOISE, ID 83704**

(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 annual licensure survey conducted from 12/9/14 to 12/11/14. The survey was conducted by: Ashley Henscheid, QIDP, Team Lead	M 000		
MM428	16.03.11.120.10(c) Temperature of hot water The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the potential for insufficiently hot water being available for tasks such as hand washing and bathing. The findings include: 1. During an environmental review conducted with the Home Manager on 12/10/14 at 9:38 a.m., the water temperature in the master bathroom was noted to be 98.6 degrees Fahrenheit. The hallway bathroom was noted to be 98.2 degrees Fahrenheit. The kitchen sink was noted to be 99.3 degrees Fahrenheit. The sink in the medication bathroom was noted to be 96.1 degrees Fahrenheit. During the environmental review the Home Manager was informed of the low water temperature. The Home Manager stated water temperatures were measured regularly and had	MM428	The manager purchased an instant read, battery activated thermometer. Manager will also test water by placing hand under water stream. Change or drop in temp to 96.6 from 110+ should be obvious and thus alert her to problems. Pen and Ink Addition: Water temps to be checked weekly, per administrator on 1-7-15. corrected 12/12/14	

RECEIVED
JAN 04 2015
FACILITY STANDARDS

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Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Richard Davis

TITLE

Administrator

(X8) DATE

1/4/15

STATE FORM

6899

280011

If continuation sheet 1 of 2

PAGE 01

BGH

2083761869

01/04/2015 13:38

STATUS Received

PAGES 1

DURATION 44

REMOTE CSID 2083761869

TIME RECEIVED January 4, 2015 1:14:48 PM MST

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #1 PENNFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 3855 PENNFIELD STREET BOISE, ID 83704
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MM428	<p>Continued From page 1</p> <p>been within range. The Home Manager obtained the facility thermometer and measured the water in the master bathroom at approximately 116 degrees Fahrenheit. The Home Manager stated she was unaware her thermometer was not working properly and had adjusted the water heat due to the inaccurate readings.</p> <p>The facility failed to ensure water temperatures were maintained between 105 and 120 degrees Fahrenheit.</p> <p>Note: Water temperatures were re-checked on 12/11/14 at 11:00 a.m. and were found to be within an acceptable range.</p>	MM428		