



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 22, 2014

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

RE: Tomorrow's Hope - Armga, Provider #13G014

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure survey of Tomorrow's Hope - Armga, which was conducted on December 18, 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

Thair Pond, Administrator
December 22, 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 **January 2, 2015**, 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 January 2, 2015. If a request for informal dispute resolution is received after January 2, 2015, 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,



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: 12/10/2014
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA	STREET ADDRESS, CITY, STATE, ZIP CODE 12308 WEST ARMGA DRIVE 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 12/16/14 - 12/18/14. The survey was conducted by: Michael Case, LSW, QIDP Common abbreviations used in this report are: IPP - Individual Program Plan IU - International Unit LPN - Licensed Practical Nurse	W 000		
W 331	483.480(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure nursing services were provided as needed for 1 of 4 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual not receiving adequate intervention necessary to meet his health needs. The findings include: 1. Individual #1's 11/25/14 IPP stated he was a 7 year old male whose diagnoses included mild intellectual disability and autism. He was admitted to the facility on 10/27/14. During an observation on from 6:00 - 7:45 a.m., Individual #1 was observed to participate in a medication administration program. During that	W 331	Individual number 1 vitamin D has been discontinued Nurse responsible by 12/18/14 All individuals orders/recommendation have been reviewed to ensure they are being followed to meet the necessary health needs of the individuals Nurse responsible by 12/30/14 When the Dietitian emails a recommendation or order to the nurse she will cc the QMRP to ensure there is follow up Dietitian responsible by 12/30/14 All medical records and orders will be reviewed at least quarterly at the monthly QA (completing a book review) to ensure all orders and interventions are being followed to meet the necessary health needs of the individuals QMRP responsible by 12/30/14 Program Director to review all the book reviews and added any issues or needed action on to the action list and who is to follow up to ensure it is completed Program director responsible by 12/30/14	

RECEIVED
JAN - 8 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shawn S. Ford</i>	TITLE Administrator	(X6) DATE 1/7/15
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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: 12/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER TOMORROW'S HOPE - ARMGA			STREET ADDRESS, CITY, STATE, ZIP CODE 12306 WEST ARMGA DRIVE BOISE, ID 83709		
(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 331	<p>Continued From page 1</p> <p>time, Individual #1 was observed to take Vitamin D (a supplemental drug) 1000 IU.</p> <p>Individual #1's Medical Nutrition Therapy Dietary Evaluation, dated 11/25/14, included a review of his nutritional laboratory reports which showed his Vitamin D level was elevated. The Recommendations section stated "Discontinue vitamin D supplement." However, Individual #1's Admission Orders, dated 10/27/14, included Vitamin D 1000 IU daily. No documentation was present indicating the drug had been discontinued.</p> <p>During an interview on 12/18/14 from 11:00 - 11:15 a.m., the LPN stated Individual #1's mother had placed him on Vitamin D prior to admission due to a family history of low Vitamin D levels. The LPN stated he did not believe the physician had reviewed the lab reports or dietician's recommendations, but stated he had emailed the dietician about the issue and the dietician instructed him to leave the supplement in place.</p> <p>When asked to see the emails during the interview, the LPN provided an email from the dietician, dated 11/25/14. The email documented it was all right to leave Individual #1 on his multi-vitamin, but included an attachment requesting the physician discontinue the additional 1000 IU of Vitamin D and recheck his Vitamin D level in 3 months to see if it had decreased to a normal range.</p> <p>When questioned, the LPN was unable to confirm the request had been provided to the physician.</p> <p>The facility failed to ensure nursing services were provided to monitor and follow through with</p>	W 331			

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W 331	Continued From page 2 recommendations related to Individual #1's elevated Vitamin D level. Note: The LPN faxed the request to the physician following the interview on 12/18/14. During a follow-up interview on 12/18/14 at 12:45 p.m., it was noted the physician had signed and returned orders to discontinue Individual #1's Vitamin D supplement.	W 331			

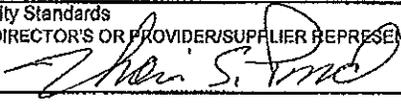
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/18/2014
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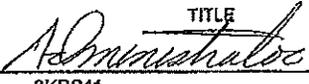
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the licensure survey conducted from 12/16/14 - 12/18/14. The survey was conducted by: Michael Case, LSW, QIDP	M 000		
MM760	16.03.11.270.03 Nursing Services Residents must be provided with nursing services in accordance with their needs. There must be a responsible staff member on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies. The nurse's duties and services include: This Rule is not met as evidenced by: Refer to W331.	MM760	Refer to W331 RECEIVED JAN - 8 2015 FACILITY STANDARDS	

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



TITLE



(X6) DATE

1/7/15