IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 13, 2016

Cliff McAleer, Administrator
Milestone Decisions, Inc #1 Grant
PO Box 10004
Moscow, ID 83843-0001

RE: Milestone Decisions, Inc #1 Grant, Provider #13G016

Dear Mr. McAleer:

This is to advise you of the findings of the Medicaid/Licensure survey of Milestone Decisions, Inc #1 Grant, which was conducted on January 7, 2016.

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 **January 26, 2016,** 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 26, 2016. If a request for informal dispute resolution is received after January 26, 2016, 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,

Karen Marshall
for Michael Case

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: 01/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(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	W 000		
	The following deficiencies were cited during the annual recertification survey conducted from 1/5/16 - 1/7/16.			
	The surveyors conducting your survey were:			
	Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD			
	Common abbreviations used in this report are:			
	CFA - Comprehensive Functional Assessment H&P - History and Physical (wellness examination) IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional		RECEIVED JAN 27 2016 FACILITY STANDARDS	
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN	W 210		
	Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.			
	This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were conducted within 30 days of admission for 1 of 1 individual (Individual #4) whose records were reviewed and who was admitted to the facility within the last year. This resulted in a lack of information being available on which to base program intervention decisions. The findings include:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cliff McAllen — TITLE: Executive Director — (X6) DATE: 1-26-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(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 210	Continued From page 1 1. Individual #4's 4/10/15 IPP stated he was a 17 year old male whose diagnoses included autistic spectrum disorder, intellectual disability, disruptive behavior disorder, mood disorder, and probable bipolar disorder. He was admitted to the facility on 8/18/15 from a sister facility within the same company. a. The facility utilized a CFA tool that addressed 9 categories of development including Self Help, Academic, Vocational, Cognitive Development, Human Awareness, Social and Emotional Development, Recreation, Leisure, and Retirement, Rights, and Health. The tool was designed to gather information related to the individual's functioning, identify needs, and develop training programs for needed skill deficits. However, Individual #4's CFA tool had been completed in March 2015 while at the sister facility, and was not reviewed or revised after Individual #4 was admitted to the facility. During an interview on 1/7/16 from 12:00 - 12:20 p.m., the QIDP stated the CFA had not been reviewed or revised when Individual #4 was admitted to the facility. The QIDP stated the facility had viewed the move as a transfer rather than an admission. The facility failed to ensure comprehensive assessments were conducted within 30 days of admission. b. Individual #4's Social Services Evaluation, dated 4/2015, was completed when Individual #4 was admitted to the sister facility, and listed the	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(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 210	Continued From page 2 name of the sister facility as the placement. However, no information was present to update or revise the assessment related to Individual #4's admission to his current placement, or information as to how that placement may impact Individual #4's social interactions and needs. During an interview on 1/7/16 from 12:00 - 12:20 p.m., the QIDP stated the Social Services Evaluation had not been reviewed or revised when Individual #4 was admitted to the facility. The facility failed to ensure Individual #4's Social Services Evaluation contained updated information within 30 days of his admission to the facility.	W 210		
W 226	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the interdisciplinary team prepared an IPP within 30 days of admission for 1 of 1 individual (Individual #4) whose records were reviewed and who was admitted to the facility within the last year. This resulted in an IPP being utilized that had been developed at a sister facility, and had the potential to result in delays in identifying, prioritizing, and addressing his needs. The findings include:	W 226		3/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(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 226	Continued From page 3 1. Individual #4's 4/10/15 IPP stated he was a 17 year old male whose diagnoses included autistic spectrum disorder, intellectual disability, disruptive behavior disorder, mood disorder, and probable bipolar disorder. Individual #4 was admitted to the facility on 8/18/15 from a sister facility within the same company. However, the IPP in his record was completed at the sister facility on 4/10/15. An IPP had not been completed following his admission to the facility. During an interview on 1/7/16 from 12:00 - 12:20 p.m., the QIDP stated the IPP had not been completed when Individual #4 was admitted to the facility. The QIDP stated the facility had viewed the move as a transfer rather than an admission. The facility failed to ensure Individual #4's IPP and programs were prepared and implemented within the required time frame.	W 226		
W 329	483.460(b)(1) PHYSICIAN PARTICIPATION IN THE IPP A physician must participate in the establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medical status was assessed by a physician and	W 329		3/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(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 329	Continued From page 4 incorporated into the IPP for 1 of 1 individual (Individual #4) whose records were reviewed and who was admitted to the facility within the last year. This resulted in the potential for the individual to not receive all necessary services. The findings include: 1. Individual #4's 4/10/15 IPP stated he was a 17 year old male whose diagnoses included autistic spectrum disorder, intellectual disability, disruptive behavior disorder, mood disorder, and probable bipolar disorder. He was admitted to the facility on 8/18/15 from a sister facility within the same company. Individual #4's medical record contained an H&P, dated and signed by a physician on 3/17/15. During an interview on 1/7/16 from 12:00 - 12:20 p.m., the QIDP stated an H&P had not been completed as part of the admission process. The QIDP stated the facility had viewed the move as a transfer rather than an admission. The facility failed to ensure a physician participated in Individual #4's initial IPP.	W 329		
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 of personnel for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This	W 440		2/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(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 5 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 drills were reviewed and did not include documentation that evacuation drills had been completed for the swing shift (3:00 - 11:00 p.m.) during the first quarter (January - March) of 2015. During an interview on 1/7/16 from 12:00 - 12:20 p.m., the Associate Director stated the drill had been missed due to an oversight. The facility failed to ensure evacuation drills were completed each quarter for each shift of staff.	W 440		

PRINTED: 01/13/2016
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER: MILESTONE DECISIONS, INC #1 GRANT

STREET ADDRESS, CITY, STATE, ZIP CODE: 922 N GRANT ST, MOSCOW, ID 83843

(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 deficiencies were cited during the licensure survey conducted from 1/5/16 - 1/7/16. The surveyors conducting your survey were: Michael Case, LSW, QIDP, Team Lead Karen Marshall, MS, RD, LD Common abbreviations used in this report are: QIDP - Qualified Intellectual Disabilities Professional	M 000		
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W210 and W226.	MM159	RECEIVED JAN 27 2016 FACILITY STANDARDS	
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n)(2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W329.	MM166		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cliff McAleer
TITLE: Executive Director
(X6) DATE: 1-26-16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER: MILESTONE DECISIONS, INC #1 GRANT

STREET ADDRESS, CITY, STATE, ZIP CODE: 922 N GRANT ST, MOSCOW, ID 83843

(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
MM194	16.03.11704.01(b) Handling Be handled, processed, and stored in an appropriate manner that prevents contamination. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure linens were stored in an appropriate manner to prevent contamination for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for linens to become contaminated. The findings include: 1. Observations were conducted at the facility on 1/5/16 and 1/6/16 for a total of 3 hours and 15 minutes. During those times, linens were not observed to be stored in a manner to prevent potential contamination. Examples included, but were not limited to, the following: a. On 1/5/16 from 11:35 a.m. - 12:25 p.m. and on 1/6/16 from 7:00 - 8:20 a.m., 3 brown cloth items were in direct contact with the floor in one of two linen closets on the lower level of the facility. b. During the environment review on 1/6/16 from 10:50 - 11:30 a.m., the same cloth items were in direct contact with the floor in the same linen closet. The Administrator was present. When interviewed the Administrator said the cloth items were cushion slip covers and should not be stored in direct contact with the floor. The facility failed to ensure linens were stored in a manner to prevent potential contamination.	MM194		2/1/16
MM215	16.03.11711.01 Good Repair	MM215		2/20/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER: MILESTONE DECISIONS, INC #1 GRANT

STREET ADDRESS, CITY, STATE, ZIP CODE: 922 N GRANT ST, MOSCOW, ID 83843

(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
MM215	Continued From page 2 Each building used by the ICF/ID and its equipment must be in good repair. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the interior of 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. An environmental review was conducted at the facility on 1/6/16 from 10:50 - 11:30 a.m. The Administrator was present. During this time, the following was noted: - There was a patched, unpainted 18 by 8 inch area on the wall in the upstairs hallway. - There was a 10 by 10 inch hole in the wall at the end of the upstairs hallway. - There was a 6 by 8 inch hole in the wall under the window in the blue room. - There was a 2 by 2.5 inch hole in the wall to the right of the back door. During the observation, the Administrator was made aware of the issues. The facility failed to ensure that environmental repairs were completed and maintained.	MM215		
MM218	16.03.11711.01(c) Clean and Sanitary The building must be kept clean and sanitary, and every reasonable precaution must be taken-	MM218		3/1/16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	13G016		01/07/2016

NAME OF PROVIDER OR SUPPLIER: MILESTONE DECISIONS, INC #1 GRANT

STREET ADDRESS, CITY, STATE, ZIP CODE: 922 N GRANT ST MOSCOW, ID 83843

(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
MM218	Continued From page 3 to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all surfaces were kept clean and sanitary for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the kitchen stove and the vinyl flooring in the kitchen being maintained under less than sanitary conditions. The findings include: 1. During an observation on 1/6/16 from 7:00 - 8:20 a.m., there was grey and white ash build-up on the inside bottom of the kitchen oven and the inside of the oven door was coated with a thick build-up of a brown and black substance. The QIDP was present. When interviewed, the QIDP said the oven needed to be cleaned more frequently. 2. During the environmental review of the facility on 1/6/16 from 10:50 - 11:30 a.m., the vinyl located under and around the kitchen refrigerator was black in color. The Administrator was present. When interviewed, he said he had cleaned the ash build-up from the kitchen oven. However, he had not noticed that the vinyl under and around the kitchen refrigerator was black in color. The facility failed to ensure all surfaces were maintained under clean and sanitary conditions.	MM218		

PLAN OF CORRECTION

#13G106

W210

The QIDP and/or the Social Worker will perform assessments or reassessments of individual # 4's CFA and his Social Services Evaluation to ensure they contain updated information as needed to base program intervention decisions. They will also review any other individuals that have been admitted within the year for compliance and will make appropriate updates as needed. The QIDP will review the regulations with the Associate Director and create an Admittance checklist. This checklist will be filled out for all future admits and reviewed by the Associate Director for accuracy.

Completed date: 3-01-16

W226

The QIDP prepare a new IPP for Individual #4. The QIDP will also review records of any other individuals in the home that have been admitted within the last year for compliance and will make appropriate updates as needed. The QIDP will review the regulations with the Associate Director and create an Admittance Checklist. This checklist will be completed for all future admits and will be reviewed by the Associate Director for accuracy.

Completed date 3-01-16

W329

The QIDP will ensure physician participation in individual #4's new IPP. This will be accomplished by either a doctor visit or a written summary of any changes in the IPP and in the new environment that affect the health and well-being of this person. The written summary will be signed by his physician. The QIDP will also review records for any other individuals admitted this year for compliance and will make appropriate updates as needed. The QIDP will review regulations with the Associate Director and create an Admittance checklist. This checklist will be completed for all future admits and will be reviewed by the Associate Director for accuracy.

Completed date: 03-01-16

W440

To ensure the facility will hold evacuation drills quarterly for each shift of personnel the QIDP and the House Administrator have been given a monthly schedule of when to conduct the drills. This practice will be for the individuals affected by the deficient practice as well as all individuals in the home. A reminder will be put on the weekly staff meeting agenda starting at the beginning of each month. Once the evacuation drill has been completed the House Admin. Will give the completed form to the Associate Director who will chart it on an annual form.

Completed date: 02-05-16

MM159- Refer to Plan of Correction for W210 and W226

MM166- Refer to Plan of correction for W329

MM194- The facility will ensure all linens will be stored in a manner to prevent potential contamination. A determination will be made to see if additional storage equipment or space is needed. This corrective action will be for all individuals in the home. A section will be added to the night shift checklist ensuring linens are stored appropriately. The checklist will be reviewed monthly by the House Administrator.

Completed date: 02-01-16

MM215- The House Administrator will ensure the environmental repairs are completed and maintained. The House Administrator will review, prioritize and schedule repairs noted in this report with the Maintenance Dept. This corrective action will be for all individuals in the home. Maintenance will do a monthly inspection of the home to determine repairs necessary. House Administrator will review, prioritize and schedule repairs monthly with the Maintenance Dept.

Completed: 2-20-16

MM218- The House Administrator will ensure all surfaces are maintained in a clean and sanitary condition. This will be accomplished by the House Administrator scheduling the cleaning and the repairing or replacing of the items noted in this report with Direct Care Staff and will the Maintenance Dept. This corrective action will be for all individuals in the home. Cleaning the oven will be added to the monthly deep cleaning list and any areas needing cleaning or repair will be noted on the monthly deep cleaning list. The House Administrator will review the completed monthly deep cleaning list for completion.

Completed: 03-01-15