



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 12, 2016

Cliff McAleer, Administrator
Milestone Decisions, Inc #2 6th St
PO Box 10004
Moscow, ID 83843-0001

RE: Milestone Decisions, Inc #2 6th St, Provider #13G019

Dear Mr. McAleer:

This is to advise you of the findings of the Medicaid/Licensure survey of Milestone Decisions, Inc #2 6th St, 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

Cliff McAleer, Administrator
January 12, 2016
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 25, 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:

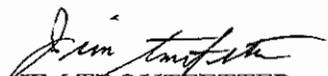
www.icfmr.dhw.idaho.gov

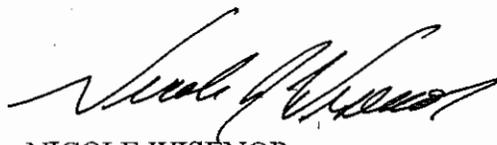
Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by January 25, 2016. If a request for informal dispute resolution is received after January 25, 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,


JIM TROUXFETTER
Health Facility Surveyor
Non-Long Term Care


NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/pmt
Enclosures

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

PRINTED: 01/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2016
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NAME OF PROVIDER OR SUPPLIER MILESTONE DECISIONS, INC #2 6TH ST	STREET ADDRESS, CITY, STATE, ZIP CODE 1430 E SIXTH STREET MOSCOW, ID 83843
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 1/5/16 - 1/7/16.</p> <p>The surveyor conducting your survey was:</p> <p>Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are: HRC - Human Rights Committee IPP - Individual Program Plan</p>	W 000	<p>See attached Plan of Correction</p>	
W 262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure procedures that had the potential to violate individuals' rights were implemented only with the approval of the human rights committee for 2 of 4 individuals (Individuals #1 and #2) whose records were reviewed. This resulted in a lack of protection of individuals' rights through approvals for the use of video surveillance cameras. The findings include:</p> <p>1. During observations conducted in the facility on 1/5/16 and 1/6/16, video cameras were noted to be mounted near the ceiling in the common areas of the facility.</p>	W 262		<p>RECEIVED JAN 22 2016 FACILITY STANDARDS</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chad McAleen TITLE: Executive Director (X6) DATE: 1-22-16

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.

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

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W 262	Continued From page 1	W 262			
W 263	<p>Individuals #1 and #2's records were reviewed and did not include approval from the facility's HRC for video camera use in the facility.</p> <p>When asked about HRC approval for video camera use, during an interview on 1/7/16 from 12:20 - 12:37 p.m., the Executive Director stated he could not find documentation of HRC approval.</p> <p>The facility failed to ensure HRC approval for the use of video cameras in the facility was obtained for Individuals #1 and #2.</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the guardian for 1 of 4 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior consent on a restrictive intervention. The findings include:</p> <p>1. Individual #2's IPP, dated 7/30/15, documented a 68 year old female whose diagnoses included severe intellectual disability.</p>	W 263		2/15/16	

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W 263	Continued From page 2 During observations conducted in the facility on 1/5/16 and 1/6/16, video cameras were noted to be mounted near the ceiling in the common areas of the facility. Individual #2's record was reviewed and did not include consent from her guardian for use of a video camera. When asked about guardian consent for the video camera use, during an interview on 1/7/16 from 12:20 - 12:37 p.m., the Executive Director stated he could not find documentation of guardian consent.	W 263			
W 440	483.470(i)(1) EVACUATION DRILLS The facility failed to ensure guardian consent for the use of video cameras in the facility was obtained for Individual #2. 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 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 in the event of an emergency. The findings include: 1. The facility's evacuation drills were reviewed and did not include documentation that an evacuation drill had been completed for the swing	W 440		2/15/16	

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W 440	<p>Continued From page 3 shift (3:00 - 11:00 p.m.) during the first quarter (January - March) of 2015.</p> <p>During an interview on 1/7/16 from 12:20 - 12:37 p.m., the Administrator stated the evacuation drill for the swing shift had not been completed due to an oversight.</p> <p>The facility failed to ensure an evacuation drill was completed for the swing shift during the first quarter of 2015.</p>	W 440			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER
MILESTONE DECISIONS, INC #2 6TH ST

STREET ADDRESS, CITY, STATE, ZIP CODE
**1430 E SIXTH STREET
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 surveyor conducting your survey was: Jim Troutfetter, QIDP	M 000	See Attached Plan of Correction	
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 W262 and W263.	MM159		
MM169	16.03.11700 Physical Environment The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an IGF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W440.	MM169		

RECEIVED
JAN 22 2016
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

Chip McAtley

Executive Director

1-22-16

Plan of Correction
#13G019

W262

The QIDP will review records to ensure all programs designed to manage inappropriate behavior and other programs that involve risks to client protection and rights have consents signed by HRC. Any consents not in place will be immediately sent out to HRC. This will be for the individuals affected by the deficient practice and for all individuals in the home. The QIDP and the House Administrator will review and revise the IPP checklist to ensure there is adequate designation to sign off that the appropriate consents have been sent out and returned. This will be monitored by the Associate Director or the Executive Director reviewing the completed IPP checklist. If a restrictive program is added at any other time during the year we will add it to the IPP checklist and follow the same procedure.

Date completed: 2-15-16

W263

The QIDP will review records to ensure all restrictive programs have written informed consents from the client, parent or legal guardian. Any consents not in place will be immediately sent out for signatures. This will be for the individuals in the home affected by the deficient practice as well as all individuals in the home. The QIDP and the House Administrator will review and revise the IPP checklist to ensure there is adequate designation to sign off that the appropriate consents have been sent out and returned. This will be monitored by the Associate Director or the Executive Director reviewing the completed checklist. If a restrictive program is added at any other time during the year we will add it to the IPP checklist and follow the same procedure.

Date completed: 2-15-16

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 every month. Once the evacuation drill has been completed the House Admin will give the completed form to the QIDP who will chart in on an annual form.

Date completed: 02-05-16

MM159- Refer to Plan of Correction for W262 and W263

MM169- Refer to Plan of Correction for W440