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
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Boise, Idaho 83720-0009
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January 14, 2016

Cliff McAleer, Administrator
Milestone Decisions, Inc #3 Lexington
PO Box 10004
Moscow, ID 83843-0001

RE: Milestone Decisions, Inc #3 Lexington, Provider #13G044

Dear Mr. McAleer:

This is to advise you of the findings of the Medicaid/Licensure survey of Milestone Decisions, Inc #3 Lexington, 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
	13G044		01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS, INC #3 LEXINGTON	2087 LEXINGTON AVENUE 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 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 DCS - Direct Care Staff H&P - History and Physical (wellness examination) IPP - Individual Program Plan MAR - Medication Administration Record QIDP - Qualified Intellectual Disabilities Professional	W 000	See attached Plan of Correction	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided privacy during cares for 1 of 8 individuals (Individual #3) residing at the facility. This resulted in a lack of privacy during toileting routines. The findings include: 1. Individual #3's 6/22/15 IPP stated he was a 69 year old male whose diagnoses included mild	W 130	RECEIVED JAN 27 2016 FACILITY STANDARDS	

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.

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W 130	Continued From page 1 mental retardation, cerebral palsy, and spastic quadriplegia. He was non-ambulatory and required the use of a power wheelchair for mobility. The facility utilized a power standing device to transfer Individual #3 from his wheelchair to the toilet for toileting. Once in the device, staff were able to transport Individual #3 from his bedroom to the bathroom. During an observation on 1/5/16 at 3:45 p.m., Individual #3 entered his bedroom in his power wheelchair, followed by a DCS. Approximately 2 minutes later, the same DCS transported Individual #3 from his bedroom to the bathroom using the power stander. However, Individual #3 was not wearing pants, but was transported to the bathroom in his boxer shorts. As he was being transported, two female housemates (Individuals #4 and #7), as well as 2 other DCS, were located in the living room with a clear view of Individual #3 being transported to the bathroom. During an interview on 1/7/16 from 12:40 - 12:55 p.m., the QIDP stated Individual #3 should have been wearing pants to be transported to the bathroom, or at least have been covered with a blanket. The facility failed to ensure Individual #3's privacy was protected while being transported to the bathroom.	W 130		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the	W 210		3/1/16

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W 210	Continued From page 2 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 #2) 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: 1. Individual #2's 4/23/15 IPP stated he was a 29 year old male whose diagnoses included autism, moderate mental retardation, PICA (persistent eating of substances with no nutrition value such as soil, soap, or paint), allergic rhinitis, hyperlipidemia, obesity, trichotillomania (a hair pulling disorder), and perseveration. 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.	W 210		

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W 210	Continued From page 3 However, Individual #2's CFA tool had been completed in April 2015 while at the sister facility, and was not reviewed or revised after Individual #2 was admitted to the facility. During an interview on 1/7/16 from 12:40 - 12:55 p.m., the QIDP stated the CFA had not been reviewed or revised when Individual #2 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 #2's April 2015 Social Services Evaluation was completed when Individual #2 was admitted to the sister facility, and listed the name of the sister facility as the placement. However, no information was present to update or revise the assessment related to Individual #2's admission to his current placement, or information as to how that placement may impact Individual #2's social interactions and needs. During an interview on 1/7/16 from 12:40 - 12:55 p.m., the QIDP stated the Social Services Evaluation had not been reviewed or revised when Individual #2 was admitted to the facility. The facility failed to ensure Individual #2'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	W 226		3/1/16

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W 226	Continued From page 4 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 #2) 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: 1. Individual #2's 4/23/15 IPP stated he was a 29 year old male whose diagnoses included autism, moderate mental retardation, PICA (persistent eating of substances with no nutrition value such as soil, soap, or paint), allergic rhinitis, hyperlipidemia, obesity, trichotillomania (a hair pulling disorder), and perseveration. Individual #2 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 4/23/15. An IPP had not been completed following his admission to the facility. During an interview on 1/7/16 from 12:40 - 12:55 p.m., the QIDP stated the IPP had not been completed when Individual #2 was admitted to the facility. The QIDP stated the facility had viewed the move as a transfer rather than an	W 226		

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W 226	Continued From page 5 admission. The facility failed to ensure Individual #2'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 incorporated into the IPP for 1 of 1 individual (Individual #2) 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 #2's 4/23/15 IPP stated he was a 29 year old male whose diagnoses included autism, moderate mental retardation, PICA (persistent eating of substances with no nutrition value such as soil, soap, or paint), allergic rhinitis, hyperlipidemia, obesity, trichotillomania (a hair pulling disorder), and perseveration. He was admitted to the facility on 8/18/15 from a sister facility within the same company. Individual #2's medical record contained an H&P,	W 329		3/1/16

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W 329	Continued From page 6 dated and signed by a physician on 10/27/15. His H&P documented the last review was on 10/2/14. During an interview on 1/7/16 from 12:40 - 12:55 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 #2's initial IPP.	W 329		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions, which had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. An environmental review was conducted at the facility on 1/6/16 from 10:10 - 10:45 a.m. During that time, a basket containing the following was observed in Individual #1's bedroom: - A tube of Clobetasol USP 0.05% (a corticosteroid cream) - A can of Tinactin foot spray (an antifungal drug)	W 382		2/20/16

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W 382	Continued From page 7 Individual #1's Physician's Order Sheet, signed by the physician on 12/11/15, stated the Clobetasol was for psoriasis flairs, and the antifungal foot spray was for athlete's foot and the cracks between his toes. The QIDP, who was present during the environmental review, stated the drugs should not have been left in Individual #1's bedroom, but were to be locked in the medication cabinet. The facility failed to ensure all drugs were maintained under locked conditions.	W 382		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 3 of 7 DCS (DCS A, DCS B, and DCS C) observed implemented infection control procedures to prevent and control infection and/or communicable diseases. That failure had the potential to provide opportunities for cross-contamination to occur and negatively impact the health of 8 of 8 individuals residing in the facility. The findings include: 1. Observations were conducted at the facility on 1/5/16 and 1/6/16. During those times, the following infection control concerns were noted: a. An observation was conducted on 1/6/16 from 7:10 - 8:05 a.m. During that time, the following was observed:	W 454		2/20/16

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W 454	Continued From page 8 - At 7:15 a.m., DCS A assisted Individual #8 to use the remote control to change the channel on the television. DCS A, along with DCS B, then donned gloves and began setting the table for breakfast. Neither staff was observed to wash their hands. Both staff were observed to place their gloved fingers inside the clean dishes (bowls and cups). After setting the table, both staff were observed to remove their gloves and drink coffee in the kitchen. Neither staff was observed to wash their hands. - At 7:20 a.m., Individual #6 called out from his bedroom. DCS A went into Individual #6's bedroom and physically assisted him to reposition in bed. DCS A then went to the living room and assisted Individual #8 with the television remote. DCS A was not observed to wash his hands. - At 7:25 a.m., DCS A obtained a cup from the kitchen and handed it to Individual #5. DCS A then went to the medication administration room and Individual #5 followed. DCS A donned clean gloves, but was not observed to first wash his hands. DCS A stood in the medication administration room doorway, with his gloved hand in his pocket, waiting for Individual #5. Once Individual #5 arrived at the medication administration room, DCS A grasped his wheelchair with his gloved hands to assist him over the threshold, then adjusted his own pants. DCS A removed Individual #5's medication blister packs from the cabinet and ran his gloved hand	W 454		

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W 454	Continued From page 9 down the MAR as he matched the blister packs to the MAR. DCS A held the blister packs over a medication cup and assisted Individual #5 to punch the medications into the cup. After Individual #5 had taken his medications, DCS A removed his gloves but did not wash his hands. - At 7:30 a.m., DCS A cued Individual #3 for his medications. DCS A entered the kitchen, put on clean gloves, and dished up frozen yogurt into a bowl. DCS A took the yogurt to the medication administration room, removed his gloves, and removed Individual #3's medication basket. DCS A donned new gloves, but did not wash his hands. DCS A ran his gloved hand down the MAR comparing the medication blister packs to the MAR. DCS A then carried the medications, MARs, and yogurt to Individual #3's bedroom where he punched the medications into the yogurt for Individual #3. After Individual #3 took his medications, DCS A returned the medications to the medication cabinet and removed his gloves. He scratched his hair and adjusted his hat. DCS A went to the kitchen and drank coffee. He was not observed to wash his hands. - At 7:50 a.m., DCS A entered the kitchen and obtained a cup. He ate some quiche that was on a plate in the kitchen, and took the cup to the medication administration room. DCS A was not observed to wash his hands. DCS A began to don gloves as Individual #7 entered the medication administration room. DCS A then pulled off the one glove he had	W 454		

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W 454	Continued From page 10 halfway on his hand, tied Individual #7's shoelace, then donned the same glove. DCS A cued Individual #7 to remove her medication basket, then ran his gloved hand down the MAR as he compared the blister packs to the MAR. DCS A assisted Individual #7 to punch her medications into medication cups. DCS A removed his gloves, but was not observed to wash his hands. During an interview on 1/6/16 from 8:00 - 8:05 a.m., DCS A stated he had been trained on infection control practices, including thoroughly washing his hands. When asked about the observation, DCS A stated he probably should have washed his hands before and after glove use, but was not sure. b. An observation was conducted at the facility on 1/5/16 from 3:10 - 3:55 p.m. During that time, the following was observed: - At 3:20 p.m., DCS C was observed to enter the kitchen and don gloves. DCS C was not observed to first wash his hands. DCS C placed a banana, milk, ice, honey, and peanut butter into a blender. DCS C removed his gloves, went to the table and asked Individual #5 if he would like a different activity. DCS C returned to the kitchen and donned clean gloves. DCS C was not observed to wash his hands. DCS C finished preparing the smoothie and gave it to Individual #1 at the dining table. DCS C then removed his gloves, but was not observed to wash his hands.	W 454		

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W 454	Continued From page 11 During an interview on 1/6/16 at 9:30 a.m., the RN stated all staff had been trained on infection control practices, including hand washing. The RN stated staff should be washing or sanitizing hands before donning gloves, and after their removal. The RN stated staff observed were not following infection control practices. The facility failed to ensure appropriate infection control procedures were implemented.	W 454		

PRINTED: 01/13/2016
FORM APPROVED

Bureau of Facility Standards

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STREET ADDRESS, CITY, STATE, ZIP CODE: 2087 LEXINGTON AVENUE, MOSCOW, ID 83843

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the state 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	M 000	see attached Plan of Correction	
MM134	16.03.11200 Client Protections The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W130.	MM134	RECEIVED JAN 27 2016 FACILITY STANDARDS	
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		
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to	MM166		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] 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
	13G044		01/07/2016

NAME OF PROVIDER OR SUPPLIER: MILESTONE DECISIONS, INC #3 LEXINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE: 2087 LEXINGTON AVENUE, MOSCOW, ID 83843

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MM166	Continued From page 1 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 and W382.	MM166		
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 8 of 8 individuals (Individuals #1 - #8) 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 2 hours and 35 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 9:40 - 10:30 a.m. and 5:35 - 7:20 p.m., pillows and blankets were observed in direct contact with the floor in the hallway linen closet. b. During the environment review on 1/6/16 from 10:10 - 10:45 a.m., the same pillows and blankets were in direct contact with the floor in the hallway	MM194		2/1/16

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
	13G044		01/07/2016

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MM194	Continued From page 2 linen closet. The Administrator was present. When interviewed the Administrator said the pillows and blankets 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		
MM218	16.03.11711.01(c) Clean and Sanitary 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 and staff interview, it was determined the facility failed to ensure all surfaces were kept clean and sanitary for 8 of 8 individuals (Individual #1 - #8) residing at the facility. This resulted in the kitchen stove and the overhead hood screen in the kitchen being maintained under less than sanitary conditions. The findings include: 1. During the environmental review of the facility on 1/6/16 from 10:10 - 10:45 a.m., there was grey and white ash build-up on the inside bottom of the kitchen oven. In addition above the kitchen stove, there was a thick layer of dust and brown grease build-up on the overhead hood screen. The Administrator was present. When interviewed, the Administrator said the staff used the stove's self-cleaning option but did not know if the staff were aware of the need to wipe the ash out of the oven after the self-cleaning cycle was done. The Administrator also said the screen in the overhead hood needed to be cleaned more frequently.	MM218		2/10/16

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
	13G044		01/07/2016

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MM218	Continued From page 3 The facility failed to ensure all surfaces were maintained under clean and sanitary conditions.	MM218		

PLAN OF CORRECTION

#13G044

W130

House Administrator will review privacy practices for this individual and all other individuals in the home to ensure privacy is maintained during personal care routines. House Administrator will train all staff on changes or additions to privacy practices. House Administrator will perform regular Quality Assurance checks which will be reviewed by Associate Director for compliance.

Completed date: 2-15-16

W210

The QIDP and/or the Social Worker will perform assessments or reassessments of individual #2's CFA and 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 will prepare a new IPP FOR Individual #2. The QIDP will also review records of any other individuals in the home who 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 reviewed by the Associate Director for accuracy.

Completed date: 3-01-16

W329

The QIDP will ensure physician participation in individual #2 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 within the 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.

Competed date: 3-01-16

W382

All staff at the home will receive documented training on med pass procedures and protocols as they pertain to keeping all drugs and biologicals locked except when being prepared for administration. This corrective action will be for all the individuals in the home. The Nursing Dept. will do monthly QA checks and the RN will monitor by reviewing completed QA forms.

Completed date: 2-20-16

W454

The Nursing Dept. will give two Infection Control Inservices for the staff at this facility. Staff unable to attend will review the written material and sign off that they have received the training. This corrective action will be for all individuals in the home. The House Administrator will do monthly QA checks and the RN will monitor by reviewing the completed QA forms.

Competed date: 2-20-16

MM134- Refer to Plan of Correction for W130

MM159- Refer to Plan of Correction forW210 and W 226

MM166- Refer to Plan of Correction for W329 and W382

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 spaceis 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: 2-01-16

MM218- The House Administrator will ensure all surfaces are maintained in a clean and sanitary condition. This will be accomplished by reviewing and revising the monthly deep cleaning list. This corrective action will be for all individuals in the home. The House Administrator will monitor the corrective action by reviewing and signing off on the checklist every month.

Completed date: 2-10-16