



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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

September 15, 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 Fire Life Safety Survey, which was concluded at Milestone Decisions, Inc #3 Lexington, on September 8, 2016.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to our staff during our visit. If you have any questions, please call our office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins
Supervisor
Facility Fire Safety and Construction Program

NE/lj

Enclosure

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

PRINTED: 09/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2016
NAME OF PROVIDER OR SUPPLIER MILESTONE DECISIONS, INC #3 LEXINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	<p>INITIAL COMMENTS</p> <p>The facility is single story Type V (III) building, built in 1983. The facility is protected by a 13D automatic fire sprinkler system with system sprinkler heads in habitable spaces. There is a complete fire alarm/smoke detection system installed. Currently the building is licensed for 8 ICF/IID beds.</p> <p>The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted on September 8, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33 Existing Residential Board and Care Occupancies in accordance with 42 CFR 483.470 (j).</p> <p>The Survey was conducted by:</p> <p>Nate Elkins Supervisor Facility Fire Safety & Construction</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.