IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 29, 2014

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 15, 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; and,

5. Include dates when corrective action 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 **October 13, 2014**, 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 October 13, 2014. If a request for informal dispute resolution is received after October 13, 2014, 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 our staff during our visit. If you have any questions, please call our office at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Fire Life Safety & Construction Program

MPG/lj

Enclosure

Printed: 09/25/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE STRUCTURE B. WING	(X3) DATE SURVEY COMPLETED
	13G044		09/15/2014

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
K 000	INITIAL COMMENTS The facility is single story Type V (III) building, built in 1983. The facility is protected by a 13 D 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-MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on September 15, 2014. 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). The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K0150	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1 This Standard is not met as evidenced by: Based on record review, physical inspection and interview, the facility failed to ensure that curtains and draperies installed in the facility were flame resistive as specified in NFPA 701. Not maintaining the flame spread properties of curtains and other loosely hanging decorations would allow these items to burn past incipient stages during a fire event and hinder the safe evacuation of clients. This deficient practice	K0150	See attached RECEIVED OCT 10 2014 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cliff McAleer | TITLE: Administrator | (X6) DATE: 10-9-14

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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K0150	Continued From page 1 affected all residents, staff and visitors on the date of the survey. The facility is licensed for 8 ICF/ID beds and had a census of 8 on the day of the survey. Findings include: 1) During record review of the facility conducted on September 15, 2014 from 1:00 PM to 2:00 PM, the facility failed to provide documentation that curtains installed in the facility had been treated with a fire retardant solution. 2) During the facility tour conducted on September 15, 2014 from 2:00 PM to 4:00 PM, physical inspection of the curtains installed in the bedrooms did not indicate they were treated or had any flame resistive markings or tags. 3) During the exit conference conducted on September 15. 2014 from 4:00 PM to 4:45 PM, the Administrator provided documentation of a product purchased for treatment dated September 14, 2005. When asked if the facility had this product available for examination, the Administrator stated he did not. Further interview revealed the facility had replaced curtains in the homes since that date. Actual NFPA standard: 33.7.5* Furnishings, Bedding, and Decorations. 33.7.5.1 New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 10.3.1. 10.3.1* Where required by the applicable provisions of	K0150		

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

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K0150	Continued From page 2 this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films	K0150		

PRINTED: 09/25/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G044	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	09/15/2014

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M 000	16.03.11 Initial Comments The facility is single story Type V (III) building, built in 1983. The facility is protected by a 13 D 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-MR beds. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on September 15, 2014. 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) and IDAPA 16.03.11, Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/ID facilities. This Rule is not met as evidenced by: Please refer to federal tags on CMS 2567 K 150 Curtains, draperies and loosely hanging decorations	MM309	RECEIVED OCT 10 2014 FACILITY STANDARDS	

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cliff McAleer | TITLE: Administrator | (X6) DATE: 10-9-14

PLAN OF CORRECTION

13G044

K0150—Facility Administrator and House Administrator will inventory all curtains, draperies and loosely hanging furnishings in the home.
Maintenance Dept. will treat all inventoried items with flame retardant in accordance with the provisions of 10.3.1. 32.7.5.1, 33.7.5.1.
A list of all inventoried items will be maintained at the home indicating the date, the type of fire retardant applied and a description and location of the item.
House Administrator will notify Maint. Dept if a furnishing is to be replaced. The item will be treated with the fire retardant solution prior to being installed.
Review of the list will be done annually.
Fire Retardant will be re-applied as per manufacturers instructions.

MM309- Refer to K0150

Completion Date: Oct. 31, 2014

RECEIVED
OCT 10 2014
FACILITY STANDARDS