IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 11, 2008

Shelly Brubaker
10118 W Overland Rd
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Dear Administrator,

Thank you for submitting Plan of Correction for SL Start & Associates Residential Habilitation services dated 8/8/2008. The Department has reviewed and accepted the Plan of Correction in response to the Department's Compliance Review findings. As a result, we have issued a full certificate effective 8/8/2008 unless otherwise suspended or revoked.

This certificate is contingent upon the correction of deficiencies. Your agency has submitted documentation to substantiate that your Plan of Correction has been met. No additional correspondence is required.

You can reach me if you have any questions at 208-364-1906 or 1-877-457-2815.

Thank you for your patience and accommodating us through the survey process.

Rebecca Fadness
Program Supervisor
DDA/RH Survey and Certification

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RESIDENTIAL HABILITATION AGENCY COMPLIANCE REVIEW

AGENCY NAME: SL START **REVIEW DATE(s):** 4/28 – 5/2/08

NOTE: This document contains a listing of findings made by the survey team. The summary of survey findings is based on the survey team's professional knowledge and interpretation of IDAPA requirements. In the Column, "Agency's Plan for Compliance", the statement should reflect the agency's plan for compliance action and anticipated time for plan to be implemented.

REVIEW TEAM MEMBERS: Rebecca Lemmons, Eric Brown

SURVEY FINDINGS

Therapy Observation Notes:

Deficiencies:	Agency's Plan for Compliance:
IDAPA 16.04.17.301.03 Personnel Records. **j.** Verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks" **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • Staff #4's file contained a final clearance letter from employment with a previous agency dated 3-3-03. The staff was hired by SL Start 4-9-04 and no re-check was completed.	1. What corrective action(s) will be taken? 2. Who will be responsible for implementing each corrective action? 3. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 4. Dates for when the corrective action will be completed? **SL Start will require that the individual complete an updated background clearance. The HRA, Quality Assurance Director and Branch Manager will ensure that bi-annual assessments are completed on personnel files per SL Starts QA policy and that clearance letters and re-checks will be completed in accordance with IDAPA rules. All corrections will be completed by August 8, 2008. A copy of the clearance letter is attached**

IDAPA 16.03.10.705.01. Providers of residential habilitation services must meet the following requirements: **d.** Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: i. Instructional techniques: Methodologies for training in a systematic and effective manner; ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; iii. Feeding; iv. Communication; v. Mobility; vi. Activities of daily living; vii. Body mechanics and lifting techniques; viii. Housekeeping techniques; and ix. Maintenance of a clean, safe, and healthy environment. **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • Staff files did not contain evidence that each required training topic had been specifically trained.	1. What corrective action(s) will be taken? 2. How will the agency identify staff who may be affected by the deficiency(s)? If staff are identified what corrective action will be taken? 3. Who will be responsible for implementing each corrective action? 4. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 5. Dates for when the corrective action will be completed? **SL Start will ensure that each new individual that is hired complete a designated new hire orientation. This orientation will include instructional classroom time; see attached training list, as well as a designated 40 hours of shadowing in a home with a seasoned staff and follow the in home orientation checklist prior to working a shift on their own. SL Start will utilize their personalized training data base and pull all staffs' records to ensure that these procedures have been followed. If staff is identified as being deficient in this area, they will be given a new orientation checklist to review with their supervisor and resubmit to the training coordinator. The HRA, staff training coordinator and program managers will work together to identify which staff are in non compliance and set specific deadlines for said training or retraining to occur. All retraining for identified staff will occur by 8/31/08. On going training will occur every other week during new hire and checklists turned in the week following their on site shadowing. SL Start will also continue to utilize their personalized training data base on a monthly basis to pull and identify staff that may be deficient in this area. See attached new hire and in home orientation checklists.**
Medicaid Provider Agreement-Additional Terms A-5.8: The Provider conducts a quality assurance program which includes quarterly audits of services, site visits, participant satisfaction, and annual professional credential and competency review. The provider shall implement a Quality Improvement plan for any deficiencies noted. **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • Review of agency files did not reveal evidence of an annual professional credential and competency review.	1. What corrective action(s) will be taken? 2. Who will be responsible for implementing each corrective action? 3. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 4. Dates for when the corrective action will be completed? **SL Start will add a statement to their QA policy that is reflective of the need to assess each professional and evaluate their credentials and competency on an annual basis. The Branch Manager will work in conjunction with the Quality Assurance Manager and Director of Operations to make adjustments to the current QA policy and create a review tool that is reflective of each professional's skills and**

	abilities. The HRA, Branch Manager, and Quality Assurance Director will conduct bi annual reviews of each professional's personnel and training files, as well as conduct annual reviews of performance in accordance with SL Starts performance management plan. See attached QA policy. Assessment tool that will be used for review will be developed and in place by 8/31/08 and used in accordance with SL Starts annual performance management plan.
IDAPA 16.04.17.302.06 Termination Procedures. The agency must terminate residential habilitation services if, as a result of a person-centered planning process conducted by the person-centered planning team, it is demonstrated that the participant is no longer in need of or desires Residential Habilitation services. The agency must notify the client in writing that the termination of services will occur and must develop a transition plan for termination of those services. The participant will be entitled to appeal the termination. The agency may not terminate services when to do so would pose a threat of endangerment to the participant or others. **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • The agency does not currently have a policy or procedure related to termination of services that satisfies the components of this rule.	1. What corrective action(s) will be taken? 2. Who will be responsible for implementing each corrective action? 3. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 4. Dates for when the corrective action will be completed? **SL Start will write a discharge policy as a part of our Operations Manual that will be reflective of the possible need to discharge an individual if it is deemed necessary by the PCP team that it is no longer in the best interest of the agency or the individual to continue to provide residential habilitation services. The Branch Manager will work in conjunction with the Vice President of Supported Living, as well as the Director of Operations to create said policy. SL Start will review on an annual basis the content of said document to ensure that the language and purpose of the document are in compliance with IDAPA rules and regulations. Policy will be written by 8/8/08. See attached policy.**
IDAPA 16.04.17.403. PARTICIPANT FINANCES. When the residential habilitation agency or its employees, affiliated residential habilitation providers or contractors are designated as the payee on behalf of the participants, the agency must establish and maintain an accounting system that: **02.** No Commingling of Funds. Precludes any commingling of participant funds with agency funds. **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • The agency's policy and procedure for handling participant finances does not address the prohibition of commingling participant funds.	1. What corrective action(s) will be taken? 2. How will the agency identify participants who may be affected by the deficiency(s)? If participants are identified what corrective action will be taken? 3. Who will be responsible for implementing each corrective action? 4. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 5. Dates for when the corrective action will be completed? **SL Start will add a statement to their current Individual Financial Management Policy 3.1 to reflect that commingling of participants' funds is prohibited and will be monitored and maintained. SL Start will review each participant's financial records over the period of the past 6 months to search for potential errors. If said errors are to be located, then each person affected by said errors will be reimbursed**

	by SL Start and corrective actions/measures put into place. The Branch Manager, along with the branch financial specialist and company's Controller will review records and make adjustments to statements in SL Start's current individual financial management policy. Monthly reviews of bank statements, bill paying and loan reconciliation will occur, as well as bi annual financial reviews by the Controller and/or Quality Assurance Director. Policy adjustment corrections will be made by 8/8/08 and reviews of participant files will by completed by 8/31/08. See attached financial policy – page 2 last statement in when services begin.
IDAPA 16.04.14.400. Participant Records. **02.** Required Information. Records must include at least the following information: **e.** Names, addresses, and current phone numbers of family, advocates, friends, and persons to be contacted in case of an emergency **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • Participant #3's file did not contain addresses for family, advocate, or friend only phone number.	1. What corrective action(s) will be taken? 2. How will the agency identify participants who may be affected by the deficiency(s)? If participants are identified what corrective action will be taken? 3. Who will be responsible for implementing each corrective action? 4. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 5. Dates for when the corrective action will be completed? **SL Start will obtain and record the required name, address and phone numbers for all friends, family, and advocates that are listed on each individual's summary sheet. SL Start will complete a review of each participant's current summary sheet that contains all pertinent information for accuracy and completion. The Branch Manager, along with the Program Managers will conduct the review. Each individuals information will be reviewed a minimum of bi annually through case file reviews and through weekly visits to homes. Corrective actions will be completed for individual by 8/8/08 and a review for all participants currently being served by 8/31/08. See attached summary sheet correction.**
IDAPA 16.04.14.400. Participant Records. **02.** Required Information. Records must include at least the following information: **i.** Results of an age appropriate functional assessment, and person centered plan. **FINDINGS:** Based upon documents review the agency is not in	1. What corrective action(s) will be taken? 2. How will the agency identify participants who may be affected by the deficiency(s)? If participants are identified what corrective action will be taken? 3. Who will be responsible for implementing each corrective action? 4. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules?

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compliance. Agency files **lacked evidence as follows:** • Participant #2's file did not contain a functional assessment.	5. Dates for when the corrective action will be completed? **SL Start will complete an age appropriate functional assessment for said participant. SL Start will conduct a case file review per their QA policy to seek further deficiencies in other participants' files. If deficiencies are identified in other files, SL Start will take appropriate action in completing appropriate assessments for other individuals. Each Program Manager will conduct a review and complete any necessary assessments for participants on their case load. Bi Annual case file reviews will be completed according to SL Starts QA policy, along with annual reviews at PCP meetings to ensure compliance with IDAPA rules. Corrective action will be completed by 8/8/08. See attached assessment.**
IDAPA 16.04.14.400. Participant Records. **02.** Required Information. Records must include at least the following information: **j.** Psychosocial information. **FINDINGS:** Based upon documents review the agency is not in compliance. Agency files **lacked evidence as follows:** • Participant #2's file did not contain psychosocial information	1. What corrective action(s) will be taken? 2. How will the agency identify participants who may be affected by the deficiency(s)? If participants are identified what corrective action will be taken? 3. Who will be responsible for implementing each corrective action? 4. How the corrective action(s) will be monitored to ensure consistent compliance with IDAPA Rules? 5. Dates for when the corrective action will be completed? **SL Start will either obtain or schedule an evaluation for required document from a Targeted Service Coordinator, Independent Assessor, Parent or Guardian or a qualified evaluator. SL Start will conduct a case file review per their QA policy to seek further deficiencies in other participants' files. If deficiencies are identified in other files, SL Start will take appropriate action in requesting or scheduling necessary documentation. Each Program Manager will conduct a review and request and/or obtain appropriate documentation. Bi Annual case file reviews will be completed according to SL Starts QA policy, along with annual reviews at PCP meetings to ensure compliance with IDAPA rules. Corrective action will be completed by 8/8/08. See attached psychosocial information.**

Survey report completed by : Cynthia Jonsson Date: 5/16/08

Agency Administrator Signature: Shelly Brubaker Date: 8/6/08

01/08

Plan of correction accepted: Debbie Gidnes Date: 8/11/08