



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

<b>Agency:</b>	Community Connections South Central	<b>Region(s):</b>	5
<b>Agency Type:</b>	Res Hab	<b>Survey Dates:</b>	September 16, 2015
<b>Certificate(s):</b>	RH-5352 RH-5353	<b>Certificate(s) Granted:</b>	<input type="checkbox"/> 6 - Month Provisional <input checked="" type="checkbox"/> 1 - Year Full <input type="checkbox"/> 3 - Year Full

Rule Reference/Text	Findings	Agency's Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)	Date to be Corrected (mm/dd/yyyy)
No deficiencies were cited over the course of the survey.	No deficiencies were cited during the course of the survey. The provider is not required to submit a Plan of Correction to the Department.	<ol style="list-style-type: none"> <li>1. <a href="#">Click here to enter text.</a></li> <li>2. <a href="#">Click here to enter text.</a></li> <li>3. <a href="#">Click here to enter text.</a></li> <li>4. <a href="#">Click here to enter text.</a></li> </ol>	<a href="#">Click here to enter a date.</a>

<b>Agency Representative &amp; Title:</b> No signature required <i>* By entering my name and title, I agree to implement this plan of correction as stated above.</i>	<b>Date Submitted:</b> 9/17/2015
<b>Department Representative &amp; Title:</b> Pam Loveland-Schmidt, Licensing & Certification <i>* By entering my name and title, I approve of this plan of correction as it is written on the date identified.</i>	<b>Date Approved:</b> 9/17/2015