



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  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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April 20, 2016

Steve Young, Administrator  
Yellowstone Group Home #4 Fox Hollow  
560 West Sunnyside  
Idaho Falls, ID 83402

RE: Yellowstone Group Home #4 Fox Hollow, Provider #13G066

Dear Mr. Young:

This is to advise you of the findings of the Medicaid/Licensure survey of Yellowstone Group Home #4 Fox Hollow, which was conducted on April 18, 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

Steve Young, Administrator  
April 20, 2016  
Page 2 of 2

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 **May 3, 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](http://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 May 3, 2016. If a request for informal dispute resolution is received after May 3, 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  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

KM/pmt  
Enclosures

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

PRINTED: 04/19/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>YELLOWSTONE GROUP HOME #4 FOX HOLLOW</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>370 HOLLOW DRIVE IDAHO FALLS, ID 83402</b>
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(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
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the recertification survey conducted from 4/11/16 to 4/18/16.</p> <p>The surveyors conducting your survey were:</p> <p>Karen Marshall, MS, RD, LD, Team Leader Jim Troutfetter, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>CFA - Comprehensive Functional Assessment IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional</p>	W 000	<p><b>RECEIVED</b></p> <p><b>MAY - 2 2016</b></p> <p><b>FACILITY STANDARDS</b></p>	
W 124	<p><b>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a guardian was provided with comprehensive information necessary to make informed decisions for 1 of 3 individuals (Individual #2) whose medical records were reviewed. This resulted in insufficient information being provided</p>	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>QIDP</b>	(X6) DATE <b>4/29/16</b>
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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 124	Continued From page 1 to a guardian on which to base consent decisions. The findings include:  1. Individual #2's IPP, dated 3/19/15, documented a 19 year old male whose diagnoses included mild intellectual disability.  His record documented he did not receive a flu shot for the 2015/2016 year as his guardian had refused it.  However, no further information related to informed consent of the risks versus the benefits of declining a flu vaccination could be found.  During an interview on 4/15/16 from 8:30 - 8:57 a.m., the LPN there was no documentation related to the risks versus benefits of refusing the flu shot.  The facility failed to ensure the guardian was fully informed of the benefits and risks of declining a flu shot for Individual #2.	W 124			
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN  Participation by the client, his or her parent (if the client is a minor); or the client's legal guardian is required unless the participation is unobtainable or inappropriate.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an individual and his legal guardian participated in the IPP process for 1 of 3 individuals (Individual #2) whose records were reviewed and who had a guardian. This failure had the potential for a	W 209			

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W 209	Continued From page 2 guardian not to be informed of and contribute to the IPP process. The findings include:  1. Individual #2's IPP, dated 3/19/15, documented a 19 year old male whose diagnoses included mild intellectual disability.  His record contained an IPP, dated 3/19/16, that had a meeting sign in sheet that did not contain documentation of Individual #2's participation or guardian participation.  During an interview on 4/15/16 from 8:30 - 8:57 a.m., the Program Manager stated Individual #2 and his guardian did not attend the IPP as the guardian could not attend on that date. He further stated there was another IPP review scheduled at a later date so the guardian could attend.  However, Individual #2's record did not contain evidence this meeting had taken place.  The facility failed to ensure participation in the IPP process of an individual's legal guardian and Individual #2.	W 209			
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE  At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.  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 updated annually or as	W 259			

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W 259	Continued From page 3 needed for 1 of 3 individuals (Individual #1) whose assessments were reviewed. This resulted in a lack of assessment information on which to base program decisions. The findings include:  1. Individual #1's IPP, dated 12/28/15, documented a 36 year old male whose diagnoses included mild intellectual disability.  His record contained a CFA that was undated and did not document the QIDP or IDT had reviewed the assessment for accuracy within the previous year.  When asked during an interview on 4/15/16 from 8:30 - 8:57 a.m., the Program Manager verified a review of the CFA for accuracy was not documented and the CFA was not dated.  The facility failed to ensure Individual #1's CFA documented it had been reviewed within the previous year or updated as needed.	W 259			
W 326	483.460(a)(3)(iii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain special studies as recommended for 1 of 3 individuals (Individual #1) whose medical records were reviewed. This resulted in an individual not receiving an orthopedic or podiatrist evaluation as recommended. The findings include:	W 326			

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W 326	<p>Continued From page 4</p> <p>1. Individual #1's IPP, dated 12/28/15, documented a 36 year old male whose diagnoses included mild intellectual disability.</p> <p>His record contained an Annual Physical Therapy Evaluation, dated 12/15/15, which stated "Because of his presentation of BILATERAL ANKLE SUPINATION, perhaps he also would be a candidate for assessment for ORTHOTICS to counter same."</p> <p>The evaluation also documented "I would recommend that he be assessed by either an orthopedic surgeon or a podiatrist."</p> <p>However, no documentation related to an orthopedic or podiatrist evaluation could be found.</p> <p>When asked during an interview on 4/15/16 from 8:30 - 8:57 a.m., the facility's LPN stated Individual #1 had not been assessed by either an orthopedic surgeon or a podiatrist.</p> <p>The facility failed to ensure Individual #1 received an orthopedic or podiatrist evaluation as recommended.</p>	W 326		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2016</b>
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M 000	16.03.11 Initial Comments  The following deficiencies were cited during the state licensure survey conducted from 4/11/16 to 4/18/16.  The surveyors conducting your survey were:  Karen Marshall, MS, RD, LD, Team Leader Jim Troutfetter, QIDP	M 000		
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 W124.	MM134		
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 W209 and W259.	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 	TITLE  	(X6) DATE <b>4/29/16</b>
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Bureau of Facility Standards

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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 W326.	MM166		
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RECEIVED  
MAY - 2 2016  
FACILITY STANDARDS

4/27/16

Karen Marshall  
Health Facility Surveyor  
Non-Long Term Care  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009

RE: Foxhollow, Provider #13G066

Dear Karen Marshall:

Thank you for your considerateness during the recent annual recertification survey at the Foxhollow home. Please see our responses below for each citation and give us a call if you have any questions or concerns.

**W124**

1. The IDT has contacted the guardian of Individual #2 to inform them of the need for a signed consent in regards to the refusal of the 2015-2016 flu vaccine. A declination form, with a list of risks and benefits and a VIS form from the CDC website was provided for the guardians.
2. All individual's charts are currently being reviewed to ensure that guardians are notified of risks and benefits of denied/refused services. Any discrepancies will be addressed immediately.
3. Guardians will be provided with a declination form to sign when services are refused or declined. Enough time in advance will be provided to contact teach guardian to discuss the decision to have their individual vaccinated or not.
4. Aspire Human Services will schedule a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review of accuracy of records including individual files and risk and benefits. Any discrepancies will be addressed immediately
5. Person Responsible: Program Manager, LPN, QIDP & Program Supervisor
6. Completion Date: 5/31/16

**W209**

1. Individual #2's guardians were provided with a copy of the IPP. Guardians were asked if they wanted a follow-up meeting to discuss.
2. All individual's charts are currently being reviewed to ensure that guardians are notified of planned meetings.
3. An invitation letter with designated date and time for IDT meetings will be mailed to guardians and individuals two weeks prior to meeting. Alternative options will be provided if unable to attend, such as conference calls and/or a follow-up meeting.

4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review of accuracy of records including individual files and communication records. Any discrepancies will be addressed immediately.
5. Person Responsible: Program Manager, QIDP, & Program Supervisor
6. Completion Date: 5/31/16

**W259**

1. Individual #1's CFA is updated, current and signed by the QIDP.
2. All individual's charts are currently being reviewed to ensure objectives are based on the performance of each individual.
3. A review of each individual chart will focus on ensuring objectives are revised based on actual performance of each individual and the expectation that the CFA is revised as individuals status changes.
4. Currently Aspire Human Services has scheduled at a minimum of two internal reviews annually for each individual served. One part of the review verifies that objectives are based on individual's actual performance.
5. Person Responsible: Program Manager and QIDP.
6. Completion Date: 5/31/16

**W326**

1. Individual #1 was seen by the podiatrist on 4/19/16.
2. All files are currently being reviewed to verify that all recommended screenings have been administered.
3. A training has been scheduled for the nursing teams including nursing aid(s) at Aspire Human Services, on part of the training will focus on assuring that all recommended screening occur as scheduled.
4. Currently Aspire Human Services has scheduled a minimum of two internal reviews annually for each individual served. The internal review verifies that all recommended screenings occur.
5. Person Responsible: Program Manager, LPN & QIDP.
6. Completion Date: 5/31/16

Kimberly Eckstein  
QIDP



4/29/2016

Karen Marshall  
Health Facility Surveyor  
Non-Long Term Care  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009

RE: Fox Hollow, Provider #13G066  
Dear Karen Marshall:

Thank you for your considerate observations during your recent visit at the Springfield home on April 12, 2016. Please see our responses below for each citation and please give us a call if you have any questions or concerns.

**MM134**

Currently Aspire Human Services has a policy and procedure in place which outlines the participant's rights.

1. All employees that work in Nursing services and/or Behavioral services will be re-trained on company policy for Participants rights. The training will focus on the right to refuse services and the right to be informed of the services offered, the expected risks and benefits of these services, and alternative forms of services.
2. Aspire Human Services in Idaho Falls is creating a schedule for the completion of the chart reviews. After chart reviews are completed the LPN and QIDP will coordinate the correction of any identified errors.
3. All refused services will be documented and the participant/guardian will be provided with risks vs. benefits information. This information will then be placed in the participants chart.
4. Aspire Human Services will schedule a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review of accuracy of records including individual risks and benefits. Any discrepancies will be addressed immediately.
5. Person Responsible: Program Manager, LPN & QIDP
6. Completion Date: 5/31/2016

Please refer to response given under W124.

**MM159**

1. Individual #2's parents/guardians were provided a copy of the IPP. The parents were offered a follow-up meeting to discuss any issues, concerns or any changes that they would like to see pertaining to the efficacy of his programs. Individual #1s CFA has been reviewed, updated and signed by the QIDP.
2. Aspire Human Services will send information to the parents, guardians, and individual informing of the date and time of the IDT meeting. Alternate methods of communication will be available, such as conference calling and scheduling a follow up meeting or phone conference. All individual charts are currently being reviewed to ensure objectives are based on the performance abilities of each individual, any changes will be reflected on the Comprehensive Functional Assessment, sign and dated by the QIDP.
3. All letters of informed meetings, phone conferences and follow-up meetings will be documented and placed in individual's charts. If guardian chooses not to participate a copy of the meeting notes or IPP will be mailed.
4. Aspire Human Services will schedule a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review of accuracy of records including assessments and parent/guardian and individuals participation. Any discrepancies will be addressed immediately.
5. Person Responsible: Program Manager & QIDP
6. Completion Date: 5/31/2016

Please refer to response given under W209 and W259

**MM166**

1. Individual 2's was seen by the podiatrist on 4/19/2016. Any recommendations have been followed up on, with provided equipment and instruction to use.
2. All the files are currently being reviewed to follow to ensure all recommended screenings have been administered. Any discrepancies will be addressed immediately.
3. A training will be scheduled for the nursing teams including the nursing aid(s) at Aspire Human Services that all recommendations will be followed up in a timely manner.
4. Aspire Human Services will schedule a minimum of two internal reviews annually for each individual served. The internal review tool is being revised to include a review of accuracy of records including assessments and recommendations any discrepancies will be addressed immediately.
5. Person Responsible: Facility Nurse and QIDP
6. Completion Date: 5/31/2016

Please refer to response under W326

Kim Eckstein  
QIDP