IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Community Connections North Inc	**Region(s):**	1
Agency Type:	Residential Habilitation	**Survey Dates:**	02/28/2017-03/01/2017
Certificate(s):	RHA-3904	**Certificate(s) Granted:**	☐ 6 - Month Provisional ☐ 1 - Year Full ☒ 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.	1. *Click here to enter text.* 2. *Click here to enter text.* 3. *Click here to enter text.* 4. *Click here to enter text.*	*Click here to enter a date.*

Agency Representative & Title: No signature required. * By entering my name and title, I agree to implement this plan of correction as stated above.	**Date Submitted:** n/a
Department Representative & Title: Kimberly D. Cole, LSW Medical Program Specialist * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** 3/2/2017