IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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DIVISION OF MEDICAID
1070 Hiline Rd. Suite 260
Pocatello, Idaho 83201
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Website: www.ddacertification.dhw..idaho.gov

May 20, 2010

Donna Butler, Administrator
Dawn Enterprises, Inc.
P.O. Box 388
Blackfoot, Idaho 83221

Dear Ms. Butler:

Thank you for submitting Dawn Enterprises, Inc. Plan of Correction for Residential Habilitation services dated April 14, 2010. 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 Dawn Enterprises, Inc. a full certificate effective April 24, 2010 unless otherwise suspended or revoked.

This certificate is contingent upon the correction of deficiencies. Your agency will be required to submit documentation to substantiate that your Plan of Correction has been met. Documentation must be submitted within 7 days of the date of completion listed on your agency's plan of correction and no later than **July 26, 2010**. You may submit supporting documentation as follows:

Fax to:	208-239-6269
Email to:	lovelanp@dhw.idaho.gov
Mail to:	Dept. of Health & Welfare Medicaid-Survey & Certification 1070 Hiline, Suite 260 Pocatello, Idaho 83201
Or deliver to:	Above address

You can reach me if you have any questions at 208-239-6267.

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

Pam Loveland-Schmidt

Pam Loveland-Schmidt, DS
Medical Program Specialist
DDA/RH Survey and Certification

Submit by Email | Print Form

Statement of Deficiencies

Residential Habilitation Agency

Dawn Enterprises, Inc.
RHA-379

280 N Cedar St
Blackfoot, ID 83221
(208) 785-5890

Survey Type: Recertification

Entrance Date: 4/14/2010
Exit Date: 4/14/2010

Initial Comments: Survey Team: Pam Loveland-Schmidt, Medical Program Specialist; and Rebecca Brodhecker, Supervisor.

Observations:

[Participant 1] No observation conducted; affiliation only.

[Participant 2] No observation conducted; affiliation only.

[Participant 3] was observed with Res Hab staff ([Employee 5]) in the community (Ridley's) working on socialization, behavior, and shopping skills. The staff had a good rapport with the individual. She provided choices, prompts, and reinforcement as appropriate. Overall, staff worked well with the participant.

[Participant 4] was observed in the community at the public swimming pool. The objective worked on was exercise in the pool, which was a formal goal. The staff and participant were observed walking laps in the pool several times. It appeared as though the staff had a good rapport with the participant. This goal was discussed with the Administrator and QMRP regarding "exercise" being recreational in nature and not a Medicaid billable service.

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
Additional Term RH A-5.2	QA Program	1 - ALL PARTICIPANTS/GUARDIANS WERE INFORMED THAT ALTERNATIVE FORMS OF SERVICES ARE AVAILABLE AND SIGNED THE CHECKLIST STATING THAT THEY WERE INFORMED. 2 - ALL PARTICIPANTS/GUARDIANS WERE INFORMED AND SIGNED THE CHECKLIST. 3 - THE QMRP INFORMED ALL PARTICIPANTS/GUARDIANS AND HAD THEM SIGN THE CHECKLIST FORM.
A.5. Quality Improvement. The provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules. Results of individual quality improvement reviews conducted by IDHW shall be transmitted to the provider within 45 days of a	[Participants 1, 2, 3, and 4]'s records lacked evidence that the agency informed the participant or guardian of alternative forms of services available.	

review being completed. If deficiencies have bee identified by the review, the provider shall submit to IDHW a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to IDHW within 45 days of receiving the results of a quality assurance review. Upon request, a provider shall also forward to IDHW the results of any implemented corrective action plan. At a minimum quality of services shall be evaluated according to the following criteria: A.6.2. The provider informs each participant or guardian of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.		4 REVIEWING ALTERNATIVE FORMS OF SERVICES WAS ADDED TO THE PARTICIPANT INTAKE/ANNUAL REVIEW CHECKLIST FORM. THIS FORM IS SIGNED AT INTAKE AND ANNUALLY. 5 - ALL CORRECTIONS WERE COMPLETED BY 5-6-2010.

Scope and Severity: Widespread / No Actual Harm - Potential for Minimal Harm	Date to be Corrected: 05-06-2010	Administrator Initials:
Administrator Signature (confirms submission of POC):		Date: 05-06-2010
Team Leader Signature (signifies acceptance of POC): Dawn Bovland-Schmitt		Date: 5/20/10