



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

IDAHO DEPARTMENT OF
HEALTH & WELFARE

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
1070 Hilline Rd. Suite 260
Pocatello, Idaho 83201
PHONE: (208) 239-6267
FAX: (208) 239-6269
Email: lovelanp@dhw.idaho.gov
Website: www.ddacertification.dhw.idaho.gov

August 26, 2010

Bill Benkula, Administrator
WDB, Inc.
P.O. Box 1862
Twin Falls, Idaho 83301

Dear Mr. Benkula:

The Department reviewed the Residential Habilitation (Res Hab) services offered by your agency on August 17, 2010 through August 18, 2010. The purpose of the review was to renew your Res Hab certificate and assure that your agency provides quality services in compliance with IDAPA 16.04.17 Rules governing Residential Habilitation Agencies, Medicaid Provider agreement additional terms and all applicable rules. Based on observation of services and documentation presented during the review, no deficient practices were identified.

Thank you for accommodating the survey team during the review process. Please e-mail at: lovelanp@dhw.idaho.gov or call me with any questions or comments at 208-239-6267.

Sincerely,


Pam Loveland-Schmidt, Adult & Child DS
Medical Program Specialist
Medicaid Survey and Certification

Enclosure

Statement of Deficiencies

Residential Habilitation Agency

WDB Inc
RHA-279

141 Shoshone St N
Twin Falls, ID 83301
(208) 734-4344

Survey Type: Recertification

Entrance Date: 8/17/2010

Exit Date: 8/18/2010

Initial Comments: Survey Team: Pam Loveland-Schmidt, Medical Program Specialist.

Observations:

[Participant 1] was observed in the home with direct care staff preparing a shopping list. The staff had a good rapport with the participant. The staff provided prompts and reinforcement as appropriate.

[Participant 2] was observed in the home working on self care brushing her teeth. The participant appeared to respond well to the direct care staff and the staff utilized cues from the participant to prevent behaviors.

[Participant 3] was observed in the home washing dishes. The staff was observed collecting data and redirected the participant to completing the task.

[Participant 4] was observed in the home working on utilizing her words when she does or does not want to do something. The direct care staff worked well with the participant.

Rule Reference/Text	Category/Findings	Plan of Correction (POC)	
<No Deficiencies>	<Substantial Compliance>		
<No Deficiencies Cited>			
Scope and Severity: /		Date to be Corrected:	Administrator Initials:
Administrator Signature (confirms submission of POC):			Date:
Team Leader Signature (signifies acceptance of POC):			Date: