IDAHO DEPARTMENT OF HEALTH & WELFARE

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December 9, 2011

Thair Pond, Administrator
Tomorrow's Hope Satellite Services
1655 W. Fairview Ave, Ste. 100
Boise, ID 83702

Dear Mr. Pond:

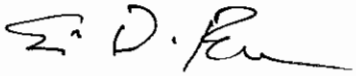
Thank you for submitting the Plan of Correction for Tomorrow's Hope Satellite Services dated December 21, 2011. Survey and Certification has reviewed and accepted the Plan of Correction in response to the Department's Compliance Review findings. As a result, we have issued Tomorrow's Hope Satellite Services a full three (3) year certificate effective from January 31, 2012 through January 31, 2015.

According to IDAPA 16.03.21.125.02, this certificate is contingent upon correction of deficiencies. Your agency is required to submit documentation to substantiate that you your Plan of Correction has been met. Please submit these documents with references to citations clearly marked, following the order listed on the Statement of Deficiencies. Documentation must be submitted within seven days of the date of completion listed on your agency's Plan of Correction. All supporting documentation must be submitted no later than close of business Friday, February, 17, 2012. You may submit supporting documentation as follows:

Fax:	(208) 364-1811
Email:	ALC@dhw.idaho.gov
Mail:	Idaho Department of Health and Welfare Administration of Licensing and Certification PO Box 83720-0009 Boise, ID 83720
Deliver:	DDA/ResHab Survey

Thank you for your patience while accommodating us through the survey process. If you have any questions, you can reach me if at (208) 364-1906.

Sincerely,



ERIC D BROWN
Program Supervisor
DD Survey and Certification

Submit by Email | Print Form

Statement of Deficiencies

Developmental Disabilities Agency

Tomorrow's Hope Satellite Services
4TOMORW018

1655 W Fairview Ave Ste 100
Boise, ID 83702-5173
(208) 319-0760

Survey Type: Recertification

Entrance Date: 10/24/2011

Exit Date: 10/28/2011

Initial Comments: Survey Team: Eric Brown, Program Supervisor, Licensing and Certification.

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.10.655.07.a.iv	Program Documentation (data/progress)	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
655. DDA SERVICES: PROCEDURAL REQUIREMENTS. 07. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11) a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11) iv. When a participant receives developmental therapy, documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. (7-1-11)	During review of [Participant 2]'s file, it was determined that the participant's Provider Status Review document did not contain information indicating why the participant continued to need the service.	**DDA Services: Procedural Requirements - a written description must be included in the status review of the participant's progress towards the achievement of the therapeutic goals and the reason why he continues to need services.** Participants # 2 status review was update to include a written description for the reasons he continues to need services. By 11/25/11 Program Director Responsible All participants status reviews will be reviewed to ensure they have a written description of continued need of services By 11/25/22 Program Director Responsible The ISP PSR will include review of the status review to ensure that is has the written description of the reason why the participant continues to need services. By 11/28/11 DS Responsible PSR will be reviewed quarterly at the monthly QA to ensure status review has required documentation By 11/28/11 Program Director responsible

Scope and Severity: Isolated / No Actual Harm - Potential for Minimal Harm		**Date to be Corrected:**	**Administrator Initials:**

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.10.655.08	Implementation Plan	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
655.DDA SERVICES: PROCEDURAL REQUIREMENTS. 08. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The Program Implementation Plan must include the following requirements: (7-1-11)	During review of [Participant 2]'s file, it was determined that two goals listed on the participant's Individual Support Plan (ISP) did not have corresponding Program Implementation Plans (PIPs) and that two PIPs were not related to goals on the participant's ISP. In addition, during reivew of [Participant 4]'s file, it was determined that the PIPs had not been written and implemented within 14 days after the first day of ongoing programming. Implementation took place nearly one month after the ISP start date.	<u>16.03.10.655.08</u> **DDA Services: PROCEDURAL REQUIREMENTS** **Program Implementation Plan must be written and implemented within 14 days after the first day of ongoing programming.** Participant # 2's two program put in place and implemented. By 11/1/11 Program Director Responsible Implementation plans to be reviewed to ensure all plans listed on the ISP have been implemented. By 11/28/11 DS Responsible DS's to complete the ISP PSR to ensure that all programs listed on the plan have been implemented to be done at the start of the new plan. By 11/28/11 DS Responsible All ISP PSR to be reviewed at the monthly QA and signed off by the Program director B11/28/11 Program Director Responsible

Scope and Severity: Isolated / No Actual Harm - Potential for Minimal Harm		**Date to be Corrected:**	**Administrator Initials:**

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.21.410.01.a	Training	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
410. GENERAL TRAINING REQUIREMENTS FOR DDA STAFF. Each DDA must ensure that all training of staff specific to service delivery to the participant is completed as follows: (7-1-11) 01. Yearly Training. The DDA must ensure that staff or volunteers who provide DDA services complete a minimum of twelve (12) hours of formal training each calendar year. Each agency staff providing services to participants must: (7-1-11) a. Participate in fire and safety training upon employment and annually thereafter; and (7-1-11)	During review of the agency's staff files, it was determined that [Employee 12] did not have documentation of receiving annual fire safety training.	**16.03.21.410.01 a General Training requirements for DDA staff** Employee #12 received the annual fire safety training as of 11/18/11 By 11/18/11 Program Director Responsible All required training has been added to the training log to ensure all staff are meeting their required trainings. By 11/18/11 Program Director Responsible DS to document on a weekly basis all training the staff has received, to be reviewed by HR and Program Director at the monthly QA. By 10/30/11 DS Responsible HR to attend Monthly QA to review all staff training records. Any missing training will be added to the action list and DS to schedule the staff to attend the needed trainings. By 11/28/11 DS Responsible

Scope and Severity: Isolated / No Actual Harm - Potential for Minimal Harm | **Date to be Corrected:** | **Administrator Initials:**

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.21.410.01.b	Training	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
410. GENERAL TRAINING REQUIREMENTS FOR DDA STAFF. Each DDA must ensure that all training of staff specific to service delivery to the participant is completed as follows: (7-1-11) 01. Yearly Training. The DDA must ensure that	During review of agency staff files, it was determined that [Employees 8 and 13] did not have current CPR certification.	

staff or volunteers who provide DDA services complete a minimum of twelve (12) hours of formal training each calendar year. Each agency staff providing services to participants must: (7-1-11) b. Be certified in CPR and first aid within ninety (90) days of hire and maintain current certification thereafter; and (7-1-11)		**16.03.21.410.01 b General Training Requirements for DDA Staff** Employees 8 and 13 have been schedule to attend CPR in Dec. By 12/8/11 DS Responsible All required training has been added to the training log to ensure all staff are meeting their required trainings. By 11/18/11 Program Director Responsible DS to document on a weekly basis all training the staff has received, to be reviewed by HR and Program Director at the monthly QA. By 10/30/11 DS Responsible HR to attend Monthly QA to review all staff training records. Any missing training will be added to the action list and DS to schedule the staff to attend the needed trainings. By 11/28/11 DS Responsible

Scope and Severity: Pattern / No Actual Harm - Potential for Minimal Harm | **Date to be Corrected:** | **Administrator Initials:**

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.21.500.03.a	Building Standards	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
500. FACILITY STANDARDS FOR AGENCIES PROVIDING CENTER-BASED SERVICES. The requirements in Section 500 of this rule, apply when an agency is providing center-based services. (7-1-11) 03. Fire and Safety Standards. (7-1-11) a. Buildings on the premises must meet all local and state codes concerning fire and life safety that are applicable to a DDA. The owner or operator of a DDA must have the center inspected at least annually by the local fire authority and as required by local city or county ordinances. In the absence of a local fire authority, such inspections must be obtained from the Idaho State Fire Marshall's office. A	During review of agency documentation, it was determined that the agency did not have documenation that the local fire authority had inspected the agency's Boise facility. The agency was not able to produce documentation of the last inspection. The inspection was scheduled and completed during the review. (The agency corrected the deficiency during the course of the survey. The agency is required to answer questions 2-4 on the Plan of Correction.)	**16.03.21.500.03a When providing center based services buildings on the premises must meet all local and state codes concerning fire and life safety that are applicable to a DDA.** Inspection was completed. By 10/25/11 Program director Responsible Fire inspection to be kept in the monthly QA book to ensure that it has been done and current. By 10/25/11 Program Director Responsible

copy of the inspection must be made available to the Department upon request and must include documentation of any necessary corrective action taken on violations cited; (7-1-11)		The fire department inspection has been added to the building PSR to be completed monthly. By 10/25/11 DS Responsible The building PSR to be reviewed at the monthly QA and signed off by the Program Director to ensure all areas meet criteria. Anything with a TO to be added to the action list and completed by the following monthly QA. By 11/16/11 Program Director responsible

Scope and Severity: Isolated / No Actual Harm - Potential for More Than Minimal Harm | **Date to be Corrected:** | **Administrator Initials:**

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.21.500.05.b	Building Standards	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
500. FACILITY STANDARDS FOR AGENCIES PROVIDING CENTER-BASED SERVICES. The requirements in Section 500 of this rule, apply when an agency is providing center-based services. (7-1-11) 05. Food Safety and Storage. (7-1-11) b. When the agency does not provide food service for participants, it must keep refrigerators and freezers used to store participant lunches and other perishable foods in good repair and equipped with an easily readable thermometer. Refrigerators must be maintained at forty-one degrees Fahrenheit (41°F) or below. Freezers must be maintained at ten degrees Fahrenheit (10°F) or below. (7-1-11)	During the Boise facility walk-through, it was determined that only one of the five refridgerators/freezers contained a thermometer. This issue was corrected immediately during survey. (The agency corrected the deficiency during the course of the survey. The agency is required to answer questions 2-4 on the Plan of Correction.)	**16.03.21.500.05b Food Safety and Storage** **Thermometers were placed in the fridges.** The building PSR to included checking that the thermometer are in the fridge and the fridge is the correct temperature. By 11/15/11 Program Director Responsible The DS to complete a monthly PSR on the building. By 11/15/11 DS Responsible The building PSR to be reviewed at the monthly QA and signed off by the Program Director to ensure all areas meet criteria. Anything with a TO to be added to the action list and completed by the following monthly QA. By 11/16/11 Program Director responsible

Scope and Severity: Widespread / No Actual Harm - Potential for Minimal Harm | **Date to be Corrected:** | **Administrator Initials:**

Rule Reference/Text	Category/Findings	Plan of Correction (POC)
16.03.21.900.01.d	Setting for Service Delivery	Please refer to the questions on the cover sheet to formulate your Plan of Correction. Text does not flow to the next page; you will need to click in the field on the next page to continue if your Plan of Correction straddles pages. You may overwrite the instructions in this field.
900. REQUIREMENTS FOR AN AGENCY'S QUALITY ASSURANCE PROGRAM. Each DDA defined under these rules must develop and implement a quality assurance program. (7-1-11) 01. Purpose of the Quality Assurance Program. The quality assurance program is an ongoing, proactive, internal review of the DDA designed to ensure: (7-1-11) d. Skill training activities are conducted in the natural setting where a person would commonly learn and utilize the skill, whenever appropriate; and (7-1-11)	During file review, it was documented that [Participant 2] worked on the community goal of physically crossing the street while inside the DDA facility. This objective was not conducted in the natural settiing as specified on the PIP.	16.03.21.900.01d Quality Assurance Programs All staff have been trained regarding running community programs and scoring the community programs. By 10/31/11 Program Director Responsible DS to review the program documentation and informal schedule to ensure they are running programs correctly and documenting correctly. By 10/31/11 DS Responsible Program PSR to be completed on programs at monthly QA to review if the program was run in the natural environment and that the program was documented correctly. By 10/31/11 DS Responsible Program PSR to be reviewed by the program director at the monthly QA any areas where there are TO will be added to the action list and corrected by the next month. By 10/31/11 Program Director Responsible

Scope and Severity: Isolated / No Actual Harm - Potential for Minimal Harm	**Date to be Corrected:**	**Administrator Initials:**
Administrator Signature (confirms submission of POC): Thomas S. Pond, Adm		**Date:** 11/21/11
Team Leader Signature (signifies acceptance of POC): [signature]		**Date:** 12/9/11