IDAHO DEPARTMENT OF
HEALTH & WELFARE

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April 17, 2014

Robynn Howell, Administrator
Royal Journeys, LLC
P.O. Box 1429
Idaho Falls, ID 83403-1429

Dear Ms. Howell:

Thank you for submitting the Plan of Correction for Royal Journeys, LLC dated April 16, 2014, in response to the recertification survey concluded on February 28, 2014. The Department has reviewed and approved the Plan of Correction.

As a result of the recertification survey, we previously issued Royal Journeys, LLC three-year certificates for the Ammon, Rexburg, and Rigby locations effective from April 1, 2014, through March 31, 2017, unless otherwise suspended or revoked. Per IDAPA 16.03.21.125, these certificates were issued on the basis of substantial compliance and are contingent upon the correction of deficiencies.

Thank you for your patience while accommodating us through the survey process. If you have any questions, you can reach me at (208) 239-6267 or lovelanp@dhw.idaho.gov.

Sincerely,

Pam Loveland-Schmidt

PAMELA LOVELAND-SCHMIDT, Adult & Child DS
Medical Program Specialist
DDA/ResHab Certification Program

PLS/slm

Enclosure
1. Approved Plan of Correction

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Statement of Deficiencies

Developmental Disabilities Agency

Royal Journeys
DDA-4519

2664 1st Street
Ammon, ID 83401-4500

Survey Type: Recertification

Entrance Date: 2/25/2014

Exit Date: 2/28/2014

Initial Comments: Survey Team: Pam Loveland-Schmidt, Medical Program Specialist, DDA/ResHab Certification Program; Eric Brown, Program Manager, DDA/ResHab Certification Program; and Kerrie Ann Hull, Medical Program Specialist, DDA/ResHab Certification Program.

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.009.01 009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Verification of Compliance. The agency must verify that all employees, subcontractors, agents of the agency, and volunteers delivering DDA services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)	Six of 15 employee records reviewed lacked documentation the agency verified that all employees, subcontractors, agents of the agency, and volunteers delivering DDA services complied with IDAPA 16.05.06, "Criminal History and Background Checks." For example: Employee 10's hire date was 01/13/2014, and his first day worked with participants was 01/14/2014. The agency transferred his DHW criminal history check completed by another agency dated 09/09/2013 on 02/21/2014, but the agency did not complete a local Idaho State Police (ISP) check. Employee 11's date of hire was 10/03/2011. Her self-declaration application was completed on 10/03/2011. She missed her fingerprinting appointment on 10/20/2011, then rescheduled	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. All employees will comply exactly with criminal history background requirements. Employees will not be allowed to work with participants without satisfactorily completing background screening. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All staff files will be reviewed and corrective steps will be taken to brings background checks into compliance. Employees will not be allowed to work with participants until corrections are fulfilled. 3. Who will be responsible for implementing each corrective action? Administrator or designee.	2014-04-11

	for 11/17/2011. The employee was fingerprinted on 12/08/2011, which was 2 months and 2 days after the employee's start date. Employee 12's date of hire was 03/04/2013. Her start date was 03/13/2013. The agency completed a local ISP check dated 03/07/2013 and cleared the local ISP check on 03/24/2013, but the DHW criminal history was not completed until 07/16/2013. The agency did not have documentation that this employee passed her criminal history check from 03/04/2013-07/16/2013. The agency did not complete the DHW criminal history check (CHC) per rule requirements.	4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? The corrective actions will be monitored upon employee hire as a condition of employment and formally as part of the agency's quality assurance program.
	Employee 13's date of hire was 06/12/2013. Her DHW CHC dated 08/02/2012 was for another agency. The agency did not add the employee to their agency in the DHW CHC database until 02/21/2014. The agency had a local ISP check dated 06/12/2013, but the ISP invoice receipt date was not until 08/23/2013 and cleared local ISP on 08/29/2013. The agency did not complete the CHC per rule requirements. Employee 14's date of hire was 10/31/2013 and start date was 11/01/2013. The employee had a DHW CHC for another agency completed 12/19/2012. The agency did not add this employee to their agency in the DHW CHC database until 02/21/2014 and there was no documentation of a local ISP check. The agency did not have documentation that this employee passed her criminal history check from 10/31/2013 to the date of survey. Employee 15's date of hire was 05/17/2013 and start date was 05/21/2013. The employee had a DHW CHC for another agency dated	

	12/19/2012. The agency did not add the employee in the DHW CHC database until 02/21/2014. There was a local ISP check in the employee record, but no documentation that the employee cleared it. The agency did not have documentation that this employee passed his criminal history check from 05/17/2013 to 02/21/2014.		
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.410.03.b 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) 03. Additional Training for Professionals. Training of all professional staff must include the following as applicable to their work assignments and responsibilities: (7-1-11) b. Consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques. (7-1-11)	One of seven employees observed lacked evidence the DDA ensured that all training of staff specific to service delivery to participants was completed to include additional training for professionals. For example, Employee 9 placed Participant C in a basket restraint. This restraint was not identified as a possible intervention and was a restrictive component, which had not been reviewed or approved per rule requirements.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Staff will be retrained to only implement techniques they have been trained on including interventions requiring specialized training such as restraints. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All staff will be retrained on expectations and the corrective measures defined in item #1 will adequately resolve the deficient practice. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be monitored during weekly supervision, monthly observations, ongoing training, and part of the quality assurance program.	2014-05-01

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.500.04.a 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) 04. Evacuation Plans. Evacuation plans must be posted throughout the center. Plans must indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the building. (7-1-11) a. The DDA must conduct quarterly fire drills. At least two (2) times each year these fire drills must include complete evacuation of the building. The DDA must document the amount of time it took to evacuate the building; and (7-1-11)	One of four facilities reviewed lacked evidence that the agency documented quarterly fire drills per rule requirements. At least two (2) times each year, these fire drills must include complete evacuation of the building. The DDA must document the amount of time it took to evacuate the building. For example, the Rexburg adult center's fire drill on June 5, 2013, did not include time it took to evacuate. In addition, the fire drill documentation for the Rexburg center did not include evacuation duration for March 21, 2013; August 28, 2013; December 5, 2013; and January 22, 2014.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Fire drills will occur pursuant to regulation and include and required elements for compliance. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? The corrective actions in item #1 will resolve affects on other participants. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be formally monitored quarterly during fire drills.	2014-04-11

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.601 601. RECORD REQUIREMENTS. Each DDA certified under these rules must maintain accurate, current, and complete participant and administrative records. These records must be maintained for at least five (5) years. Each participant record must support the individual's choices, interests, and needs that result in the type and amount of each service provided. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each signature must be accompanied both by credentials and the date signed. Each agency must have an integrated participant records system to provide past and current information and to safeguard participant confidentiality under these rules. (7-1-11)	Two of 12 participant records reviewed (Participants 1 and A) lacked documentation that the agency certified under these rules maintained accurate, current, and complete participant and administrative records. For example: The data collection sheet for Participant 1 dated 1/8/2013 lacked credentials for staff providing the service. The data collection sheet dated 1/14/2015 and signed by both direct care staff and the Developmental Specialist on 1/14/2015 had not occurred yet as of the date of the survey. The date is not clearly documented. Participant A's record did not address his specific needs and the authorized services were not provided per the authorized plan. For instance, the plan authorized 3 hours/week from 09/03/2013-05/28/2014. For the week of 01/12/2014, the agency provided 2 hours of habilitative intervention (HI); the week of 01/19/2014 the agency provided 1 hour of HI; and the week of 01/26/2014 2 hours of HI.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. The documentation of services will contain all elements required in regulation. All staff will be retrained on the documentation requirements. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All participant documentation will be reviewed to ensure compliance. The corrective measures identified in item #1 should resolve the deficiency. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? The corrections will be monitored ongoing, during weekly supervision, and as a component of the agency's quality assurance program.	2014-05-01

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.601.01.b 601. RECORD REQUIREMENTS. Each DDA certified under these rules must maintain accurate, current, and complete participant and administrative records. These records must be maintained for at least five (5) years. Each participant record must support	Five of 12 participant records reviewed lacked documentation that each record contained Program Implementation Plans (PIPs) that included the participant's name, baseline statement, measurable objectives, written instructions to staff, service environments, target date, and corresponding program	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. PIPs will be reviewed and revised to contain requirements in regulation. Staff will be retrained on these longstanding agency expectations.	2014-06-02

the individual's choices, interests, and needs that result in the type and amount of each service provided. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each signature must be accompanied both by credentials and the date signed. Each agency must have an integrated participant records system to provide past and current information and to safeguard participant confidentiality under these rules. (7-1-11) 01. General Records Requirements. Each participant record must contain the following information: (7-1-11) b. Program implementation plans that include participant's name, baseline statement, measurable objectives, written instructions to staff, service environments, target date, and corresponding program documentation and monitoring records when intervention services are delivered to the participant. (7-1-11)	documentation and monitoring records when intervention services were delivered to the participant. For example: Participant A's objectives were vague and not specific to participant needs. Participant B's toileting program stated in training to take him to the bathroom every 2 hours, and the Training and Steps stated to take him to the bathroom every 1 hour. Instructions did not correspond and were not measurable due to the two different instructions. Participant C's PIPs did not address setting a timer for sitting in the swing and resetting the timer. Also, it was unclear where the swing, weighted vest, etc. had been recommended by the occupational therapist or physical therapist, or an assessed need had been determined. Participant 3's Program 3 stated he will assist during changing with an indirect prompt 90% of the time for 3 consecutive months—this was not a measurable objective. The PIP lacked documentation of how the participant will " assist." PIP instructions and data collection steps did not clarify how the participant will " assist." Program 2 stated he will be out of his chair for a specific amount of time daily with a direct prompt at 90% of the time for 3 consecutive months. Instructions did not state that the amount of time should be recorded; however, data collection reviewed for September, October, November, and December lacked documentation of the time spent out of his chair. Participant 5's Program 4 stated she will demonstrate her knowledge of community locations. Instructions were not clear on how	2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All PIPs for all participants will be reviewed and modified accordingly. 3. Who will be responsible for implementing each corrective action? Administrator of designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrective action will be reviewed ongoing, during new employee orientation training, and as a component of the agency's quality assurance program.

	she will demonstrate this knowledge. In addition, her baseline for Program 1 did not match the objective. Participant 6's economic self-sufficiency PIP did not have any specific instructions on what money skills she is to work on. The goal was "she will work on money skills with an indirect prompt at 90% for three consecutive months by 9/30/14." The instructions to staff did not give specific direction on which skills they were to work on or how they were to work on them. REPEAT DEFICIENCY from survey of December 7, 2012.		
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.601.01.d. 601. RECORD REQUIREMENTS. Each DDA certified under these rules must maintain accurate, current, and complete participant and administrative records. These records must be maintained for at least five (5) years. Each participant record must support the individual's choices, interests, and needs that result in the type and amount of each service provided. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each signature must be accompanied both by credentials and the date signed. Each agency must have an integrated participant records system to provide past and current information and to safeguard participant confidentiality under these rules. (7-1-11) 01. General Records Requirements. Each participant record must contain the following information: (7-1-11)	Two of 12 participant records reviewed lacked documentation that each participant record contained a profile sheet with identifying information reflecting the current status of the participant, including residence and living arrangement, contact information, emergency contacts, physician, current medications, allergies, special dietary or medical needs, and any other information required to provide safe and effective care. For example: Participant F's profile sheet did not address his allergy to Penicillin (hives) addressed on the physician's report dated 09/23/2013. Participant 5's profile sheet only included diagnosis of MMR and schizoaffective disorder. The plan of service indicated additional diagnoses of bipolar disorder, hearing impairment, brain damage and external tremors that were not included in the participant's profile sheet.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Participant profiles will include all required elements in rule. Staff will be retrained to ensure compliance. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All profiles will be reviewed and modified accordingly. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? The corrections will be monitored upon intake, during employee training, and as a component of the agency's quality assurance program.	2014-05-01

d. Profile sheet containing the identifying information reflecting the current status of the participant, including residence and living arrangement, contact information, emergency contacts, physician, current medications, allergies, special dietary or medical needs, and any other information required to provide safe and effective care; (7-1-11)	REPEAT DEFICIENCY from survey of December 7, 2012.		

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.601.02 601. RECORD REQUIREMENTS. Each DDA certified under these rules must maintain accurate, current, and complete participant and administrative records. These records must be maintained for at least five (5) years. Each participant record must support the individual's choices, interests, and needs that result in the type and amount of each service provided. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each signature must be accompanied both by credentials and the date signed. Each agency must have an integrated participant records system to provide past and current information and to safeguard participant confidentiality under these rules. (7-1-11) 02. Status Review. Written documentation that identifies the participant's progress toward goals defined on his plan, and includes why	Two of 12 participant records reviewed lacked written documentation that identified the participants' progress toward goals defined on their plans, and/or included why the participant continued to need the service. For example: Participant A's Provider Status Review did not address progress toward goals. It stated he had not mastered this skill and needed continued facilitation and support, but it did not state what the agency will do to promote progress. Participant E's Provider Status Review did not address data for Month 3, 4, and 5 of the six-month PSR; it stated "GNA" (Goal Not Addressed).	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. All staff will be retrained on compliance standards for completing provider status review to include why participant continues to need the services. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All provider status reviews will be reviewed for compliance moving forward. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be monitored ongoing, through employee training and as a component of the agency's quality assurance program.	2014-05-01

the participant continues to need the service. (7-1-11)			
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.900.01.a 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) a. Services provided to participants produce measurable outcomes, are high quality, and are consistent with individual choices, interests, needs, and current standards of practice; (7-1-11)	Two of 12 participant records reviewed lacked evidence the quality assurance program was an ongoing, proactive, internal review of the DDA designed to ensure services provided to participants produce measurable outcomes, are high quality, and are consistent with individual choices, interests, needs, and current standards of practice. For example: Participant A's data did not produce measurable outcomes and did not address the individual's choices, interests, and needs. The agency's Provider Status Review did not address progress. Based upon agency documentation, the participant was losing the skill with agency skill training. Participant E's record lacked data for PIPs 1 and 2; it was not possible to determine measurable outcomes.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. All professional staff will be retrained on writing objectives that ensure progress can be achieved and correct data collection procedures. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All PIPs for all staff will be reviewed and modified accordingly. The corrective training should resolve the deficient practice. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be monitored through ongoing employee training and as a component of the agency's quality assurance program.	2014-06-02

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.900.02.g 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) 02. Quality Assurance Program Components. Each DDA's written quality assurance program must include: (7-1-11) g. Ongoing review of participant progress to ensure revisions to daily activities or specific implementation procedures are made when progress, regression, or inability to maintain independence is identified. (7-1-11)	One of 12 participant records reviewed lacked evidence the agency's written quality assurance program included an ongoing review of participant progress to ensure revisions to daily activities or specific implementation procedures are made when progress, regression, or inability to maintain independence is identified. For example, Participant A's record showed loss of progress based upon agency skill training. There was no documentation that changes had been made to the PIPs in order to promote progress.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. All professional staff will be retrained on writing objectives that ensure progress can be achieved and when to change implementation procedures. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All PIPs for all staff will be reviewed and modified accordingly. The corrective training should resolve the deficient practice. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be monitored through ongoing employee training and as a component of the agency's quality assurance program.	2014-06-02

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.915.10 915. POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF SOCIAL SKILLS AND MANAGEMENT OF MALADAPTIVE BEHAVIOR. Each DDA must develop and implement written policies and procedures that address the development of participants' social skills and management of maladaptive behavior. These policies and procedures must include statements that address: (7-1-11) 10. Review and Approval. Ensure programs developed by an agency to manage maladaptive behavior are only implemented after the review and written approval of the professional. If the program contains restrictive or aversive components, a licensed individual working within the scope of their license, must also review and approve, in writing, the plan prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals. (7-1-11)	Based on observation of services to 1 of 7 participants, it was determined the agency lacked evidence it implemented written policies and procedures addressing the development of participants' social skills and management of maladaptive behavior. For example, staff was observed working with Participant C in the home. During the observation, the staff implemented a basket hold on the participant, which was not addressed in the PIPs or written approval by the professional per rule requirements.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Staff will be retrained to only implement techniques they have been trained on including interventions requiring specialized training such as restraints. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All staff will be retrained on expectations and the corrective measures defined in item #1 will adequately resolve the deficient practice. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be monitored during weekly supervision, monthly observations, ongoing training, and part of the quality assurance program.	2014-05-01

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.915.11.c 915. POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF SOCIAL SKILLS AND MANAGEMENT OF MALADAPTIVE BEHAVIOR. Each DDA must develop and implement written policies and procedures that address the development of participants' social skills and management of maladaptive behavior. These policies and procedures must include statements that address: (7-1-11) 11. Appropriate Use of Interventions. Ensure interventions used to manage participants' maladaptive behavior are never used: (7-1-11) c. As a substitute for a needed training program; or (7-1-11)	Based on observation of services provided to 1 of 7 participants, it was determined the agency lacked evidence it ensured interventions used to manage participants' maladaptive behavior were never used as a substitute for a needed training program. For example, staff was observed working with Participant C in the home. During the observation, the staff implemented a basket hold on the participant, which was not addressed in the PIPs. The PIPs did not appear to give instructions to the staff as to what steps needed to be taken if the behavior continued or increased.	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the survey report. Staff will be retrained to only implement techniques they have been trained on including interventions requiring specialized training such as restraints. 2. What will the agency do to identify any other participants, staff, or systems that may be affected by the deficiency? If identified, what corrective actions will be taken? All staff will be retrained on expectations and the corrective measures defined in item #1 will adequately resolve the deficient practice. 3. Who will be responsible for implementing each corrective action? Administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? Corrections will be monitored during weekly supervision, monthly observations, ongoing training, and part of the quality assurance program	2014-05-01

Administrator/Provider Signature: Robyn Harrell RN	Date: 4-16-14
Department POC Approval Signature: Pam Loveland-Schmidt	Date: 4/17/2014

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.