



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
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DIVISION OF LICENSING & CERTIFICATION  
P.O. Box 83720  
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May 3, 2013

Brian Fay, Administrator  
Community Connections of Pocatello  
1675 South Maple Grove Road  
Boise, ID 83709

Dear Mr. Fay:

Please find enclosed the Statement of Deficiencies report for your Developmental Disabilities Agency (DDA). The report is based on the recertification survey of your agency that was conducted from April 24, 2013, through April 25, 2013, for the purpose of renewing your DDA certificate.

Congratulations! Based on observation of services and documentation presented during the review, no deficient practices were identified. As a result, Community Connections of Pocatello has been issued a three-year certificate effective from July 1, 2013, through June 30, 2016.

Thank you for accommodating the survey team during the review process. Please contact me with any questions or comments at [lovelanp@dhw.idaho.gov](mailto:lovelanp@dhw.idaho.gov) or (208) 239-6267.

Sincerely,

PAMELA LOVELAND-SCHMIDT, ADULT & CHILD DS  
Medical Program Specialist  
DDA/ResHab Certification Program

PLS/sm

Enclosures

1. Compliance Report Participant/Employee Key
2. Statement of Deficiencies
3. Renewed Developmental Disabilities Agency Certificate



# Statement of Deficiencies

*Developmental Disabilities Agency*

Community Connections of Pocatello  
DDA-1133

771 Yellowstone Ave  
Pocatello, ID 83201-  
(208) 377-9814

**Survey Type:** Recertification

**Entrance Date:** 4/24/2013

**Exit Date:** 4/26/2013

**Initial Comments:** Survey Team: Pam Loveland-Schmidt, Medical Program Specialist, DDA/ResHab Certification Program; and Eric Brown, Supervisor, DDA/ResHab Certification Program.

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
<No Deficiencies> 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.		

**Administrator/Provider Signature:**

**Date:**

**Department POC Approval Signature:**

**Date:**

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