IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 3, 2013

Carl Jones, Administrator
Joshua D. Smith Foundation
347 Constitution Way
Idaho Falls, ID 83402-3538

Dear Mr. Jones:

Thank you for submitting the Plan of Correction for Joshua D. Smith Foundation dated August 28, 2013, in response to the recertification survey concluded on June 27, 2013. The Department has reviewed and accepted the Plan of Correction.

As a result of the survey, we issued Joshua D. Smith Foundation three-year certificates effective from August 1, 2013, through July 31, 2016, unless otherwise suspended or revoked. Per IDAPA 16.03.21.125, these certificates are 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.

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

Joshua D. Smith Foundation
7JOSUA027-4

347 Constitution Way
Idaho Falls, ID 83402-3538
(208) 523-5674

Survey Type: Recertification

Entrance Date: 6/24/2013

Exit Date: 6/27/2013

Initial Comments: Survey Team: Pam Loveland-Schmidt, Medical Program Specialist, DDA/ResHab Certification Program; Bobbi Hamilton, Medical Program Specialist, DDA/ResHab Certification Program; and Eric Brown, Supervisor, DDA/ResHab Certification Program. This report has been amended.

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.500.01 500. 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) 01. Accessibility. Agencies designated under these rules must be responsive to the needs of persons receiving services and accessible to persons with disabilities as defined in Section 504 of the federal Rehabilitation Act, the Americans with Disabilities Act (ADA) Accessibility Guidelines, and the uniform federal accessibility standard. The DDA must submit a completed checklist to the Department to verify compliance with the ADA requirements. This checklist must be provided to the Department with the application for certification. (7-1-11)	During the walk-through and review of the agency's center locations, it was identified that 1 of 4 locations (Salmon) lacked handrails per ADA requirements in the ADA bathroom. The bathroom lacked a handrail behind the toilet.	1. Handrail behind toilet will be replaced. Additionally the Facility Review form (JDSF-110) will be revised to identify adaptions made to meet ADA requirements for each facility. Quarterly facility reviews will include ensuring that adaptions are still in place and in good working order. JDSF Facility Standards policy will be updated to identify new facility review process. 2. Corrective action will be implemented in all facilities. 3. Handrail will be replaced by a contractor determined by the administrator. JDSF forms and policy will be updated by information manager. Quarterly reviews will continue to be conducted by the program manager or designee. 4. Quarterly facility reviews will be reviewed by administrator when completed to address any lapses in meeting ADA requirements. 5. September 20, 2013	2013-09-20

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.500.03.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) 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 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)	During the walk-through and review of the agency's center locations, as well as through review of agency records, it was identified that at 3 of 4 locations (Idaho Falls, Arco, and Driggs) fire inspections by the local fire authority were not completed annually or the necessary corrective actions were not taken on the violations cited from those inspections. For example: The Idaho Falls facility lacked documentation that the citations addressed in the fire inspection dated December 24, 2011, were corrected. The citation was for extension cords (D-1). In addition, the agency lacked documentation of a 2012 fire inspection. The Arco facility lacked documentation of a fire inspection for 2011 and 2012. The Driggs facility lacked documentation of a fire inspection for 2012.	1. A project will be created through JDSF online project management program with assignment of task and due dates for scheduling annual fire inspections and follow-up for corrective actions required. Documentation of inspections and corrective actions will be uploaded into network digital file storage for review by administrator when completed. JDSF Facility Standards policy will be updated to identify new policy for completing annual fire inspections. 2. Corrective action will be implemented in all facilities. 3. Policy revision and set-up of project management tool will be completed by information manager. Scheduling and follow-up of inspections will be completed by staff assigned through project management program. 4. Lapses in scheduling and completing annual inspections by the due date will be flagged through the project management tool until completed. 5. September 15, 2013	2013-09-15

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.500.04.a-b 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) b. A brief summary of each fire drill conducted must be written and maintained on file. The summary must indicate the date and time the drill occurred, participants and staff participating, problems encountered, and corrective action(s) taken. (7-1-11)	Review of agency records revealed that 4 of 4 locations (Idaho Falls, Arco, Driggs, and Salmon) completed at least quarterly fire drills, but lacked documentation within their fire drill summaries of participants and staff participating in the drills.	1. Fire Drill and Evacuation Summary (JDSF-119) will be revised to include all components identified in 500.04.b. JDSF Facility Standards Policy will be changed to include method for completing and submitting JDSF-119 to Administrator on a quarterly basis to ensure compliance with requirement for quarterly drills. All staff will receive training on the implementation of new forms and policies for conducting fire drills. 2. Corrective action will be implemented in all facilities. 3. Policy and form development will be completed by information manager. Policy implementation will be completed by Administrator. Training will be scheduled and facilitated by training coordinator. 4. According to JDSF Facility Standards Policy, fire drills and evacuations will be reviewed quarterly by Administrator to ensure requirements of 500.04. a-b are being met. 5. September 15, 2013	2013-09-15

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.500.06.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) 06. Housekeeping and Maintenance Services. (7-1-11) a. The interior and exterior of the center must be maintained in a clean, safe, and orderly manner and must be kept in good repair; (7-1-11)	During the walk-through and review of the agency's center locations, it was identified that 1 of 4 locations (Salmon) lacked evidence the agency assured the interior was kept in good repair. For example, the ADA bathroom door had multiple holes at the bottom from a wheel chair hitting it (per agency staff report).	1. Kickplates will be installed on all doors that are in locations where they are prone to wheelchair damage. Quarterly facility reviews will be used to identify disrepair throughout facilities. 2. Corrective action will be implemented in all facilities. 3. Kickplates will be installed by a contractor determined by the administrator. Quarterly reviews will continue to be conducted by the program manager or their designee. 4. Quarterly facility reviews will be reviewed by administrator when completed to address any repair issues throughout all facilities. 5. September 20, 2013 for Salmon location All other locations as needed but no later than March 15, 2014	2013-09-20

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.511.01 511. MEDICATION STANDARDS AND REQUIREMENTS. 01. Medication Policy. Each DDA must develop written medication policies and procedures that outline in detail how the agency will ensure appropriate handling and safeguarding of medications. An agency that chooses to assist participants with medications must also develop specific policies and procedures to ensure this assistance is safe and is delivered by qualified, fully-trained staff. Documentation of training must be maintained in the staff personnel file. (7-1-11)	Review of agency records revealed that for 6 of 10 participants (Participants 1, 2, 4, 5, and 9) the agency was not following its own medications policies and procedures. For example: For Participant 4, the agency did not follow its written medication policy. On June 24 and 25, 2013, there was no documentation verifying the receipt of the participant's medications by the agency. At the Idaho Falls facility, medications for Participants 5, 9 and 2 lacked documentation for June 25, 2013. The agency's documentation stated medications should be given on this date. There was no accompanying documentation as to why medications were not given. Participant 1 was lacking documentation for June 25, 2013. The dates on his bubble pack were different for the days the agency was assisting with these medications. One participant's medication was no longer used; it was a pain medication but no longer needed. It was still in the medication box and not returned to the participant/provider as per agency policy. Further, the agency policy stated, "All medications go home daily	1. JDSF will be updating the Medication policy to a "no exceptions" system where all medications must come in calendarized packaging and must be for the day on which the medication is to be given. Any medications that do not follow this policy will not be administered and the guardian or care provider will be immediately notified so they can make other arrangements for the medications to be administered. All JDSF staff will be required to read new medication policy and all staff with "Assistance with Medications" training will be provided training on implementing new policy. 2. Corrective action will be implemented in all facilities. 3. Medication policy will be updated by information manager. Policy implementation will be completed by Program Manager. Training will be scheduled and facilitated by training coordinator. 4. Program manager will complete a quarterly review of medication logs and storage to insure that policy is being followed. 5. September 1, 2013	2013-09-15

	regardless of which methodology is used. In addition, the person responsible for making sure the medications are given and taken appropriately. In the case where a participant may be out of the building during regular scheduled medication times, this person will be responsible to ensure medications are taken upon the participant's return." At the Arco facility, medication was given to the agency by the provider for Participant 6 in a bubble pack and the dates given to the agency were not for the dates the agency assisted. For instance, the bubble pack was for the week of June 12, 2013, and they were assisting and documenting for the week of June 24, 2013.		

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 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	Review of agency records revealed that objectives written for 2 of 10 participants (Participants 7 and 10) were not measurable. For example, Participants 7 and 10 had objectives that were implemented that did not have measurable objectives. The term " appropriate" can be defined in many ways and can be observed/measured differently by employees. This is a very subjective, and therefore immeasurable, term. For the " counting money" objective, it was not identified under what "certain amount" the participant would need to count to and from. Examples include: • "Appropriate dining skills" • Brush teeth for an "appropriate amount of time" • "Actively listen" • "When given an amount of money under a certain amount, (participant) will correctly count …"	1. Training has been scheduled for all professional staff responsible for writing implementation plans. Training is based on guidelines given in "Advancing Skills of Developmental Specialists" and other similar resources. All existing implementation plans will be reviewed to ensure that objectives are measurable. Corrections will be made to implementation plans as necessary. 2. Corrective action will be implemented across all participant records as needed. 3. Training will be scheduled and facilitated by training coordinator. Deficient implementation plans will be corrected by implementing developmental specialist. 4. Implementation plans will be periodically reviewed by program manager to monitor compliance. 5. As 12-week reviews are completed, no later than October 1, 2013.	2013-10-01

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)	• "Exhibit appropriate behaviors while out in the community"		

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)	Review of agency records revealed that there was no written documentation on the Status Review as to why the participant continued to need the service for 10 of 10 participants. For example: On Participants 8 and 9's Provider Status Review (PSR), there was no written documentation as to why the participant continued to need the service. It was identified on the PSRs that the participants' progress was decreasing due to the agency increasing the prompting levels within the current objective. The PSR stated, "Added 1 verbal prompt," but did not identify why the continuation of the services was needed. Participant 3's PSR stated that the prompt level increased to one verbal prompt, instead of decreasing prompt level. It appeared as	1. Requirement was previously being completed by documenting need for services on a separate form (Plan Review Record, JDSF-204) from the Status Review. JDSF will change review procedure to document continued need for services on the Status Review form. 2. Corrective action will be implemented for all participant records. 3. Reviewing developmental specialist will begin documenting need for continued services on the Status Review instead of the Plan Review Record (JDSF-204). 4. Status Reviews will be periodically reviewed by the program manager to monitor compliance. 5. As 12-week reviews are completed, no later than October 1, 2013.	2013-10-01

02. Status Review. Written documentation that identifies the participant's progress toward goals defined on his plan, and includes why the participant continues to need the service. (7-1-11)	though the baselines did not address the actual prompt level he is at. For instance, the "control drooling" baseline was at 0% success on the steps of this task. The objective goal was "will complete the steps on the task analysis on the first attempt at 50% of the week using the prompt levels identified on the TA." The PRS stated the prompt level on steps #2, #3, #4 would be increased to one verbal prompt, etc. Increasing the prompt level does not promote progress and does not address why he continues to need services.		

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	Review of agency records revealed that for 1 of 10 participants (Participant 4) the agency's quality assurance review did not ensure that progress or regression was being identified. For example, on the Task Analysis for an objective, when reviewed by the Developmental Specialist in the area in which the Developmental Specialist identifies "weeks towards meeting criteria for objective," the Developmental Specialist indicated 0. For Participant 4's Objective 3B, initial criteria	1. JDSF will increase monitoring of implementation plan reviews to ensure that plans are being revised as necessary. Program Manager will provide guidance to implementation developmental specialist when changes need to be made to implementation plans. 2. All participant files will be reviewed to ensure compliance. 3. Review of plans will be conducted by Program Manager. cont.	2013-10-01

progress, regression, or inability to maintain independence is identified. (7-1-11)	for this objective was set at 63% for 12 consecutive weeks. The participant was to complete this skill independently (no prompting identified on the Program Implementation Plan). The participant had been above criteria for longer than the identified 12 consecutive weeks. This objective should have been achieved during the week of September 10, 2012. On September 27, 2012, a Provider Status Review was completed and the criteria for this objective was increased to 100% for 12 consecutive weeks. After this increase, verbal prompts were added to Steps 6 and 7, although the participant previously demonstrated the ability to successfully complete all steps within this objective independently. This objective was then implemented for an additional 24 weeks where the participant's progress remained stable and was then "deleted off new plan." It was identified that the prompting levels being added to the objective may have been unnecessary due to the participant being able to complete the skill independently.	cont. 4. Program Manager will conduct periodic reviews of Implementation plans to ensure compliance on an on-going basis. 5. As 12-week reviews are completed, no later than October 1, 2013.	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.915.05 915. 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.	Review of agency records revealed that the agency did not develop or implement objectives to teach alternative adaptive skills to replace the maladaptive behaviors for 2 of 10 participants (Participants 7 and 8). For example, for Participants 7 and 8, there were no alternative skills being taught to assist in decreasing inappropriate behavior. For Participant 7's objective to "exhibit appropriate	1. Training has been scheduled for all professional staff responsible for writing implementation plans. Training is based on guidelines given in "Advancing Skills of Developmental Specialists" and other similar resources. All existing implementation plans will be reviewed to ensure that they include alternative adaptive skills as needed for replacement of maladaptive behaviors. cont.	2013-10-01

These policies and procedures must include statements that address: (7-1-11) 05. Behavior Replacement. For intervention services, ensure that programs to assist participants with managing maladaptive behavior include teaching of alternative adaptive skills to replace the maladaptive behavior.(7-1-11)	behaviors while in the community," the objective did not identify skills to teach. The Implementation Plan and Task Analysis outlined behaviors that the participant was not to engage in while in the community. Behavior reduction objectives should include replacement/ alternative skills to teach to assist in decreasing inappropriate behaviors.	cont. 2. Corrective action will be implemented across all participant records as needed. 3. Training will be scheduled and facilitated by training coordinator. Deficient implementation plans will be corrected by implementing developmental specialist. 4. Implementation plans will be periodically reviewed by Program Manager to monitor compliance. 5. As 12-week reviews are completed, no later than October 1, 2013.	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.915.11.b 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	During observation of agency staff and participants, it was observed that interventions were being utilized by the staff for their convenience for 2 of 10 participants (Participants 6 and 11). For example, Participants 6, 7, 8 and 11 were observed in the center location. It was	1. Training will be provided to all therapy staff on the use of appropriate interventions. Paraprofessional Observation (JDSF-114) will be updated to include identifying if inappropriate interventions are being used by therapy staff and corrective action will follow based on current JDSF Observation Program Policy.	2013-09-15

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) b. For the convenience of staff; (7-1-11)	observed that the staff person was not utilizing appropriate interventions or language to assist with developing the participants' social skills and management of inappropriate behaviors for Participants 6 and 11. It was observed that the staff was using language that was not conducive to teaching the participant a skill but rather for their convenience.	cont. 2. Corrective action will be implemented in all facilities and with all staff who provide developmental therapy. 3. Training will be scheduled and facilitated by training coordinator. 4. Monthly paraprofessional observations will be used to ensure that developmental therapy staff are using interventions appropriately. 5. September 15, 2013	

Administrator/Provider Signature: [signature] **Date:** 8/28/2013

Department POC Approval Signature: Pam Loveland-Schmidt **Date:** 09/03/2013

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