IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 18, 2013

Teresa Walker, Administrator
Adolescent and Child Development Center, LLC
151 North 3rd Avenue, Suite 110
Pocatello, ID 83201-6367

Dear Ms. Walker:

Thank you for submitting the Plan of Correction for Adolescent and Child Development Center, LLC dated November 12, 2013, in response to the recertification survey concluded on September 20, 2013. The Department has reviewed and approved the Plans of Correction.

As a result of the recertification survey, we previously issued Adolescent and Child Development Center, LLC a one-year certificate effective from October 14, 2013, through September 30, 2014, unless otherwise suspended or revoked. Per IDAPA 16.03.21.125, this certificate is issued on the basis of substantial compliance and is 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 239-6267.

Sincerely,

Pam Loveland-Schmidt

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

PLS/slm

Enclosure
1. Approved Plan of Correction

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Statement of Deficiencies

Developmental Disabilities Agency

Adolescent and Child Development Center, LLC
06AACDC158

151 N 3rd Ave Ste 110 and 112
Pocatello, ID 83201-6369
(208) 232-5622

Survey Type: Recertification

Entrance Date: 9/17/2013

Exit Date: 9/20/2013

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, Manager, DDA/ResHab Certification Program.

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.654.02.a.iii 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-13) a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11) iii. Guide treatment; (7-1-11)	Two of 4 participant records reviewed (Participants 1 and 3) lacked evidence that the comprehensive developmental assessment guided treatment. For example: Participant 1's comprehensive developmental assessment dated July 21, 2013, recommends 22 hours a week of group and individual community-based developmental therapy (DT). The program implementation plans (PIP's) identified that this objective would be implemented with the group and individual. Per data collection sheets and billing records, he was only receiving group services. Participant 3's developmental assessment recommendations stated, "It is important that she maintain her skills so that she does not lose them." The recommendations also stated	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 evaluations will be reviewed and modified to ensure they guide treatment. 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 agency will address this as though all participants' assessments are affected. The corrective action identified will address 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?	2013-12-16

	center-based DT, but did not address the environments where the individual had the need. In addition, they did not include or address the recommendations from the occupational therapy, physical therapy, and speech language pathology assessments, which stated she has plateaued. The DT skill training did not appear to be the right service for her physical ability and were not addressed in the assessment.	The corrective action will be monitored through the agency's quality assurance program conducted quarterly and ongoing	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.654.02.a.iv 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-13) a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11) iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)	One of 4 participant records reviewed (Participant 1) lacked evidence that the comprehensive developmental assessment identified the participant's current and relevant strengths, needs, and interests when these were applicable to the respective discipline. For example, Participant 1's developmental assessment dated July 21, 2013, did not include interests.	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 evaluations will be reviewed and updated to include strengths, needs, and interests. 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 agency will address this as though all participants' assessments are affected. The corrective action identified will address the deficiency 3. Who will be responsible for Implementing each corrective action? 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? The corrective action will be monitored through the agency's quality assurance program completed quarterly and ongoing.	2013-12-16

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.654.04.a.iii 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 04. 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) iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)	Three of 4 participant records reviewed (Participants 1, 2, and 3) lacked documentation of a review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. For example: Participant 1's PIP frequency of data collection for city transportation: "Data will be taken one or more times per session with a minimum of 3 trials." This language was consistent with all 5 objectives. Data from data sheets identified that this minimum data collection was not being met. Data for this objective was only collected 1 time during August 2013. There was no evidence the professional made changes to meet the PIP instructions. Participant 2's task analysis (TA) identified on the PIP was inconsistent with the TA that was identified on the data sheet. For instance, the " washing hands" PIP had 7 steps. Data sheet for "washing hands" had only 5 steps (which was different than the PIP). Staff were collecting data inconsistently with what was	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 data will be reviewed by the professional and changes will include the dated initials. 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 agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency 3. Who will be responsible for implementing each corrective action? The administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored weekly and monthly through the agency's quality assurance program.	2013-12-02

	identified on the IP's. There was no evidence the professional made changes to meet the PIP instructions. Participant 3's provider status review stated she had made progress, which for all steps but one she required hand-over-hand, which, as written, did not meet the goal for the objective. The objective stated "Will feed herself following 1 direct verbal prompt of 80% of the time averaged over 3 consecutive months by 12/31/13." One of five steps appeared to be making progress, but for the other four steps had not made progress. There was no documentation as to what changes had been made to accurately document progress as stated on the PIP. The developmental specialist (DS) reviewed the data sheets approximately every week and did not identify that the employees were collecting data inconsistently with what was outlined on the PIP's.		
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.654.04.a.iv 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 04. 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. Documentation of six (6) month and annual reviews by the Developmental Specialist that	One of 4 participant records reviewed (Participant 3) lacked documentation of six-month and annual reviews by the DS that included a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continued to need services. For example, Participant 3's provider status review (PSR) stated she has made progress, which for all steps but one she required hand-over-hand, which, as written, did not meet the goal for the objective. The objective stated, "Will feed herself following 1 direct verbal prompt of 80% of the time averaged over 3 consecutive months by 12/31/13." The participant appeared to be making progress for	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 status reviews will include justification why the participant continues to need 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? The agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency 3. Who will be responsible for implementing each corrective action?	2013-12-02

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. (7-1-13)	one of five steps, but for the other four steps the participant had not made progress. There was no documentation as to what changes had been made to promote progress and why she continued to need services.	The administrator or designee. 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored ongoing, semiannually and annually.	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.654.05 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 05. 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	One of 4 participant records reviewed (Participant 1) lacked evidence the PIP was written and implemented within fourteen (14) days after the first day of ongoing programming. For example, Participant 1's PIP's lacked an implementation date and there was no documentation the PIP's were implemented within 14 days of ongoing programming.	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 implemented within 14 days of ongoing 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? There are no other participants affected. 3. Who will be responsible for implementing each corrective action? The administrator or designee. 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored ongoing and weekly when new participants enter services to meet timeframes	2013-12-02

Program Implementation Plan must include the following requirements: (7-1-11)			
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.654.05.b 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 05. 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) b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)	One of 4 participant records reviewed (Participant 2) lacked documentation that the PIP included a baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. For example, Participant 2's PIP's included baselines, but they were not accurate within the "gain attention" objective. The objective "will get people's attention appropriately following 1 direct verbal prompt 70% of the time averaged over 3 consecutive months," the baseline stated "actively participates in using communication 10% of the time." For the baseline "discuss communication," the objective was written to "gain attention" and the baseline addressed "actively participates in using communication," which did not correlate. Also, as noted on the individual service plans (ISP), it stated, "He is mostly non-verbal."	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. Baselines will be re-probed and corrected for all inaccurate baselines identified by professional. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored weekly during staff training and supervision during baseline collections periods.	2013-12-16

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.654.05.f 654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS. 05. 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) f. Target Date. Target date for completion. (7-1-11)	One of 4 participant records reviewed (Participant 1) lacked documentation that the PIP included a target date for completion. (The agency corrected the deficiency during the course of the survey. The agency is required to address questions 2-4 on the plan of correction.)	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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored ongoing and during quarterly quality assurance reviews.	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.664.01.a.v 664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS. 01. General Requirements for Program Documentation. The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: (7-1-11) a. Direct service provider information that includes written documentation of the service provided during each visit made to the participant, and contains, at a minimum, the following information: (7-1-11) v. Specific place of service. (7-1-11)	Three of 4 child participant records reviewed (Participants A, B, and C) lacked evidence that the direct service provider information included written documentation of the service provided during each visit made to the participant, and contained, at a minimum, the specific place of service. For example: Participant A's habilitative support (HS) data sheet stated "community" only for July 2, 9, 16, 22, and 29, 2013. Participant B's HS data sheet stated "community" only for July 1, 8, and 15, 2013. Participant C had what appeared to be habilitative intervention (HI) data collection sheets that had a section for the specific place of service, but it was left blank.	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 specific location will documented in participants' records. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored weekly during supervision and staff training.	2013-12-02

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.664.02.a 664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS. 02. Habilitative Supports Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the following	Participant A's record lacked documentation of monthly summaries completed by the HS staff since the initiation of services (July, August, and September 2013). Participant B's record lacked documentation the	1. What actions will be taken to correct the deficiency? The plan should address agency systems and not just the examples specified in the	2013-12-02

must be completed: (7-1-11) a. On a monthly basis, the habilitative support staff must complete a summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. (7-1-11)	HS staff completed the monthly summary for July 2013; the habilitative interventionist (HI) completed the summary. Participants C and D's monthly summaries were completed by the HI, not the HS.	survey report. Monthly summaries will be corrected and completed accurately. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will monitored monthly, upon completion of the review.	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.664.02.b 664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS. 02. Habilitative Supports Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: (7-1-11) b. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer. (7-1-11)	Three of four child participant records reviewed (Participants B, C, and D) lacked evidence the clinical supervisor reviewed the summary on a monthly basis and when recommendations for changes to the type and amount of support were identified, submitted the recommendations to the plan developer. For example: Participant B's record lacked evidence the clinical supervisor reviewed the monthly summary completed for August 2013.	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 clinical supervisor will review all summaries. 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 agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency	2013-12-16

	Participant C's plan was authorized for January 3, 2013, through January 2, 2014. The monthly summaries lacked the month of review; therefore, it was unclear if summaries were completed monthly. Participant D's plan was authorized for July 25, 2013, through July 24, 2014. The monthly summaries lacked month of review; therefore, it was unclear if summaries were completed monthly.	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? This will be monitored weekly during supervision and staff training.	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.665.02.f 665. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES. All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-11) 02. Habilitative Support Staff. Habilitative supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided, or by the Infant Toddler Program. Providers of habilitative supports must meet the following minimum qualifications: (7-1-13) f. Must complete competency coursework approved by the Department to demonstrate	One of two employee records reviewed (Employee 4) lacked documentation that providers of habilitative supports (HS) completed competency coursework approved by the Department to demonstrate competencies related to the requirements to provide the service. For example, Employee 4 had been providing HS and has not completed the coursework.	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 unqualified to provide a service will be removed from service provision. 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 agency will address this as though all participants' services are affected. The corrective a 3. Who will be responsible for implementing each corrective action? The administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur?	2013-12-02

competencies related to the requirements to provide habilitative supports. (7-1-11)		This will be monitored ongoing and upon hire.	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.683.01.b 683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS. All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, including the plan developer, and must be recommended by a physician or other practitioner of the healing arts. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: (7-1-11) 01. Family Training. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services. (7-1-11) b. Family training must be provided to the participant's parent or legal guardian when the participant is present. (7-1-11)	One of four child participant records reviewed (Participant A) lacked evidence that family training was provided to the participant's parent or legal guardian when the participant was present. For example, Participant A's family training documentation did not identify that the child was present during the service.	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. Family training will only provided when the participant is present. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored ongoing and weekly during staff supervision and training.	2013-12-02

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.683.03.b 683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS. All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, including the plan developer, and must be recommended by a physician or other practitioner of the healing arts. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: (7-1-11) 03. Habilitative Intervention Evaluation. The purpose of the habilitative intervention evaluation is to guide the formation of developmentally-appropriate objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: (7-1-11) b. Functional behavioral analysis; (7-1-11)	One of four child participant records reviewed (Participant B) lacked evidence the HI evaluation included a functional behavioral analysis. For example, Participant B's HI evaluation did not include a functional behavioral analysis (FBA). The assessment had a section that was checked "Not Applicable."	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. HI evaluations will include functional behavioral analyses. Evaluations will be corrected. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored ongoing and during quarterly quality assurance reviews.	2013-12-16

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.684.03.b 684. CHILDREN'S WAIVER SERVICES: PROCEDURAL REQUIREMENTS. 03. Program Implementation Plan Requirements. For each participant receiving intervention and family training services, the DDA or the Infant Toddler Program must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. (7-1-13) b. The program implementation plan must be written, implemented, and submitted to the plan developer 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 documented participant-based justification for the delay. (7-1-13)	Three of 3 child participant records reviewed (Participants A, B, and C) lacked evidence that the PIP was written, implemented, and submitted to the plan developer within fourteen (14) days after the first day of ongoing programming and was revised whenever the participant's needs changed. For example, Participants A, B, C, and D's records lacked documentation the PIP's were submitted to the plan developer.	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 implemented within 14 days of ongoing programming. 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 agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency 3. Who will be responsible for implementing each corrective action? Administrator designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? The agency will monitor this ongoing and weekly upon the initiation of services to verify compliance.	2013-12-02

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.684.03.c.x 684. CHILDREN'S WAIVER SERVICES: PROCEDURAL REQUIREMENTS. 03. Program Implementation Plan Requirements. For each participant receiving	Four of 4 child participant records reviewed (Participants A, B, C, and D) lacked documentation that the PIP was completed by the HI, and reviewed and approved by the clinical supervisor, as indicated by signature,	1. What actions will be taken to correct the deficiency? The plan should address agency	2013-12-16

intervention and family training services, the DDA or the Infant Toddler Program must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. (7-1-13) c. The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements: (7-1-11) x. The program implementation plan must be reviewed and approved by the clinical supervisor, as indicated by signature, credential, and date on the plan. (7-1-13)	credential, and date on the plan. For example, Participants A, B, C, and D's PIP's lacked documentation that the clinical supervisor reviewed and approved them by signing, credentialing, and dating the PIP's.	systems and not just the examples specified in the survey report. All HI PIPs will be completed by qualified staff and reviewed by the clinical supervisor prior to implementation. All PIPs will be reviewed. 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 agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency 3. Who will be responsible for implementing each corrective action? The administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored ongoing and during quarterly quality assurance reviews.	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.410.01.b.i 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) b. Be certified in CPR and first aid within ninety	Two of 9 employee records reviewed (Employees 4 and 5) lacked documentation that each agency staff providing services to participants was certified in CPR and First Aid within ninety (90) days of hire and maintained current certification thereafter. The agency must ensure that CPR and First Aid trained staff are present or accompany participants when services or DDA-sponsored activities are being provided. For example: Employee 4's record lacked documentation that	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 have CPR and first aid. 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 agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency	2013-12-16

(90) days of hire and maintain current certification thereafter; and (7-1-11) i. The agency must ensure that CPR and first-aid trained staff are present or accompany participants when services or DDA-sponsored activities are being provided. (7-1-11)	the employee was CPR and First Aid certified between August 11, 2013, and September 12, 2013. Employee 5's record lacked documentation that the employee was CPR and First Aid certified between June 28, 2013, and September 12, 2013.	3. Who will be responsible for implementing each corrective action? The administrator or designee 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? This will be monitored upon hire and during quarterly quality assurance reviews. The agency will address this as though all participants' services are affected. The corrective action identified will address the deficiency	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.500.03.f 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) f. All hazardous or toxic substances must be properly labeled and stored under lock and key; and (7-1-11)	The agency lacked evidence that all hazardous or toxic substances were properly labeled and stored under lock and key in the facility. (The agency corrected the deficiency during the course of the survey. The agency is required to complete questions 2-4 on the plan of correction.)	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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored daily and graded in the quality assurance review.	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.511.04.a 511. MEDICATION STANDARDS AND REQUIREMENTS. 04. Assistance with Medication. An agency may choose to assist participants with medications; however, only a licensed nurse or other licensed health professional may administer medications. Prior to unlicensed agency staff assisting participants with medication, the following conditions must be in place: (7-1-11) a. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program, a course approved by the Idaho State Board of Nursing, or other Department-approved training; (7-1-11)	One of 8 employee records reviewed (Employee 7) lacked documentation that each staff person who assisted with participant medications had successfully completed and followed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program, a course approved by the Idaho State Board of Nursing, or another Department-approved training. For example, Employee 7's record had documentation as having assisted a DDA participant with her medications. There was no documentation that Employee 7 had successfully completed a Department-approved medication training course.	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 have proper certification. No staff will be allowed to assist without it. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored upon hire and during the quarterly quality assurance review.	2013-12-02

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)	Five of 7 participant records reviewed (Participants 1, 2, 3, C, and D) lacked evidence that each participant record clearly documented the date, time, duration, and type of service, and included the signature of the individual providing the service, for each service provided. For example: Participant 1's data sheets for August 9, 13, and 16, 2013, lacked documentation of the type of service. Participant 2's data sheets for July 26 and 30, 2013, and August 26, 2013, lacked documentation of the type of service. Participant 3's record included agency documentation that employees documented " Home/Community" for all data from March 14, 2013, through August 16, 2013. The participant was authorized for center services only. Participant C's record lacked evidence that the type of service was clearly documented. It appeared that Family Training was documented on the "IBI Therapy Progress notes," which is not an authorized service. The notes had been signed and credentialed by the HI. Participant D's monthly HS review was completed by the HI, not the HS, and was signed by the 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. All required elements will be included in the documentation of services. Documentation will accurately reflect the services rendered. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored ongoing and during quarterly quality assurance review.	2013-12-16

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	One of 7 participant records reviewed (Participant A) lacked evidence that the profile sheet contained the identifying information reflecting the current status of the participant,		2013-12-16

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) 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)	including current medications. For example, Participant A's profile sheet did not include current medications. The medical/social history dated April 30, 2013, states the participant takes Melatonin; the plan of service dated June 5, 2013, states the participant takes Melatonin; and the HI evaluation dated July 1, 2013, states the participant takes Melatonin. REPEAT DEFICIENCY from the recertification survey conducted on March 15, 2013.	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 required elements will be included in the profile. All will be reviewed and edited. 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 agency will address this as though all participants' services are affected. The corrective action identified will address 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? This will be monitored ongoing and during quarterly quality assurance review.	

Administrator/Provider Signature: Teresa L Walker QIDP, CHI, BA **Date:** 11/12/13

Department PIC Approval Signature: Pam Haviland Eaton **Date:** 11/14/13.

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