IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 13, 2013

Sabrina Swope, Ph.D., Administrator
Affinity, Inc.
8100 West Emerald Street, Suite 150
Boise, ID 83704

Dear Dr. Swope:

Thank you for submitting the Plan of Correction for Affinity, Inc. dated November 11, 2013, in response to the developmental disabilities agency recertification survey concluded on October 18, 2013. The Department has reviewed and approved the Plan of Correction.

As a result of the survey, Affinity, Inc. was issued a provisional certificate effective from October 28, 2013, through April 30, 2014, unless otherwise suspended or revoked. Per IDAPA 16.03.21.126.01:

> *"A provisional certificate is issued contingent upon the correction of deficiencies in accordance with a plan developed by the agency and approved by the Department. Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. If so, then certification will be granted. If not, the certificate will be denied or revoked."*

Our office will be in contact with you about the date of the follow-up survey. Thank you for your patience while accommodating us through the recertification process. If you have any questions, please contact Eric Brown, Program Manager, at 364-1906.

Sincerely,

Bobbi Hamilton, BCaBA

BOBBI HAMILTON, B.Ca.BA.
Medical Program Specialist
DDA/ResHab Certification Program

BH/slm

Enclosure
1. Approved Plan of Correction

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Statement of Deficiencies

Developmental Disabilities Agency

Affinity, Inc.
4AFF060-1

8100 W Emerald St Ste 150
Boise, ID 83704
(208) 375-0752

Survey Type: Recertification

Entrance Date: 10/15/2013

Exit Date: 10/18/2013

Initial Comments: Bobbi Hamilton, Medical Program Specialist, DDA/ResHab Certification Program; and Eric Brown, Manager, DDA/ResHab Certification Program. This report was amended on November 7, 2013.

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.656.01.b.i-iii 656. GENERAL STAFFING REQUIREMENTS. 01. Standards for Paraprofessionals Providing Developmental Therapy. When a paraprofessional provides developmental therapy, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 655 of these rules. A paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. For paraprofessionals to provide developmental therapy in a DDA, the agency must adhere to the following standards: (7-1-13) b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or	Based on review of agency records, it was determined that for Employees 5 and 6 the weekly supervision that was provided did not meet the rule requirements to (i) give instructions; (ii) review progress; and (iii) provide training on the programs and procedures to be followed.	1. The supervision form has been modified to meet the specific requirements set in this rule. All DDA staff have been made aware of the requirements. 2. All previous supervision records were reviewed by the Administrator. No corrective action is possible for past supervision meetings. 3. The Administrator and Clinical Supervisor will be responsible for the supervision of all DDA staff. 4. The supervision requirements for each staff will be monitored by the Quality Assurance Team. 5. The corrective action completed 11/1/13	2013-11-01

more often if necessary: (7-1-11) i. Give instructions; (7-1-11) ii. Review progress; and (7-1-11) iii. Provide training on the program(s) and procedures to be followed. (7-1-11)			

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.664.01.a.iii 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) iii. A statement of the participant's response to the service; and (7-1-11)	Based on review of agency records, it was determined that for Participant 1 the agency did not have documentation of the participant's response to the service.	1. All Habilitative Support documentation has been modified to include the participant's response to service. 2. The Administrator reviewed all documentation, of which could not be corrected for the past. 3. The Administrator and Clinical Supervisor are responsible for ensuring the corrective action is implemented. 4. The Quality Assurance team and the Clinical Supervisor will monitor the HS documentation for appropriateness, completeness and timeliness of session documentation. 5. This will be completed no later than 11/11/13	2013-11-11

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)	Based on review of agency records, it was determined that for Participants 1 and 2 the agency did not have written documentation of the specific place of service when services were provided.	1. All DDA staff were trained on 11/6/13 on what the minimum requirements for documentation. All of the HS documentation forms were revised to include specific location. 2. The Administrator and Clinical Supervisor reviewed all of the HS documentation. While it was not possible to do any corrective action, the staff were made aware of the required documentation. 3. The Clinical Supervisor and Administrator will be responsible for monitoring the HS staff to ensure compliance. 4. The Quality Assurance team will review all documentation from the previous week by Tuesday at 10am each week. 5. The completion of this corrective action was 11/1/13	2013-11-01

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)	Based on review of agency records, it was determined that for Participant 1 the record lacked documentation that the Clinical Supervisor reviewed the Habilitative Supports summary on a monthly basis.	1. The policy requirement has been modified to include the review of all HS documentation at least monthly by the Clinical Supervisor. 2. All HS documentation was reviewed by the Administrator and Clinical Supervisor. No correction could be done on prior records. 3. The Administrator and Clinical Supervisor as well as the Quality Assurance team will be responsible for ensuring that the HS documentation is reviewed at least monthly. 4. The Quality Assurance team will monitor for the Clinical Supervisor's review on all HS documentation. 5. This corrective action was completed 11/1/13.	2013-11-01

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.665.02.c 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	Based on review of agency records, it was determined that for Employee 4 the employee had not received instruction in the needs of the participant who was to be provided the service.	1. All new and existing DDA staff will get appropriate instruction on the individual participant needs prior to being allowed to deliver service. 2. All DDA participant files were reviewed by the Administrator, Developmental Specialist and	2013-11-30

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) c. Have received instructions in the needs of the participant who will be provided the service; (7-1-11)		Clinical Supervisor to ascertain what specific and pertinent information might be missing from the clients record. The Clinical Supervisor reviewed each record with the corresponding DDA staff to ensure they are fully informed about the participant's needs. The Medical Sheet and Profile sheets will be modified to include all necessary information is available on the Profile sheet and each DDA staff has been given their respective participant's information. 3. Every participant's file was reviewed for completeness of information. Each DDA staff has been informed of the new information and expectation. 4. The corrective action will be monitored through weekly supervision, staff meetings and the performance of the DDA staff, which is monitored through Monthly Observations by the Clinical Supervisor. 5. The completion of the amendment to the Profile Sheets and staff re-training will be complete by 11/30/13	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.10.684.03.c 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) c. The program implementation plan must be completed by the habilitative interventionist,	Based on review of agency records, it was determined that for Participant 2 the Implementation Plans were not completed by the Habilitative Interventionist.	1. All Habilitative Intervention Program Implementation Plans will be completed by the HI staff, and reviewed by the Clinical Supervisor. 2. Each HI Staff were informed that they would be responsible for the completion of all Program Implementation Plans for the participants they work with, and that their work required Clinical Supervisor review and approval. 3. All HI staff, the Administrator and Clinical Supervisor met to discuss each participant receiving HI services. The program implementation	2013-11-30

and must include the following requirements: (7-1-11)		plans that had not been reviewed by the Clinical Supervisor will be reviewed no later than 11/30/13. 4. The Quality Assurance team will monitor and ensure that all HI PIP's are completed and reviewed by the Clinical Supervisor. The Clinical Supervisor will review all PIP's created by the HI professional, which will be discussed during the weekly supervision. 5. This corrective action will be completed no later than 11/30/13,	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.10.684.03.c.iii 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) c. The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements: (7-1-11)	Based on review of agency records, it was determined that for Participant 2 the Program Implementation Plan did not include a measureable objective. For example, Participant 2's file included an Implementation Plan for an objective that identified that the participant was to "...choose a functional replacement behavior consistent with typically developed peers..." The required "functional replacement behavior" was not identified or defined within the implementation plan or instructions to staff.	1. The Administrator reviewed all of the Habilitative Intervention objectives/ goals, to adjust, modify, and amend the Program Implementation Plans that had objectives that were not measurable. 2. The Administrator and Clinical Supervisor have reviewed all of the Program Implementation Plans for Habilitative Intervention services. 3. The Habilitative Intervention staff will be responsible for modifying and ensuring that the objectives are measurable. The Clinical Supervisor must review and approve all Program Implementation Plans.	2013-11-30

iii. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)	REPEAT DEFICIENCY from April 2012 survey (previously 16.03.10.655.08.c).	4. The Quality Assurance team, as well as the professionals creating the objectives and PIP's will be trained on how to write a measurable objective and one time per month they will complete a peer review of documentation during their training/ group meeting time. 5. The corrective action of the objectives not being measurable will be completed no later than 11/30/13. The peer review of documentation will be completed monthly, but the first peer review will begin 12/2013.	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.410.01.c 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) c. Be trained to meet any special health or medical requirements of the participants they serve. (7-1-11)	Based on review of agency records, it was determined that for Employee 4 the employee had not been trained in any special health or medical requirements of the participants they serve. For example, Employee 4's primary Habilitative Supports client had an epilepsy diagnosis. The employee had not been trained in any health or medical requirements specific to that medical condition.	1. All DDA participant files were reviewed with the staff responsible for carrying out the identified service. Discussion and training about specific Medical or Health needs were pointed out and documented in the training and supervision form. An all staff meeting was held to inform the DDA staff of the requirement to be fully aware of their participant's Medical and Health needs. 2. The Administrator and Clinical Supervisor have made contact with all of the providers, parents, guardians through telephonic communication, as well as formal letter requesting all information or changes in current Medical and Health status. 3. The Administrator and Clinical Supervisor are responsible for obtaining the participant information and disseminating this information to	2013-11-30

		staff. 4. The corrective action will be monitored through the Clinical supervision meetings, and regular observations with the participant and staff. Quality Assurance Team will ensure modifications, addendum's and changes are clearly recorded in the participant record. 5. This corrective action will be completed no later than 11/30/13	
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.500.04 500. 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)	Based on a review of the facility, it was determined that for the Nampa location the agency's evacuation plans did not include the location of all fire extinguishers. REPEAT DEFICIENCY from the October 2012 survey.	1. The agency has reexamined all of the evacuation plans and ensured that the fire extinguisher locations are clearly indicated. 2. The review of the agency's policy and procedures around fire safety has been reviewed. 3. The Administrator is responsible to ensure that the evacuation plans are inclusive of all necessary information. 4. The corrective action will be monitored by the agency's safety committee. 5. The corrective action was completed on 11/9/13	2013-11-08

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.500.04.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) 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	Based on review of agency documentation, it was determined that the agency's fire drill summary did not include all of the requirements in rule. For example, fire drill summaries completed for the Boise and Nampa locations did not include problems encountered or the corrective actions taken.	1. The fire evacuation documentation was modified to include a result section that asks specifically whether any problems were encountered, the corrective actions necessary and the review of the Safety Committee persons. 2. The agency modified it's entire procedure to accommodate the new format of recording evacuation drills. 3. The Administrator is responsible to ensure the compliance of documentation of fire drill evacuations. 4. The corrective action will be monitored by the Quality Assurance team and Administrator. 5. This corrective action was completed 11/1/13	2013-11-01

drill occurred, participants and staff participating, problems encountered, and corrective action(s) taken. (7-1-11)			
Rule Reference/Text	**Findings**	**Plan of Correction**	**Date to be Corrected**
16.03.21.501.02 501. VEHICLE SAFETY REQUIREMENTS. Each DDA that transports participants must: (7-1-11) 02. Transportation Safety Policy. Develop and implement a written transportation safety policy. (7-1-11)	Based on review of agency policies and procedures, it was determined that the agency was not implementing their transportation policy as indicated within its policy.	1. The transportation safety policy has been revised to include verification by HR for licenser issues whenever any staff member has an out of state license. The law requires 90 day allowance to obtain an in state license. Staff that do not have a license will be monitored on a case by case basis for appropriateness and job fit. 2. All DDA staff HR files were reviewed and all have an Idaho driver's license. 3. The Administrator will be responsible for ensuring that the HR staff stay current with DDA staff employee files and when something expires the staff will be notified or the staff will be suspended from work until the appropriate documentation is received. 4. The Quality Assurance Team will be responsible for checking the HR files for any variance from Policy, these variances will be brought to the Administrator. 5. This was completed 11/1/13.	2013-11-01

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.501.04 501. VEHICLE SAFETY REQUIREMENTS. Each DDA that transports participants must: (7-1-11) 04. Applicable Laws, Rules, and Regulations. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. (7-1-11)	Based on review of agency policy and procedures, it was determined that the agency was not adhering to all laws, rules, and regulations applicable to drivers. For example, Employee 4 did not have a current Idaho driver's license.	1. The policy has been revised to include verification by HR for licenser issues whenever any staff member has an out of state license. The law requires 90 day allowance to obtain an in state license. Staff that do not have a license will be monitored on a case by case basis for appropriateness and job fit. 2. All DDA staff HR files were reviewed and all have an Idaho driver's license. 3. The Administrator will be responsible for ensuring that the HR staff stay current with DDA staff employee files and when something expires the staff will be notified or the staff will be suspended from work until the appropriate documentation is received. 4. The Quality Assurance Team will be responsible for checking the HR files for any variance from Policy, these variances will be brought to the Administrator on a case by case basis. 5. This was completed 11/1/13.	2013-11-01

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.510.03 510. HEALTH REQUIREMENTS. 03. Employees. Each employee who has direct contact with participants must be free of communicable disease and infected skin lesions while on duty. (7-1-11)	Based on review of agency records, it was determined that Employee 6 did not have documentation to ensure that the staff was free from communicable diseases. (The agency corrected the deficiency during the course of survey. The agency is required to address question 2-4 on the Plan of Correction.)	2. All DDA staff HR files were reviewed for discrepancy or inconsistency. 3. The Administrator and Clinical Supervisor will be apprised of any issues related to the staff acknowledgment of being free from communicable diseases. 4. The Administrator and HR Director will ensure that all staff working with participants have signed an acknowledgment that they are able to work with participants. Variances will be brought to the Administrator.	

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)	Based on review of agency records, it was determined that for 1 of 2 participant files (Participant 2) the participant's record did not include the employee's credentials with their signature.	1. All DDA staff have been informed and re-trained to ensure they are including their signature, credential and date when signing, creating or amending any participant records or data. 2. All prior records will be reviewed and staff that are existing in the agency can go add their	2013-11-30

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)	REPEAT DEFICIENCY from the April 2012 survey.	credentials to their documentation. 3. While the past cannot be completely rectified, the DDA staff are well aware of the requirements and all of their documentation will be returned if they are not complete. The Clinical Supervisor will return the documentation when it is not complete. 4. The corrective action will be monitored by the Clinical Supervisor and Quality Assurance team and any other professional reviewing the participant's record. Any incomplete signatures will be brought the attention of the Administrator. 5. This corrective action will be compete by 11/30/13	

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	Based on review of agency records, it was determined that for Participant 3 the agency did not have a profile sheet containing all of the rule requirements. For example, Participant 3's profile sheet did not identify special dietary needs.	1. The participant profile sheets are being modified and the Medical Sheets and Face Sheets will be removed and condensed into a single or two-page Profile sheet. 2. The review of all participant records indicate that the condensing of the pertinent data is necessary. 3. The Administrator has delegated this to the Quality Assurance team, who will receive oversight by the Clinical Supervisor to ensure all of the appropriate and necessary documentation is	2013-11-30

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)		available. 4. All corrective actions will be monitored by the Clinical Supervisor and Quality Assurance team jointly. 5. All participant files will be completely redone no later than 11/30/13	

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	Based on review of agency records, it was determined that for Participants 1 and 2 the agency did not include within the Status Review written documentation information that identified why the participants continued to need the services. For example, comments that were included on Participant 1 AND Participant 2's Status Reviews for different objectives were identical and did not identify why the participants continued to need the services.	1. The provider status reviews for Developmental participants will include a question about continued need for service that will need to be answered each month. 2. A review of all participant provider status reviews were conducted by the Clinical Supervisor. While the past reviews could not be rectified, all future reviews will be inclusive of continuation of service statements. 3. The Clinical Supervisor, Developmental Specialist will be responsible for ensuring the provider status reviews are completed each month, and each record has appropriate and complete documentation to justify services.	2013-11-15

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 the participant continues to need the service. (7-1-11)		4. This corrective action will be monitored jointly by the Quality Assurance team and Administrator. 5. The October status reviews will be completed no later than November 15th, 2013 and the 15th of each month for the previous month ongoing as per policy.	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.900.01.d 900. REQUIREMENTS FOR AN AGENCY'S QUALITY ASSURANCE PROGRAM. Each DDA defined under these rules must develop and implement a quality assurance program. (7-1-11) 01. Purpose of the Quality Assurance Program. The quality assurance program is an ongoing, proactive, internal review of the DDA designed to ensure: (7-1-11) d. Skill training activities are conducted in the natural setting where a person would commonly learn and utilize the skill, whenever appropriate; and (7-1-11)	Based on review of agency records, it was determined that for Participant 2 the agency's quality assurance program did not meet the requirements to ensure that skill training activities were conducted in the natural setting where a person would commonly learn and utilize the skill. For example, Participant 2 had a Program Implementation Plan to increase the skills of "brushing teeth" and using "sanitary wipes." The locations in which therapy would be provided were identified on the Implementation Plan as "Home: bedroom, kitchen, living room," "Center: therapy room, kitchen," and "Community: parks, mall, Barnes & Noble, Library, Zoo, etc..."	1. The Clinical Supervisor has to be a stronger component of review for the HI professionals work. A regular monthly meeting will be conducted, further training of the Quality Assurance Team will also be conducted. 2. All HI participant files, records and documentation were reviewed by the Clinical Supervisor and jointly staffed with the HI professionals. 3. The Administrator and Clinical Supervisor are responsible to ensure that the documentation completed by the HI professional staff is done in a manner that is consistent with the rules and regulations governing this program. 4. The Quality Assurance team and Clinical Supervisor will review all HI professional/s work going forward. S. This will be completed no later than 11/15/13	2013-11-15

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.900.02.e 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) e. An annual review of the agency's code of ethics, identification of violations, and implementation of an internal plan of correction; (7-1-11)	Based on review of agency policies and procedures, it was determined that the agency did not complete an annual review for 2012 of the agency's code of ethics, identification of violations, and implementation of an internal plan of correction.	1. The review of the code of ethics has never been documented, however going forward this will be documented in the policy and procedure file. Any violation of the code of ethics will be documented in the employee file specifically and privately. 2. Not Applicable 3. The Administrator or designee will be responsible for ensuring that any violation of the code of ethics is handled through the disciplinary policy. 4. The HR Director and Clinical Supervisor will monitor all staff performance on a regular and ongoing basis. 5. This is compete as of 11/01/13.	

Rule Reference/Text	Findings	Plan of Correction	Date to be Corrected
16.03.21.900.02.f 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) f. An annual review of agency's policy and procedure manual to specify date and content of revisions made; and (7-1-11)	Based on review of agency policies and procedures, it was determined that within the annual review of agency policy and procedure, the content of revisions made could not be determined.	1. The revisions to policy and procedures will be review and documented annually. 2. The monitoring of IDAPA code will be done at least annually by the Administrator in cooperation with the Clinical Supervisor or as needed, when program requirements change. 3. The program policy and procedures will be the responsibility of the Administrator with cooperation of the Clinical Supervisor, Developmental Specialist and HI professionals. 4. The Quality Assurance team will review and look for documentation of amendments, changes and modifications to the policy and procedures of the agency each quarter. The policy and procedures changes will be documented by the advent of the new policy that supersedes the previous policy and procedure which is documented on the policy itself. 5. The corrective action will be completed no later than 11/15/13	2013-11-15

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)	Based on review of agency records, it was determined that for Participant 1 the agency's quality assurance program did not include an ongoing review of participant progress to ensure revisions to daily activities or specific implementation procedures were made when progress, regression, or inability to maintain independence was identified. For example, for documentation on Participant 1, the Provider Status Review revealed that for 12 of 13 programs the participant's monthly percentage of success was below baseline. The agency's quality assurance program did not document a review of the participant's progress to ensure revisions to daily activities or specific implementation procedures were made when progress, regression, or inability to maintain independence was identified. REPEAT DEFICIENCY from the October 2012 survey.	1. The agency policy requires that the professional providing oversight of the individual program implementation plans be conducted at least monthly. 2. All of the participant plan of service, program implementation plans and data related to delivery of service was reviewed by the Clinical Supervisor, Developmental Specialist and Administrator. Issues regarding program implementation, and progress or lack of progress is documented in the participants record. 3. The Developmental Specialist, Clinical Supervisor, HI professionals and Administrator will all be jointly responsible to ensure that the participant's progress is monitored on an ongoing basis and revisions or adaptations are made to ensure the participants progress are completed in a timely manner. 4. The Quality Assurance program, Professionals providing oversight, and the DDA staff have all had reviewed with the them the purpose of the services being delivered with respect to their responsibility to identify issues, regression or inability to maintain at their current skill level to the appropriate professional providing oversight to the case. 5. This corrective action will be completed no later than 11/30/13.	2013-11-30

Administrator/Provider Signature: Arlene Ducey PhD, LCSW	**Date:**	2013-11-11
Department POC Approval Signature: Bobbi Hamilton, BCaBA	**Date:**	11/12/13

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