



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – GOVERNOR  
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE (208) 364-1959  
FAX (208) 287-1164

October 31, 2013

Mike Wilson, LMSW, Administrator  
Inclusion South, Inc.  
3067 East Copper Point Drive  
Meridian, ID 83642

Dear Mr. Wilson:

Please find enclosed the Statement of Deficiencies report for your Developmental Disabilities Agency (DDA). The report is based on the recertification survey of your agency that was conducted from October 22, 2013, through October 23, 2013, for the purpose of renewing your DDA certificate.

Congratulations! Based on observation of services and documentation presented during the review, no deficient practices were identified. As a result, Inclusion South, Inc. has been issued a three-year certificate effective from December 1, 2013, through November 30, 2016.

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

Sincerely,

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

PLS/slm

Enclosures

1. Statement of Deficiencies
2. Renewed DDA Certificate



# Statement of Deficiencies

*Developmental Disabilities Agency*

Inclusion South, Inc.  
5INCLUSO068

1122 Eastland Dr N Ste 1  
Twin Falls, ID 83301-  
(208) 736-7117

**Survey Type:** Recertification

**Entrance Date:** 10/22/2013

**Exit Date:** 10/23/2013

**Initial Comments:** Surveyors present: Pam Loveland-Schmidt, Medical Program Specialist, Licensing & Certification; Bobbi Hamilton, Medical Program Specialist, Licensing & Certification; and Eric Brown, Program Manager, Medical Program Specialist, Licensing & Certification.

| Rule Reference/Text  | Findings   | Plan of Correction | Date to be Corrected |
|--|--|--------------------|----------------------|
| <No Deficiencies><br>No deficiencies were cited over the course of the survey. | No deficiencies were cited during the course of the survey. The provider is not required to submit a Plan of Correction to the Department. |                    |                      |

**Administrator/Provider Signature:**

**Date:**

**Department POC Approval Signature:**

**Date:**

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