IDAHO DEPARTMENT OF HEALTH & WELFARE
LICENSING & CERTIFICATION

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Sequel Alliance Family Services	**Region(s):**	1
Agency Type:	Developmental Disability Agency	**Survey Dates:**	06/12/18 to 6/13/18
Certificate(s):	DDA-5130	**Certificate(s) Granted:**	☐ 6 - Month Provisional ☒ 1 - Year Full ☐ 3 - Year Full

Rule Reference/Text	**Findings**	**Agency's Plan of Correction** (Please refer to the Statement of Deficiencies cover letter for guidance)	**Date to be Corrected** (mm/dd/yyyy)
16.03.21.009.01 009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Verification of Compliance. The agency must verify that all employees, subcontractors, agents of the agency, and volunteers delivering DDA services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)	In review of employee files, for 1 employee in the primary sample and 1 employee in a Criminal History Check review, the process was not completed in compliance with IDAPA 16.05.06. For example: Employee #3 was hired 8/12/15. Employee began providing direct service beginning October 2015. Employee did not complete a notarized self-declaration until 1/4/16. For employee in CHC sample # 1. Employee completed a Self-Declaration on 9/6/17. However Fingerprints were not received by the CHU until 10/31/17.	*1. All new hires will follow the attached background check policy and protocol. On new hire first day orientation they will sign and be given a copy the background acknowledgement and be notified if they will be required to complete two fingerprint based backgrounds (Health and Welfare and School District). Any staff who is not fingerprinted on the time allowed by rules, he/she will be placed on unpaid administrative leave and removed from any duties where they access clients* *2. All other staff files were reviewed. All current staff files are in good standing.* *3. HR Manager* *4. All new hire files are audited no more than 30 days after hire and audit results are sent to corporate HR for review.*	*6/26/2018*

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	The date of Fingerprints received exceed the date of the notarized self-declaration by 34 days. Employee provided services on 9/28/17 and 10/23/17 which were both after the 21 days allowed. THIS IS A REPEAT DEFICIENCY		
16.03.21.400.03.b. 400. GENERAL STAFFING REQUIREMENTS FOR AGENCIES. Each DDA is accountable for all operations, policy, procedures, and service elements of the agency. 03. Clinical Supervisor Duties. A clinical supervisor must be employed by the DDA on a continuous and regularly scheduled basis and be readily available on-site to provide for: b. The observation and review of the direct services performed by all paraprofessional and professional staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the DDA services. (7-1-11)	In a review of documentation, for one of 5 employees reviewed, did not receive an observation of the direct services performed on a monthly basis. For example: Employee #2 was not observed providing HS services in January or February of 2018. There was no indication of attempted observations with indication why observations were not possible to meet rule. THIS IS A REPEAT DEFICIENCY	*1. When observations are not completed an explanation of attempts made as well as reason(s) for inability to complete will be documented in the staff's observation file. This documentation will be signed by the Clinical Supervisor.* *2. The agency tracks monthly observations throughout the year. When an observation is not submitted, the Program Administrator will ensure that the above mentioned documentation is submitted by the Clinical Supervisor.* *3. Program Administrator will be responsible for this corrective action.* *4. Monthly review of observation completion and submission will serve as the monitoring program for this action.*	*6/15/2018*

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16.03.21.410.02.b. 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: 02. Sufficient Training. Training of all staff must include the following as applicable to their work assignments and responsibilities: b. Correct and appropriate use of assistive technology used by participants; (7-1-11)	In review of staff files, for 1 of 5 staff files reviewed there was no indication that the staff was trained to their work assignments in regard to correct and appropriate use of assistive technology used by the participant. For example: Employee #2 is assigned to work with a participant that uses assistive technology of glasses and a Proloque. There is no documentation to support that the staff received training on the use of these devices by the participant.	*1. Upon hire and each time they add a client to their caseload, each staff will complete an orientation training to include but not limited to: participant plan implementation, special medical and health needs, allergies, assistive technology, family dynamics, policy and procedure review, etc. (see attached checklist).* *2. All current staff will be trained using the orientation checklist upon approval of this corrective action plan by the Department.* *3. Program Administrator with assistance from the Clinical Supervisor team will be responsible for this corrective action* *4. Staff will not be allowed to start with a new client before submission to the Program Administrator of the orientation training packet. This will be monitored via weekly meetings between Program Administrator and Clinical Supervisor*	*7/5/2018*

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		team to address pending clients and assignment.	
16.03.21.410.02.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: 02. Sufficient Training. Training of all staff must include the following as applicable to their work assignments and responsibilities: c. Accurate record keeping and data collection procedures; (7-1-11)	In review of staff records, for 2 of 5 staff files reviewed, there was no indication that staff was trained specific to service delivery to the participants for which they were assigned prior to working with them. For example: Employee #3 was hired 8/2015 and there was no training to policies and procedures for an introductory training until 8/11/16, which still did not include DDA services including record keeping or data collection in general or specific to the participants served. There was only one note of training specific to a participant 9/17/15- one month after hire. For employee #4, there was no documentation on file of general or participant specific training in regard to	*1. Upon hire and each time they add a client to their caseload, each staff will complete an orientation training to include but not limited to: participant plan implementation, special medical and health needs, allergies, assistive technology, family dynamics, policy and procedure review, etc. (see attached checklist).* *2. All current staff will be trained using the orientation checklist upon approval of this corrective action plan by the Department.* *3. Program Administrator with assistance from the Clinical Supervisor team will be responsible for this corrective action* *4. Staff will not be allowed to start with a new client before submission to the Program Administrator of the orientation training packet. This will be monitored via weekly meetings between Program*	*7/5/2018*

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	record keeping or data collection at orientation or after.	*Administrator and Clinical Supervisor team to address pending clients and assignment.*	
16.03.21.410.02.f. 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: 02. Sufficient Training. Training of all staff must include the following as applicable to their work assignments and responsibilities: f. The proper implementation of all policies and procedures developed by the agency. (7-1-11)	For 1 of 5 Staff reviewed, there was no documentation of training on the proper implementation of policies and procedures developed by the agency in general or related to their work assignments. For example: Employee #2 was hired 8/24/16 and did not receive any policy and procedure training until 12/19/17. That documented training was on the general agency, and did not include training specific to the Developmental Disability Agency Policies and Procedures.	*1. Upon hire and each time they add a client to their caseload, each staff will complete an orientation training to include but not limited to: participant plan implementation, special medical and health needs, allergies, assistive technology, family dynamics, policy and procedure review, etc. (see attached checklist).* *2. All current staff will be trained using the orientation checklist upon approval of this corrective action plan by the Department.* *3. Program Administrator with assistance from the Clinical Supervisor team will be responsible for this corrective action* *4. Staff will not be allowed to start with a new client before submission to the Program Administrator of the orientation training packet. This will be monitored*	*7/5/2018*

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		via weekly meetings between Program Administrator and Clinical Supervisor team to address pending clients and assignment.	
16.03.21.410.03.b. 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: 03. Additional Training for Professionals. Training of all professional staff must include the following as applicable to their work assignments and responsibilities: b. Consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques. (7-1-11)	In review of documentation, for 2 of 5 staff reviewed, there was not documentation according to their work assignments in regards to consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques prior to working with the participants. For example: Employee #3 began working with the participant 10/1/15 and there is no documentation of training to meet this requirement until 12/30/15. Employee #4 was hired 10/14/16 and there was no documentation of training to meet this requirement found in the review.	*1. Upon hire and each time they add a client to their caseload, each staff will complete an orientation training to include but not limited to: participant plan implementation, special medical and health needs, allergies, assistive technology, family dynamics, policy and procedure review, etc. (see attached checklist).* *2. All current staff will be trained using the orientation checklist upon approval of this corrective action plan by the Department.* *3. Program Administrator with assistance from the Clinical Supervisor team will be responsible for this corrective action* *4. Staff will not be allowed to start with a new client before submission to the Program Administrator of the orientation*	*7/5/2018*

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		training packet. This will be monitored via weekly meetings between Program Administrator and Clinical Supervisor team to address pending clients and assignment.	
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. 03. Fire and Safety Standards. 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)	In review of documentation, there was no annual inspection by the local fire authority as would have been due by 10/20/17 until 5/23/18. This exceeds the requirement that the inspection be done annually.	*1. Annual fire inspections will be completed. Internal audits will be completed monthly by the QA team in cooperation with the Facilities Manager to review due dates of inspections for all facilities operated by SAFS. Please also see the attached Preventative Maintenance and Safety Policy.* *2. This action will be completed for all office locations on a monthly basis.* *3. QA team in cooperation with the Facilities Manager will be responsible for this corrective action.* *4. This will be added to the RAC audit completed by the QA team monthly.*	*6/26/2018*

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16.03.21.600.02.a.i. 600. 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. 02. Requirements for Participants Three to Twenty-One. For participants ages three (3) to twenty one (21), the following applies: a. For participants who are children enrolled in school, the local school district is the lead agency as required under Individuals with Disabilities Education Act (IDEA), Part B. The DDA must inform the child's home school district if it is serving the child during the hours that school is typically in session. i. The DDA participant's record must contain an Individualized Education Plan (IEP), including any recommendations for an extended school year. (7-1-11)	In review of documentation, for 1 of 4 participants reviewed, there was no documentation of receiving the child's Individualized Education Plan (IEP). For example: For Participant #3, the most current IEP on record was for the 2016 school year. THIS IS A REPEAT DEFICIENCY	*1. The agency has added requesting each participants IEP to the plan and review completion checklist (see attached) that is implemented by the Administrator and Clinical Supervisors. Additionally, IEP requests will be added to the task completion calendar within the EMR for each participant. This tool will provide reminders 1 week prior to an IEP expiration date directly to the Clinical Supervisor to remind them to request the IEP.* *2. This action will be completed for all participants, not only the ones identified as deficient in the review.* *3. Program Administrator in cooperation with the Clinical Supervisor team will be responsible for this corrective action.* *4. Checklist is to be submitted to the Program Administrator along with all supporting documentation (i.e. IEP requests, IEPs, certificates of receipt, etc.) and will be reviewed on a monthly*	*7/5/2018*

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		basis. Additionally, this item will be added to the internal audit to be performed by the QA Department.	
16.03.21.600.02.a.ii. 600. 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. 02. Requirements for Participants Three to Twenty-One. For participants ages three (3) to twenty one (21), the following applies: a. For participants who are children enrolled in school, the local school district is the lead agency as required under Individuals with Disabilities Education Act (IDEA), Part B. The DDA must inform the child's home school district if it is serving the child during the hours that school is typically in session. Ii. The DDA must document that it has provided a current copy of the child's plan of service to the child's school. (7-1-11)	In review of documentation for 4 of 4 participants reviewed, there is no documentation of the agency providing the child's school with a copy of the their implementation plans as the agency's generated plan of service. THIS IS A REPEAT DEFICIENCY	*1. The agency has added sending a copy of the participant's plan to the plan and review completion checklist (see attached) that is implemented by the Administrator and Clinical Supervisors..* *2. This action will be completed for all participants, not only the ones identified as deficient in the review.* *3. Program Administrator in cooperation with the Clinical Supervisor team will be responsible for this corrective action.* *4. Checklist is to be submitted to the Program Administrator along with all supporting documentation (i.e. printed email confirmation of sending plan, etc.) and will be reviewed on a monthly basis . Additionally, this item will be added to the internal audit to be performed by the QA Department.*	*7/5/2018*

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16.03.21.601.01.d. 601. 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. 01. General Records Requirements. Each participant record must contain the following information: d. Profile sheet containing the identifying information reflecting the current status of the participant, including residence and	In review of documentation, for 1 of 4 participants reviewed, the profile sheet did not include the participant's special medical needs. For example: Participant #1 requires glasses and a Proloque for communication. This was indicated in the record but not identified on the intake or electronic profile sheet (which were both reviewed for consideration as the required profile sheet)	*1. The agency will add Special Medical Needs and Assistive Technology information to each client's EMR profile page.* *2. This will be added to each participant's profile page, not just those identified in the survey. If the client does not have Special Medical Needs or Assistive Technology, this section will show "None".* *3. The Program Administrator will work with the QA Department to implement this corrective action.* *4. This corrective action will be monitored on a monthly basis, and each profile page will be updated with new information at least annually upon completion of annual paperwork. Any updates throughout the year will be made when the agency is made aware of such changes.*	*7/5/2018*

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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)			
16.03.21.900. Each DDA defined under these rules must develop and implement a quality assurance program. (7-1-11)	Based on review of documentation, the DDA was determined to have not implemented a complete quality assurance program. For example: For 3 of 4 participant records reviewed, there was no indication of an internal file review to ensure compliance with rules. There are 5 repeat deficiencies from the last certification survey.	*1. Client file reviews will be conducted using an internal audit tool. Using this tool, each client file will be reviewed at least once per calendar year. Additionally, file reviews will be added to the EMR task completion calendar for each participant. This function will send alerts that a file review is due for each participant 2 weeks prior to their plan end date.* *2. This will be completed for all participants, not only those identified in the survey.* *3. The Program Administrator in cooperation with the QA Department will be responsible for the implementation of this corrective action. The QA*	*7/5/2018*

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		department will be responsible for the review of client files, and the Program Administrator will be responsible for ensuring each client's file was reviewed at least once by the end of their service plan year. *4. Program Administrator will receive all file audits and will report within the QA Program annually.*	
16.03.21.900.02.d. 900. Each DDA defined under these rules must develop and implement a quality assurance program. 02. Quality Assurance Program Components. Each DDA's written quality assurance program must include d. A method for assessing participant satisfaction annually including minimum criteria for participant response and alternate methods to gather information if minimum criteria is not met; (7-1-11)	In review of documentation, for 2 of 4 participants served there is no indication that there was a method for assessing their satisfaction with services annually. For example, Participants #1 and 3 had no documentation of attempts to gain input on their satisfaction with services.	*1. Unsuccessful attempts to complete quality call back surveys will be documented and retained within the QA Program of the DDA.* *2. This will be implemented for all participants within the agency, not only those identified in the survey.* *3. The Clinical Supervisor team is responsible for the completion and documentation of quality call back surveys. The Program Administrator will be responsible for tracking within the QA Program.* *4. The Program Administrator will track call back survey completion monthly.*	*7/5/2018*

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		Clinical Supervisors will ensure attempts are made to complete the survey with each family at least annually.	

Agency Representative & Title: Hailey Scott, BSW HI * By entering my name and title, I agree to implement this plan of correction as stated above.	**Date Submitted:** 7/2/2018
Department Representative & Title: * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** 7/2/2018