IDAHO DEPARTMENT OF HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

Agency:	Human Service Alliance, Inc.	**Region(s):**	3
Agency Type:	Developmental Disabilities Agency	**Survey Dates:**	10/13/15-10/14/15
Certificate(s):	3HUMSER071	**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)
16.03.21.125 125. An agency must request renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification. The request must contain any changes in optional services provided and outcomes of the internal quality assurance processes required under Section 900 of these rules. (7-1-11)	The agency did not request renewal of its certificate less than ninety (90) days before the expiration date of their certificate.	1. *The Program Manager and Admin completed the request, however, it was not sent in. The Program Manager and Admin will work together and complete the request, in a timely manner, and insure proof it was either emailed or faxed within the required 90 days.* 2. *N/A* 3. *Program Manager and Admin* 4. *The Program Manager and Admin will continue to monitor certification expiration dates and assure the request for renewal is sent via fax or email and*	*12/1/2015*

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)
		maintain proof in their records.	
16.03.21.601.01.c. 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.	Review of agency documentation revealed that 1 out of 2 participant records reviewed lacked the results of a psychological or psychiatric assessment. For example: Records for participant #2 revealed that the participant has had a psychological evaluation completed; however the assessment was not maintained in the participant's record.	*1. The Program Manager will work with clerical staff on what should and should not be filed. The Program Manager and DS are working with the TSC, family, and ICDE on obtaining a copy of the current psyc eval. We will continue to work with the team to obtain the psyc eval.* *2. The Program Manager reviewed all participant records who require a psyc eval. All other participants have evals on record in their files. As previously stated the Program Manager will provide further training to clerical staff on what should be archived and what should remain in the participant files.* *3. The Program Manager* *4. We currently have a tracking system in place. However, the Program Manager will provide further training to insure evals required for DD services remain in the participant's books regardless of the date they were completed.*	*12/1/2015*

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01. General Records Requirements. Each participant record must contain the following information: c. When a participant has had a psychological or psychiatric assessment, the results of the assessment must be maintained in the participant's record. (7-1-11)			

Agency Representative & Title: Chris Johnson, Admin * By entering my name and title, I agree to implement this plan of correction as stated above.	**Date Submitted:** 11/9/2015
Department Representative & Title: Kerrie Ann Hull, LMSW * By entering my name and title, I approve of this plan of correction as it is written on the date identified.	**Date Approved:** 11/13/2015