### Rule Reference/Text

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.

### Findings

The agency policy and procedure for employees lacked rule requirements. For example: The policy and procedure for direct contact with participants lacked documentation it addresses infected skin lesions while on duty.

### Agency’s Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)

1. What actions will be taken to correct the deficiency?
   
   *Wording was added to the policy and to the orientation document for employees to cover rule requirements. The words “infected skin lesions” were added. All policies will be reviewed annually to ensure they encompass DDA rule requirements.*

   The plan should address agency systems and not just the examples specified in the survey report.

2. What will the agency do to identify any other participants, staff, or systems that

### Date to be Corrected (mm/dd/yyyy)

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DDA/ResHab Certification - Statement of Deficiencies

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<tr>
<th>Rule Reference/Text</th>
<th>Findings</th>
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<th>Date to be Corrected (mm/dd/yyyy)</th>
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<td>may be affected by the deficiency? No staff or participants were affected. If identified, what corrective actions will be taken? N/A 3. Who will be responsible for implementing each corrective action? The Administrator facilitated the changes and the Human Resource staff will review the documents with all current staff and any new hires. 4. How will the corrective actions be monitored to ensure the problem is corrected and does not recur? All staff will sign the revised document regarding communicable diseases and be given copies of the revised policy by 5/3/18. All policies will be reviewed annually and verified to cover rule requirements.</td>
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DDA/ResHab Certification - Statement of Deficiencies

| Agency Representative & Title: Denise Childs, Director of Facility Based Services | Date Submitted: 4/23/2018 |
| Department Representative & Title: Pam Loveland-Schmidt | Date Approved: 4/24/2018 |

* By entering my name and title, I agree to implement this plan of correction as stated above.

* By entering my name and title, I approve of this plan of correction as it is written on the date identified.